Dear **TRACY VASQUEZ**:

Thank you for choosing Aflac as your supplemental insurance carrier. We appreciate your business.

Enclosed is a packet containing the documents necessary to establish a cafeteria plan. Please carefully review the Flexible Benefits Plan Document and Summary Plan Description (SPD), and verify that all of the information about benefits offered, eligibility, plan administration, and funding is correct for the plan that you will be administering.

The Flexible Benefits Plan itself is not intended to be an ERISA plan required to have an ERISA summary plan description (SPD) even though many of the underlying benefits will be subject to ERISA and required to have their own SPDs. Nonetheless, we refer to the Flexible Benefits Plan summary as an SPD for ease of reference. Please notice that the sample Flexible Benefits Plan Document refers to the Summary Plan Description with regard to many of the plan's provisions. This approach eases administration and reduces the risk of inconsistency between the Flexible Benefits Plan Document provisions and the Summary Plan Description provisions. You should also note that these documents are only sample documents typical of a plan intended to qualify as a Section 125 Cafeteria Plan with the terms and conditions thereof, and that they may need to be modified to conform to your individual circumstances.

Aflac has developed these sample documents with legal counsel, and it is Aflac's intent and belief that the documents in form satisfy the requirements of IRS Code Section 125. However, Aflac is not in the business of offering legal counsel or tax advice, and thus, Aflac cannot and does not make any representations about the legal or tax effect of plans adopted based on the sample provisions in these documents upon any particular employer. Therefore, it is each employer's responsibility to determine, with the assistance of the employer's own legal counsel, the suitability of these particular documents, and the legal and tax effect of these plan documents upon the employer and its employees.

Since Aflac has no control over your subsequent modification and/or administration of the plan and since the Internal Revenue Service will not render an opinion as to a plan's qualified status under IRS Code Section 125, Aflac makes no representation (express or implied) as to your plan's qualification under IRS Code Section 125 and related provisions as adopted and subsequently amended by you.

You, as sponsoring employer, bear sole responsibility for amending your plan (as necessary) to comply with existing tax law and future changes, for meeting all reporting and disclosure requirements imposed by applicable law, and for the daily administration of your plan. As such, we recommend you review the following important information:

Important Compliance Issues

Nondiscrimination Testing. Failure to satisfy these requirements will cause adverse tax consequences to highly compensated and/or key employees and could possibly disqualify the plan.

Qualified Premiums. Certain insurance premiums that cover the employee (or in the case of accident or health coverage other than life insurance, the employee and tax dependents/family) may be included in the Flexible Benefits Plan Documents if adopted as part of your benefits plan. These include the following:

- Group Term Life Insurance covering the employee (eligible under IRS Code Section 79) that is equal to or less than $50,000 (Life insurance coverage on dependents is not eligible for pre-tax treatment.)
- Accidental-Death and Dismemberment (AD&D) coverage
- Group or individual dental, hospital indemnity, cancer insurance, vision, hearing, and other qualified accident and health premiums
- Group (but not individual) major medical coverage.

Effects on taxes. When including health, medical, and disability income policies within the Flexible Benefits Plan, paying for coverage on a pre-tax basis may cause certain insurance benefit payments to be subject to federal and state taxes. Accident benefits will generally be tax free. Disability benefits will be taxable if the employer paid all or part of the premium or if employees funded the coverage on a pre-tax (salary reduction) basis through the cafeteria plan. With regard to supplemental health benefits, when the premium amounts are paid on a pre-tax basis (i.e., employer paid or employee pre-tax salary reduction) benefits are excludable to the extent of unreimbursed medical care expenses. However, benefit payments (combining supplemental cash indemnity benefits as well as the total of actual medical reimbursement benefits from health and medical policies/plans) that exceed the amount of unreimbursed medical expenses would be taxable.

Continuation of Coverage. Health benefits offered through a cafeteria plan may be subject to the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Contact your COBRA administrator for more details.

Continuation of Coverage During FMLA Leave. Health benefits (including health FSA benefits) offered through a cafeteria plan are subject to the continuation provisions, and other all benefits may be subject to the reinstatement provisions of the Family and Medical Leave Act of 1993 ("FMLA"). See Question 13 of the SPD for more details on coverage offered under the Plan during FMLA leave.

HIPAA Privacy and Security Requirements. During the course of providing participants with health coverage under a health FSA (if applicable), the plan will have access to information about covered individuals that is deemed to be protected health information (PHI) by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While the Flexible Benefits Plan itself is not a health plan, HIPAA Privacy and Security Rules apply to health plans that you may offer through the Flexible Benefits Plan, including health FSAs. The employer is solely responsible for ensuring that the employer and the plan comply with HIPAA's rules. If you are a Health FSA plan sponsor, Aflac is enclosing a privacy packet (Important Privacy Information) with an overview of the HIPAA Privacy Rules. Aflac is also including general HIPAA language in the sample documentation (Section 10.18 of the Flexible Benefits Plan Document and, for full plans only, Appendix II to the SPD). The privacy information provided in this cafeteria plan packet is not provided with the intent of fully satisfying your HIPAA obligations. HIPAA's Privacy Rules are complicated, and their effects may vary for each plan. Please consult with your legal counsel regarding your required actions and plan language for your company and plan to achieve HIPAA compliance.

Plan Administration and Maintenance

Plan Document Maintenance. Each plan sponsor is responsible for reviewing the sample Flexible Benefits Plan Documents and adopting a plan that is consistent with the desired plan design and any legal requirements that may apply in your state. For your added convenience and your future reference, the most current version of the sample cafeteria plan packet will be available on the Aflac Web site (aflac.com). The sample cafeteria plan documents will be updated periodically to correspond with changes in applicable laws.

Summary Plan Description. All URM FSA plan sponsors are required to give each eligible employee a copy of the SPD within 120 days of the effective date of the initial plan year and within 90 days of the effective date of coverage for all subsequent plan years. If an employer makes a change in the plan, the employer must provide employees with a summary of the changes [a Summary of Material Modifications (SMM)] within 60 days of the adoption of the change. **Note:** While the plan and related documents are copyrighted, Aflac gives you limited permission to copy the documents as necessary for distribution to your employees for use solely in the operation of your own cafeteria plan.

Payroll Instructions. Payroll instructions will be thoroughly reviewed with you or your payroll representative by your Aflac agent.

Employee Eligibility and Elections

New Employees. For details regarding employee eligibility, please refer to Section 2.01 of the Flexible Benefits Plan Document.

Special Rule for URM Eligibility. Current tax rules require that the URM be extended solely to employees who are eligible for major medical coverage that you offer.

Employees of Affiliated Companies. If the requirements of IRS Code Section 414(b), (c), (m), or (o) are satisfied, the employees of an affiliated company may be able to participate in this plan. Please consult with your tax advisor concerning the potential impact of IRS Code Section 414(b), (c), (m), and (o).

Benefit Election Changes. Employees generally cannot change their election to participate in the pre-tax contribution payment option or vary the pre-tax contributions they have selected. For details regarding important exceptions to this general rule, please refer to Section 3.04 of the Plan Document and Question 9 of the SPD.

Due to the complexity of cafeteria plans, we recommend that you consult with your accountant, attorney or other tax advisor concerning the plan provisions, administration, and operation before executing the Plan Documents. Remember that your cafeteria plan will not be effective until your plan is adopted. **NOTE: The Flexible Benefits Plan Documents you adopt must be signed PRIOR TO THE EFFECTIVE DATE.** If your Flexible Benefits Plan Document is executed after the effective date, the IRS may attempt to challenge the qualified status of your plan. We recommend that you retain any evidence that you have showing that your plan was adopted and that enrollments were completed prior to the effective date. If no pre-tax deductions have been made thus far, you may consider changing the start date of your cafeteria plan.

Aflac will use its best efforts to provide employers with information from time to time about developments concerning Section 125 Cafeteria Plans. However, for reasons stated above, it is the employer's responsibility to maintain the qualified status of the Section 125 Cafeteria Plan in form and in operation.

We value the trust you have placed in us. If you need our help or if you have any questions, please call us toll-free at 1-800-992-3522. Our customer service representatives are here to assist you Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Sincerely,

Aflac New Account Setup Department

Enc.

FLEXIBLE BENEFITS PLAN ACCOUNT ESTABLISHMENT INFORMATION AND CHECKLIST

Important steps for establishing your Flexible Benefits cafeteria plan

➢ **For all Flex One Cafeteria Plans:**

☐ **Employer's Acknowledgment:** After executing and adopting your Plan Document, please sign and date the Employer's Acknowledgment in order to officially adopt and execute your plan. Place the signed and dated Employer's Acknowledgment in your files with a copy of your Plan Document Packet.

☐ **Summary Plan Description:** A copy must be provided to each eligible employee as soon as possible (prior to enrollment is preferred).

Important information for administering your cafeteria plan

☐ **Plan Identification Number (PIN):** The Department of Labor regulations require that welfare benefit plan sponsors assign a three-digit PIN number to their welfare plans (including URMs offered through cafeteria plans) for identification purposes. Numbering for welfare plans should begin at 501 and proceed consecutively. If you have other plans (e.g., health coverage) assign the next open number. This number must be indicated on the Summary Plan Description.

☐ **Affiliated Companies:** Only those companies described in Section 414(b), (c) or (m) of the Internal Revenue Code can participate in a cafeteria plan. In addition, if there are affiliated companies, nondiscrimination testing may be affected by affiliated companies. Consult your tax advisor.

☐ **5500 and Summary Annual Report:** While there is no Form 5500 filing requirement for the cafeteria plan itself, welfare benefit plans subject to ERISA, which may include URM flexible spending accounts (FSAs), must file Form 5500 and any applicable schedules (unless an applicable exception applies) - even if the benefits are funded through the cafeteria plan. You should contact your tax or legal advisor to find out if your Plan is subject to ERISA and whether filing a Form 5500 (including any applicable schedules) for your Plan is required.

☐ **Nondiscrimination Testing:** Tax nondiscrimination tests, including the Eligibility, Contributions and Benefits, and Concentration of Benefits tests, must be performed. In the case of Flexible Spending Accounts (FSAs), nondiscrimination tests must be performed for each FSA.

☐ **Health FSAs (URM):** You, as Plan Sponsor, are responsible for ensuring that the URM FSA maximum, is in line with your risk tolerance. Remember, IRS Notice 2005-42 allows an additional 2 ½ month period (i.e., grace period) in which to incur additional medical expenses, and IRS Notice 2013-71 allows a carryover option of up to $500 unused health FSA funds. The grace period option and carry over option cannot be offered simultaneously. If you have selected either the grace period feature or the carry over feature, the Aflac sample plan incorporates language for either option. Also, remember that participant salary reductions are subject to dollar limitations set forth by the IRS which may be adjusted annually.

☐ **Eligibility:** Any eligibility waiting period for pre-tax benefits should generally be uniformly applied. You, as Plan Sponsor, are responsible for ensuring that the eligibility period listed in your plan documents does not violate Internal Revenue Service or Department of Labor regulations.

☐ **Privacy:** You, as Plan Sponsor, are responsible for ensuring that your plan does not violate the privacy requirements set forth in the Gramm-Leach-Bliley Act of 1999 (GLB) and, if applicable, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), and the Final HIPAA Omnibus Rule. GLB regulates the privacy of financial information and applies to all Flexible Benefit plans (see the attached “Privacy Practices”). HIPAA protects privacy by regulating the disclosure of protected health information (PHI), so Plan Sponsors of only health FSAs must comply with HIPAA privacy requirements (health FSA Plan Sponsors only, see the attached “Important Privacy Information”).

☐ **HSA Documentation:** The sample Flexible Benefits Plan document includes language to enable pre-tax contributions for health savings accounts (HSAs). Any HSA will require additional documentation that must be arranged through an HSA trustee or custodian. Aflac does not serve as an HSA custodian or trustee, and does not provide such documentation.

*** If you have any questions regarding this checklist, please contact Aflac toll-free at (1-800-992-3522), and one of our Customer Service Representatives can assist you Monday through Friday from 8:00 A.M. to 7:00 P.M. EST.**

Employer Acknowledgment: Your signature verifies that an Aflac sales representative has reviewed the above information with you.

Signature	Printed Name	Date

PRIVACY PRACTICES

Protecting the privacy and confidentiality of employer and participant information through our POP cafeteria plan services is very important to American Family Life Assurance Company of Columbus (Aflac) and American Family Life Assurance Company of New York (Aflac New York). Throughout this notice when we use the name "Aflac," we will be referring to both organizations. Accordingly, we strive to comply with each of the following practices in everything we do:

- **We do not sell, rent, lease or otherwise disclose personal information about employers or employees of an employer for purposes unrelated to our products and services.** The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents and third parties as required to allow them to help us develop and provide our insurance and employee benefit products and services.

- **We work to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that the personal information of the employer and employees of the employer are properly gathered, stored and processed. We also work to maintain the security of, and internal and external access to, the personal information of our customers through the use of technology and our business practices.

- **We expect our agents and employees to respect the personal information of our customers.** Aflac has business policies and practices in place to help ensure that its employees and agents carry out these practices and otherwise protect the personal information of our customers. Both employees and agents are subject to censure, dismissal or termination for violation of these policies.

These Privacy Practices apply to our U.S. customers. Due to legal and cultural differences, our practices may vary outside the United States.

PRIVACY NOTICE

Aflac and our agents provide this notice to let you know about the current privacy practices of Aflac, and our agents. **You do not need to do anything in response to this notice. This notice is merely to inform you about how we safeguard your information.**

Collection of Information

As part of Aflac's normal operating procedures, Aflac (and our agents acting on our behalf) needs to obtain information from both the employer and the participant to determine an individual's eligibility for our products and services, and to perform our insurance functions. Aflac and our agents may collect nonpublic personal information (which includes both nonpublic personal financial information and nonpublic personal health information) about Aflac customers, including but not limited to:

- Information from the employer or the participant (including names, addresses, Social Security numbers, financial and marital status, and health and dependent child-care information);

- Information about the employer or the participants' transactions with Aflac or our agents (including claims, payment information and banking information);

- Information from consumer reporting agencies (including creditworthiness and credit history); motor vehicle records agencies (including accident reports and violations); investigators (including information regarding general character and participation in hazardous activities); insurance support organizations such as the Medical Information Bureau, Inc. (including claims, and health and insurance application histories); and the customers' health care providers (including health history), employers (including salary and benefits information) and family members.

Disclosure of Information

Aflac may disclose the nonpublic personal financial information we collect, as described above, as well as information about your transactions with us (such as your policy coverage, election amounts, premiums and payment history) to our agents or other third parties who perform services for us or functions on our behalf, including the marketing of Aflac services. Aflac may also disclose the nonpublic personal financial information we collect to other third parties as authorized by you, or as required or permitted by law.

Our agents will make disclosures of the employer or the participants' nonpublic personal financial information only while acting on Aflac's behalf and, furthermore, will make such disclosures only as Aflac itself is permitted to make.

Neither Aflac nor our agents will use or share with other parties any nonpublic personal health information about our customers for any purpose other than disclosures for the performance of insurance functions by Aflac or on our behalf, disclosures that are permitted or required by law, or to which the customer consents.

Neither Aflac nor our agents will further disclose any nonpublic personal information about a former customer of Aflac other than as may be required or permitted by law.

Confidentiality and Security

Aflac and our agents will safeguard, according to strict standards of security and confidentiality, any information we collect, receive or maintain about Aflac's customers. Aflac maintains administrative, technical and physical safeguards to ensure the security and confidentiality of our customer information and records; to protect against anticipated threats or hazards to such records; and to protect against unauthorized access to or use of such information or records.

Internally, Aflac limits access to our customers' information to only those employees who need access to the information to perform their job functions. Employees who misuse information are subject to disciplinary actions. Externally, we do not disclose customer information to any third parties unless we have previously informed the customer of the disclosure, have been authorized to do so by the customer, or are required or permitted to make the disclosure by law or our regulators.

NOTICE OF INFORMATION PRACTICES

Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia require insurers and agents to describe their information practices in addition to providing a Privacy Notice. There is significant overlap between the two notices, but in general our Information Practices include the following: Aflac may obtain information about you and any other persons proposed for insurance. Some of this information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. Residents of these states have the right to access and correct the information collected about them except information that relates to a claim or to a civil or criminal proceeding. They also have the right to receive the specific reason for an adverse underwriting decision in writing. If you wish to have a more detailed explanation of our information practices required by your state, please submit a written request to: Aflac Worldwide Headquarters, ATTN: Client Services, 1932 Wynnton Road, Columbus, Georgia 31999.

NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION

If you would like a copy of Aflac's Notice of Privacy Practices - Protected Health Information, issued pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), copies are available by sending a written request to: Aflac Worldwide Headquarters, ATTN: Privacy Office, 1932 Wynnton Road, Columbus, Georgia

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FLEXIBLE BENEFITS PLAN

PREAMBLE

The Employer hereby establishes a Flexible Benefits Plan ("Plan") for its Employees for purposes of providing eligible Employees with the opportunity to choose from among the fringe benefits available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125. The Dependent Care Expense Reimbursement Plan ("DDC") is intended to qualify as a Code Section 129 dependent care assistance plan, and the Medical Care Expense Reimbursement Plan ("URM") is intended to qualify as a Code Section 105 medical expense reimbursement plan. Although printed within this document, the DDC and URM Plans are separate written plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Sections 105 and 129 of the Code and all applicable provisions of ERISA. The DDC and the URM are available only if designated as a Benefit Plan or Policy in the Summary Plan Description (SPD).

FLEXIBLE BENEFITS PLAN

ARTICLE I - DEFINITIONS

1.01 **"Affiliated Employer"** means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m) of the Code.

1.02 **"After-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Premium Deduction Authorization (PDA) after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Plans or Policies available under the Plan.

1.03 **"Anniversary Date"** means the first day of any Plan Year.

1.04 **"Benefit Plan(s) or Policy(ies)"** means those Qualified Benefits available to a Participant under this Plan as set forth in the SPD, as amended and/or restated from time to time.

1.05 **"Board of Directors"** means the Board of Directors or other governing body of the Employer (the "Board"). The Board, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

1.06 **"Change in Status"** means any of the events described in the SPD, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year. Note: See the SPD for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

1.07 **"Code"** means the Internal Revenue Code of 1986, as amended.

1.08 **"Compensation"** means the cash wages or salary paid to an Employee by the Employer.

1.09 **"Dependent"** means any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a) except as otherwise set forth in Code Section 21 (for Dependent Care FSA purposes, if offered under the Plan), Code Section 105 (for health plan purposes, if offered under the Plan), and Code Section 223 (for Health Savings Account purposes, if offered under the Plan). Also, for DDC purposes, a Dependent shall also be defined as in Code section 21(e)(5) (i.e., dependent of the custodial parent as defined in Code Section 152(e)). Children, as defined in Code Section 152(f)(1), are considered Dependents until age 26 (regardless of residence, marital status, tax dependent status, student status, or other factors).

1.10 **"Dependent Care Reimbursement"** shall have the meaning assigned to it by Section 5.01 of the Plan.

1.11 **"Earned Income"** means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includable in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

1.12 **"Effective Date"** of this Plan is the effective date set forth in the SPD.

1.13 **"Eligible Employment-Related Expenses"** means those Qualifying Employment-Related Expenses (as defined below) paid or incurred incident to maintaining employment after the date of the Employee's participation in the DDC and during the Plan Year (plus any applicable grace period extension as described in the SPD), other than amounts paid to:

(a) an individual with respect to whom a Dependent deduction is allowable under Code Sec. 151(c) to the Participant or his Spouse;

(b) the Participant's Spouse; or

(c) a child of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

1.14 **"Eligible Medical Expenses"** means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the URM and during the Plan Year (plus any applicable grace period extension or carryover option as described in the SPD) to the extent that the expense satisfies the conditions set forth in the Summary Plan Description and are for "medical care" as defined by Code Section 213(d). For purposes of this Plan, the following expenses are not considered "Eligible Medical Expenses" even if they otherwise constitute "medical care" under Code Section 213(d): i) expenses for qualified long term care services (as defined in Code § 7702B(c)); and ii) expenses incurred for health insurance premiums; and iii) over-the-counter drugs and medicines that are not prescribed by a physician. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

1.15 **"Employee"** means any individual who is considered to be in a legal employer-employee relationship with the Employer for federal tax-withholding purposes. Such term includes "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by the Employer. The term "Employee" shall not include any leased employee (as that term is defined in Code Section 414(n)) or any self- employed individual who receives from the Employer "net earnings from self-employment" within the meaning of Code Section 401(c)(2) unless such individual is also an Employee.

1.16 **"Employer"** means the Employer and the Affiliated Employers named in the SPD provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only that entity named on the first line of the Plan Information Summary of the SPD, and not any Affiliated Employer. Affiliated Employers who sign the Plan Information Summary and/or otherwise adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

1.17 **"ERISA"** shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.18 **"Health Care Reimbursement"** shall have the meaning assigned to it by Section 5.01 of the Plan.

1.19 **"Highly Compensated Individual"** means an individual defined under Code Section 125(e) or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.20 **"Key Employee"** means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.

1.21 **"Nonelective Contribution(s)"** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Spouse and Dependents, if applicable, under one or more of the Benefit Plan(s) or Policy(ies) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Plan(s) or Policy(ies) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the SPD or enrollment material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Benefit Plans or Policies offered under the Plan in a manner set forth in the SPD of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.

1.22 **"Participant"** means an Employee who becomes a Participant pursuant to Article II.

1.23 **"Plan"** means the Flexible Benefits Plan, the SPD (defined in Section 1.35 herein) and (if applicable) the related Trust created by this document.

1.24 **"Plan Administrator"** means the person(s) or Committee identified in the SPD that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.25 **"Plan Year"** shall be the period of coverage set forth in the SPD (as extended by any applicable grace period as set forth in the SPD).

1.26 **"Premium Deduction Authorization" or "PDA"** Means the actual or deemed agreement pursuant to which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Plans or Policies with Pre-tax or

After-tax contributions and/or Benefit Credits (if offered under the plan) in accordance with Article III herein. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the PDA may be maintained on an electronic database in accordance with all applicable federal and/or state laws.

1.27 **"Pre-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Premium Deduction Authorization before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plans or Policies available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Plan or Policy afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.28 **"Qualified Benefit"** means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 124, 127, or 132 and any other benefit permitted by the Income Tax Regulations (i.e., any life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Sec. 79). Notwithstanding the previous sentence, benefits prohibited under Section 125(f) (e.g. qualified health plans (as defined in Section 1301 of the Affordable CareAct) that are purchased in the individual market through a public Exchange and long-term care insurance) are not "Qualified Benefits".

1.29 **"Qualifying Employment-Related Expenses"** means those expenses that would be considered to be employment-related expenses under Section 21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services.

1.30 **"Qualifying Individual"** means an individual defined as a “Qualifying Individual” in the Summary Plan Description.

1.31 **"Qualifying Services"** means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed which are performed:

(a) in the Participant's home; or

(b) outside the Participant's home for (1) the care of a Dependent of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six (6) individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

1.32 **"Reimbursement Account(s)” or “Account(s)"** shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Reimbursement (as defined in Section 1.18 herein) and Dependent Care Reimbursement (as defined in Section 1.10 herein) to the extent adopted by the Employer as set forth in the SPD. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

1.33 **"Spouse"** means an individual who is legally married to a Participant (and who is treated as a spouse under the Code), but for purposes of the Dependent Care Reimbursement Plan provisions, shall not include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.

1.34 **"Student"** means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.

1.35 **"Summary Plan Description" or "SPD"** means the document attached as Attachment I to the Plan document that describes the term of Plan not set forth herein. The SPD and all applicable appendices are incorporated hereto by reference.

1.36 **"Trustee"** (if applicable) means the person(s) or institution (and their successors) named on the signature page attached hereto, who have assented to being so named by their signature to this Agreement, otherwise empowered to hold and disburse the funds that are created hereunder.

ARTICLE II - ELIGIBILITY AND PARTICIPATION

2.01 **Eligibility to Participate.** Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Plan as of any applicable entry date set forth in the SPD. The provisions of this Article are not

intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Plans or Policies and the terms of eligibility and participation for the Benefit Plan(s) or Policy(ies) offered under the Plan shall be subject to the requirements specified in the governing documents of the Benefit Plans or Policies.

2.02 Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD.

2.03 Eligibility to Participate in Reimbursement Accounts. Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in the Reimbursement Accounts, if adopted by the Employer, on the date set forth in the SPD. Participation in the Reimbursement Accounts shall be effective on the date set forth in the SPD.

2.04 Qualifying Leave Under FMLA. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Plans or Policies that provide health coverage (including URM benefits to the extent offered under the Plan) on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave, and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.05 Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, the election change rules in Section 3.04 will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

ARTICLE III - BENEFIT ELECTIONS

3.01 Election of Contributions. A Participant may elect any combination of Pre-tax Contributions or After-tax Contributions (as set forth in the SPD) to fund any Benefit Plan or Policy available under the Plan, provided that only Qualified Benefits may be funded with Pre-tax Contributions. The Employer may, but is not required, to allocate Non-elective Contributions to one or more Benefit Plans or Policies offered under the Plan and to the extent set forth in the SPD or enrollment material, may allow the Participants to allocate his allotted share of Nonelective Contributions among the various Benefit Plans or Policies in a manner set forth in the SPD or enrollment material.

3.02 Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Plan as of the Effective Date should complete, sign and file a PDA with the Plan Administrator during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date. The elections made by the Participant on this initial PDA shall be effective, subject to Section 3.04, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Plan's Waiting Period**. An Employee who becomes eligible to become a Participant in this Plan after the Effective Date should complete, sign and file a PDA with the Plan Administrator (or its designated third party administrator as set forth on the PDA) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Plan as set forth in the SPD. Coverage under the component Benefit Plans or Policies will be effective in accordance with the governing provisions of such Benefit Plans or Policies.

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a PDA in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.03 or 3.04.

3.03 Annual Election Period. Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the Annual Election Period. The date that the Annual Election Period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

3.04 Change of Elections. A Participant shall not make any changes to the Pre-tax Contribution amount or, where applicable, to the Participant's elected allocation of Nonelective Contributions except for election changes permitted under this Section 3.04, and for changes made during the Annual Election Period (Section 3.03), changes caused by termination of employment (Section 3.05) and changes pursuant to the Family and Medical Leave Act (Section 2.04).

Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later. The circumstances under which a Participant may change his election under this Plan are set forth in the SPD.

3.05 Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Pre-tax Contributions. Except as provided below, if revocation occurs under this Section 3.05, no new election with respect to Pre-Tax Contributions may be made by such Participant during the remainder of the Plan Year. Rules governing elections for former participants rehired during the same Plan Year shall be set forth in the SPD.

ARTICLE IV - BENEFIT FUNDING

4.01 Source of Benefit Funding. The cost of coverage under the component Benefit Plans or Policies shall be funded by the Participant's Pre-tax and/or After-tax Contributions and/or any Nonelective Contributions provided by the Employer. The required contributions for each of the Benefit Plans or Policies offered under the Plan shall be made known to employees in enrollment materials. Pre-tax or After-tax Contributions (as elected by the Employee on the PDA) shall equal the contributions required from the Participant less any available Nonelective Contributions allocated thereto by the Employer, or where applicable, the Participant for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Plans or Policies elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pre-tax Contributions or After-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pre-tax Contributions plus any Nonelective Contributions made available by the Employer for Benefit Plan(s) or Policy(ies) offered under this Plan shall not exceed the aggregate cost of the Benefit Plan(s) or Policy(ies) elected by the Employee.

4.02 Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pre-tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

4.03 Health Care Reimbursement. To the extent offered under the Plan, each Participant's URM will be credited for Health Care Reimbursement with amounts withheld from the Participant's Compensation and any Nonelective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with Article V of this document. The entire amount elected by the Participant on the PDA as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed to the participant for Expenses incurred during the Plan Year (plus any grace period or carryover option as set forth in the SPD) shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Account (provided that the periodic contributions have been made). Thus, the maximum amount of Health Care Reimbursement at any particular time during the Plan Year will not relate to the amount that a Participant has had credited to his URM. In no event will the amount of Health Care Reimbursements in any Plan Year (plus any grace period, if applicable, as set forth in the SPD) exceed the annual amount specified for the Plan Year in the PDA for Health Care Reimbursement. Unless the Plan provides for the carry-over option of up to $500 of unused health FSA funds, any amount in excess of the pre-determined carry-over limit credited to the Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Health Care Reimbursement within the grace period (if applicable) and Run-Off period set forth in the SPD. The Plan cannot simultaneously provide for both the grace period option and the carryover option. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor (“DOL”) or Internal Revenue Service (“IRS”) regulations. The maximum annual reimbursement under the URM shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD. In no event will Participants’ PDAs include contributions that exceed the dollar limitations set forth by the IRS.

4.04 Dependent Care Reimbursement. To the extent offered under the Plan, each Participant's DDC will be credited for Dependent Care Reimbursement with amounts withheld from the Participant's Compensation, and any Nonelective Contributions allocated thereto by the Employer or where applicable, the Participant. The Dependent Care Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with Article V of this document. In the event that the amount in the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months within the same Plan Year, to be paid out as the Dependent Care Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Account for any Plan Year. Any amount allocated to the Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Dependent Care Reimbursement for the Plan Year within the Run-Off period set forth in the

SPD. Amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law. The maximum annual reimbursement amount shall not exceed the dollar limitations set forth by the IRS.

ARTICLE V - BENEFITS

5.01 Qualified Benefits. The maximum benefit a participant may elect under this Plan shall not exceed the sum of i) the aggregate premium for all Benefit Plan(s) or Policy(ies) set forth in the SPD (other than Health and DDC); ii) any pre-tax HSA contributions (if allowed under the Plan); and iii) the maximum annual Health Care Reimbursement under the URM as set forth in the SPD (if offered under the Plan); and iv) the maximum annual Dependent Care Reimbursement under the DDC as set forth in the SPD (if offered under the Plan.)

(a) **Special Rules for Health Care Reimbursement**. To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Spouse or Dependents while he is a Participant during the Plan Year (plus any grace period extension as specified in the SPD) for which the Participant's election is effective provided that the substantiation requirements of Section 6.05 herein are satisfied.

(b) **Special Rules for Dependent Care Reimbursement.** To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Employment Related Expenses incurred by him while a Participant, during the Plan Year (plus any applicable grace period extension as described in the SPD) for which the Participant's election is effective, provided that the substantiation requirements of Section 6.05 have been satisfied.

5.02 Cash Benefit. To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as a Pre-tax Contribution or After-tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Nonelective Contributions may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment material.

5.03 Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses and/or Eligible Employment Related Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6.05 herein, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

5.04 Termination of Reimbursement Accounts. Coverage under the URM and/or DDC shall cease as of the day in which a Participant is no longer employed by the Employer or when a premium payment for the respective plan(s) has been missed for any reason. Provided, however, that Participants may submit claims under the DDC for reimbursement for Eligible Employment-Related Expenses arising during the Plan Year at any time until the end of the Run-Off period set forth in the SPD. Participants in the URM may submit claims for reimbursement for Eligible Medical Expenses arising during the Plan Year and before the date of separation from service at any time until the end of the Run-Off period set forth in the SPD. Unless a COBRA election is made as set forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment ceases under this Section. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) shall be treated in accordance with Sections 4.03 or 4.04.

5.05 Coordination of Benefits Under the URM. The URM is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VI - PLAN ADMINISTRATION

6.01 Allocation of Authority. The Board of Directors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. In the case of an insured Benefit Plan or Policy, the insurer shall be the named fiduciary with respect to benefit claim determinations thereunder, and with respect to benefit claims shall have all of the powers of the Plan Administrator described herein. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;

(d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer or insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;

(e) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan. Such entity will be referred to as a third party administrator and shall be identified in the SPD;

(f) To keep records of all acts and determinations, and to keep all such records, books of account, and data and other documents as may be necessary for the proper administration of the Plan; and

(g) To do all things necessary to operate and administer the Plan in accordance with its provisions.

6.02 Payment of Administrative Expenses. Except as otherwise provided in the SPD, the Employer currently pays all reasonable expenses incurred in administering the Plan.

6.03 Reporting and Disclosure Obligations. Unless specified otherwise, it shall be the Employer and Plan Administrator's sole responsibility to comply with all filing, reporting, and disclosure requirements, imposed by the DOL and/or IRS, specifically including, but not limited to creating, filing and distributing Summary Annual Reports, Form 5500s, and SPDs. Furthermore, the Employer and Plan Administrator shall be required to amend the Plan as is necessary to ensure compliance with applicable tax and other laws and regulations.

6.04 Indemnification. The Plan Administrator shall be indemnified by the Employer against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct.

6.05 Substantiation of Expenses. Each Participant must submit a written Claim Form to the Plan Administrator identified in the SPD or its designated plan service provider to receive reimbursements from the URM and/or DDC, on a form provided by the Plan Administrator accompanied by a written statement/bill from an independent third party stating that the expense has been incurred, and the amount thereof. The forms shall contain such evidence, as the Plan Administrator shall deem necessary as to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed.

6.06 Reimbursement. Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan Administrator identified in the SPD or its designated plan service provider. Reimbursements of less than $15 may be carried forward and aggregated with future reimbursements until the reimbursable amount is greater than $15. However, claims for reimbursements outstanding at the end of the Plan Year (plus any grace period as set forth in the SPD) shall be reimbursed without regard to the $15 threshold limit. Year-end expense reimbursements must be submitted to the Plan Administrator within 90 days of the close of the Plan Year for which the PDA is effective, and during which such expense was incurred, in order to be eligible for reimbursement.

6.07 Annual Statements. The Plan Administrator shall furnish each Participant with an annual statement, showing the amounts paid or expenses incurred by the Employer in providing Medical and/or Dependent Care Expense Reimbursement during the previous calendar year and the respective Reimbursement Account balance(s) on or before January 31 following the close of the applicable Plan Year.

ARTICLE VII - FUNDING AGENT

The Plan shall be funded with amounts withheld from Compensation pursuant to PDAs, and/or Nonelective Contributions provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations promulgated by the DOL taking into consideration any enforcement procedures adopted by the DOL. If a Trust is designated Funding Agent in the SPD, an appropriate Trust Agreement shall be attached at the end of this Plan.

ARTICLE VIII - CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Plan and those claims review procedures are set forth in the SPD. The Plan's claim review procedures set forth in the SPD shall only apply to issues germane to the pre-tax benefits available under this Plan (i.e., such as a determination of: a Change in Status; change in cost or coverage; or eligibility

and participation matters under this Cafeteria Plan document), and to the extent offered under the Plan, claims for benefits under the Reimbursement Accounts.

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

9.01 Permanency. While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 9.02 and 9.03 below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

9.02 Employer's Right to Amend. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business (e.g. by approval by the Board of Directors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Plan or Policy shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

9.03 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

9.04 Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance, or termination shall be effective as of such date as the Employer shall determine. No amendment, discontinuance or termination shall allow the return to any Employer of any Reimbursement Account balance for its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries except as provided in Section 4.03 and 4.04 herein.

ARTICLE X - GENERAL PROVISIONS

10.01 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

10.02 Applicable Laws. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the state of the principal place of business of the Employer to the extent not preempted.

10.03 Post-Mortem Payments. Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving spouse (if any), otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

10.04 Nonalienation of Benefits. Except as expressly provided by the Plan Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

10.05 Mental or Physical Incompetency. Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

10.06 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

10.07 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

10.08 Source of Payments. The Employer, the Trust fund (if selected as Funding Agent), and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon

termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

10.09 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

10.10 Tax Effects. Neither the Employer, its agents, the Plan Administrator, nor the Trustee makes any warranty or other representation as to whether any Pre-tax Premiums made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary is includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated as a "cafeteria plan" under Section 125 of the Code.

10.11 Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

10.12 Headings. The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

10.13 Incorporation by Reference. Except for the Medical and Dependent Care Expense Reimbursement Plan(s), the actual terms and conditions of the separate component Benefit Plans or Policies offered under this Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. The provisions of the Medical and Dependent Care Expense Reimbursement Plan(s) are reproduced herein, but shall constitute separate plans for purposes of all applicable Code and ERISA provisions.

10.14 Severability. Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

10.15 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

10.16 Provisions Relating to Insurers. No insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract with this Plan. The insurer shall not be deemed to be a party to this Plan, nor shall it be bound to interpret the construction or validity of the Plan. The insurer shall be protected from its good faith reliance on the written representations and instructions of the Trustee and the Plan Administrator, and shall not be responsible for the initial or continued qualified status of the Plan.

10.17 Forfeiture of Unclaimed Reimbursement Account Benefits. Unless the Employer has implemented a $500 carryover with respect to the URM, any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Health or Dependent Care Expense was incurred shall be forfeited.

10.18 HIPAA Privacy. To the extent a URM is offered under the Plan, the rights and obligations of an individual covered under the URM, the Employer and Plan, with respect to permitted uses and disclosures of a covered individual's protected health information, set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be summarized in the SPD.

ARTICLE XI - CONTINUATION COVERAGE UNDER COBRA

The SPD includes provisions that shall be applicable to the URM to the extent the URM is a “group health plan” as defined by Code §§ 4980B and 5000(b)(1) and the regulations promulgated thereunder and to the extent it is offered under the Plan. The intent of those provisions (as incorporated in this Article) is to extend continuation rights required by COBRA.

IN WITNESS WHEREOF, the Employer has executed this Plan as of the date set forth below.

EMPLOYER'S ACKNOWLEDGMENT

As evidenced by the formal execution of this document, the undersigned Employer adopted and established this Plan on the Effective Date as the Flexible Benefits Plan of the undersigned Employer. In doing so, the undersigned Employer acknowledges that the Summary Plan Description ("SPD") and this Plan document are important legal instruments with significant legal and tax implications.

The Employer also acknowledges that it has read this SPD and the Plan document in their entirety, has consulted independent legal and tax counsel other than representatives of American Family Life Assurance Company of Columbus (Aflac), to the extent considered necessary, and accepts full responsibility for participation of Employees hereunder and the operation of the Plan. The Employer acknowledges that, as sponsor and Plan Administrator, it shall have sole responsibility to comply with all filing, reporting, and disclosure requirements imposed by the DOL, IRS, or any other government agency, specifically including, but not limited to, creating and filing Form 5500s and preparing and distributing SPDs and performing required nondiscrimination testing.

Furthermore, the Employer further acknowledges that it shall bear sole responsibility for amending the Plan as necessary to ensure compliance with applicable tax, labor, and other laws and regulations. The Employer acknowledges receipt of the checklist of Plan Sponsor Responsibilities included provided with the applicable plan document request form and has agreed to the obligations set forth therein.

It is also understood and agreed that American Family Life Assurance Company of Columbus (Aflac), and its subsidiaries, agents, and representatives, are not providing legal or tax advice to the undersigned Employer in connection with this Plan and that no representations are made by it with respect to the operation of the Flexible Benefits Plan pursuant to the documents provided by American Family Life Assurance Company of Columbus (Aflac) to the Employer.

This Plan shall be construed and enforced according to the Internal Revenue Code of 1986, as amended from time to time, the applicable regulations thereto, and the laws of the state of the principal place of business of the Employer.

IN WITNESS WHEREOF, the Employer has caused this Plan and Summary Plan Description to be executed on the day of _____,_____ to ratify the adoption of the Plan adopted and effective as of the Effective Date.

WITNESS:

Employer: _____

By: _____

Title: _____

Date: _____

_____

Corporate Officer

ATTACHMENT I - SUMMARY PLAN DESCRIPTION

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

PLAN INFORMATION SUMMARY

The Employer named below establishes a Flexible Benefits Plan (the "Plan") as set forth in this Summary Plan Description ("SPD") as of the Effective Date set forth below. The purpose of the Plan is to provide eligible Employees a choice between cash and the specified welfare benefits described in this Plan Information Summary (see "Benefits Provided Under the Plan"). Pre-tax Contribution elections under the Plan are intended to qualify for the exclusion from income provided in Section 125 of the Internal Revenue Code of 1986.

FLEXIBLE BENEFITS PLAN
EMPLOYER INFORMATION

1) Name and Address of Employer: **CITY OF MANOR**

   Plan Administrator: **TRACY VASQUEZ**
   PO BOX 387
   MANOR, TX 78653

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and to construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.

2) Employer's Telephone Number: **(512) 215-8287**
3) Employer's Federal Tax Identification Number: **74-1664745**
4) Plan Number Assigned to Cafeteria Plan (e.g., 501 if this is the first ERISA Plan Number assigned): _____
5) 125 Start Date: **10/01/06**
6) Effective Date of this Plan: **10/01/23**
7) Last Day of the Plan Year: **08/31/24**
   Subsequent Plan Years: **09/01-08/31**
8) Name and Address of FSA Claim Administrator: **SAME**
9) Name and Address of registered agent for service of legal process: **TRACY VASQUEZ**

10) Affiliated Employers that will participate in the Plan :

11) Employer's Type of Business: **CORPORATION**

ELIGIBILITY
All Employees employed by the Employer shall be eligible to participate under the Plan except the following:

An eligible Employee may become a Participant in the Plan:

[ ] Immediately, upon the first day of employment (but not prior to the Effective Date of the Plan).

[**X**] On the **60 day** following commencement of employment.

[ ] On the first day of the month following days of employment.

[ ] Other: **OTHER**
provided the Employee completes a Premium Deduction Authorization ("PDA"). However, eligibility for coverage under any given Benefit Plan or Policy shall be determined by the terms of that Benefit Plan of Policy, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contributions shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy.

An eligible Employee may become a Participant in the Dependent Care and/or Medical Expense Reimbursement Plan(s) (if elected below):

[ ] On the same day such Employee is eligible for the Pre-Tax Contribution benefits under the Plan.

[ ] On the day following commencement of employment.

[ ] On the first day of the month following days of employment.

[ ] Other: **OTHER**, provided the Employee completes a PDA selecting such benefits.

BENEFITS PROVIDED UNDER THE PLAN

The following Benefit Plans and Policies subject to the terms and conditions of the Plan are available for election by eligible Employees. The maximum a Participant can contribute via the PDA is the maximum aggregate cost of the Benefit Plans or Policies elected minus any Nonelective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes. Copies of the Benefit Plans or Policies (or a list of eligible Policy numbers) shall be attached as an appendix to this Plan.

[**X**] Group Major Medical Coverage

[ ] Vision Care Coverage

[ ] Disability Income - Short Term (A&S)

[**X**] Cancer Insurance

[**X**] Dental Coverage

[ ] Group Term Life Insurance

[ ] Disability Income - Long Term (LTD)

[ ] Intensive Care Insurance

[**X**] Accident Insurance

[**X**] Hospital Indemnity Insurance (HIP)

[**X**] Specified Health Event

[ ] Personal Sickness Indemnity (PSI)

[ ] Medical Care Expense Reimbursement described in Appendix I to this SPD, not to exceed $ per Plan Year pursuant to the **CITY OF MANOR** Medical Care Expense Reimbursement Plan.

Name and Address of Medical Care Expense Reimbursement Plan
COBRA Administrator (if applicable): _____
_____
_____

[ ] Dependent Care Expense Reimbursement described in Appendix I to this SPD.

[ ] Health Savings Account (as defined in Code Section 223) established with the following

Custodian/Trustee: _____

[ ] Opt-out Option: See Employer enrollment material.

THE FUNDING AGENT

The Employer selects the following Funding Agent for the Plan (check one):

❑ The Employer, which will comply with the requirements of Article VII of the Plan.

❑ The Flexible Benefits Trust created concurrently with the execution of the Plan, which shall receive contributions under the Plan in accordance with Article VII of the Plan.

ADMINISTRATIVE EXPENSES

Administrative Expenses incurred in operating the Plan shall be paid by (check one):

❑ The Employer, except as otherwise noted in the Plan.

❑ The Participants, except as otherwise noted in the Plan.

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Introduction

Your employer (the "Employer") is pleased to sponsor an employee benefit program known as a "Flexible Benefits Plan" (the "Plan") for you and your fellow employees. Under federal tax laws, it is also known as a "cafeteria plan". It is so called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them by entering into a salary redirection arrangement instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary redirection. Alternatively, your Employer may allow you to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary attached to the front of this SPD. You will be referred to the Plan Information Summary throughout the SPD. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

In some cases, the Employer may adopt a Medical Care and/or Dependent Care Reimbursement Plan. If so, they will be listed in the Plan Information Summary as "Benefits Provided under the Plan," and the SPD for each Reimbursement Plan adopted by the Employer will be set forth in Appendix I to this SPD. To the extent that the Employer adopts a Medical Care Reimbursement Plan as indicated in the Plan Information Summary, a summary of your rights and obligations under HIPAA's privacy rules is attached to this SPD as Appendix II.

You may also be able to make pre-tax contributions to a Health Savings Account (as defined in Code Section 223) through this Plan if Health Savings Accounts are identified as an included benefit under "Benefits Provided under the Plan" in the Plan Information Summary. If Health Savings Accounts are identified as a benefit plan option offered under the Plan, your rights and obligations in regard to such contributions will be set forth in the Health Savings Account Contribution Appendix attached hereto.

Questions & Answers about the Flexible Benefits Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to pay for certain benefits offered under the Plan (called "Benefit Plans or Policies") with pre-tax dollars called "Pre-tax Contributions". Pre-tax Contributions are described in more detail in Q-8 of this SPD.

Q-2. What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Plan's various pre-tax options by filling out any required enrollment form(s) for the component Benefit Plans or Policies offered under the Plan. The complete list of Benefit Plans or Policies offered under the Plan is located in the Plan Information Summary under "Benefits Offered Under the Plan." NOTE: You may only contribute with Pre-tax Contributions towards the cost of Benefit Plans or Policies that cover you, your legal Spouse, and/or your tax Dependents defined under Internal Revenue Code Section 152. Each Benefit Plan or Policy may define eligible Dependents more narrowly for purposes of coverage under the particular Benefit Plan or Policy.

Q-3. Who can participate in the Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who satisfies the eligibility requirements described in the Plan Information Summary and who is eligible to participate in any of the Benefit Plans or Policies offered under the Plan will be eligible to participate in this Plan as of the date described in the Plan Information Summary (see Q-5 of this SPD for instructions on how to become a Participant). Those employees who actually participate in the Plan are called "Participants." The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Plans or Policies offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plans or Policies, please refer to the plan summary for each of the Benefit Plans or Policies listed in the Plan Information Summary.

Only coverage for an Employee and the Employee's Dependents may be paid for under this Plan. A dependent is defined generally as an individual who would be considered the Employee's spouse under the federal income tax code or the Employee's tax dependents as defined in Code Section 152; however, for purposes of health benefits and Dependent Care Reimbursement ("DDC") benefits offered under the Plan, a dependent is defined as (i) for health plan purposes, as set forth in Code Section 105(b) and (ii) for DDC purposes, as any person who meets the requirements to be a "qualifying individual" as defined in the DDC component SPD.

Q-4. When does my participation in the Plan end?

You continue to participate in the Plan until (i) you elect not to participate in accordance with Q-9 of this SPD; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) you terminate employment with the Employer; or (iv) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will **automatically** cease, and you will not be able to make any more

Pre-tax Contributions under the Plan. If you are rehired within the same Plan Year or you become eligible again, you may make new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility. If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year unless you again lose eligibility.

Q-5. How do I become a Participant?

You become a Participant by communicating to your employer, prior to the Plan start date, your election to participate in the Plan by signing an individual Premium Deduction authorization (PDA) on which you elect one or more of the Benefit Plans or Policies available under the Plan, as well as agree to a salary redirection to pay for those benefits so elected. You will be provided a PDA when you first become eligible to participate in this Plan.

Q-6. What are the enrollment periods for entering the Plan?

If you are eligible on the effective date of the Plan, you must enroll during the enrollment period immediately preceding the effective date of the Plan. Otherwise, you must enroll during either the "Initial Enrollment Period" or the "Annual Enrollment Period". You will be notified of the dates that each enrollment period begins and ends in the enrollment material provided to you prior to each enrollment period. If you make an election during the Initial Enrollment Period, your participation in this Plan will begin on the later of your eligibility date described in the Plan Information Summary, the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated claims administrator) or the date coverage under a Benefit Plan or policy that you elect begins. The effective date of coverage under the applicable Benefit Plan(s) or Policy(ies) is governed by the terms of each Benefit Plan or Policy, as set forth in the governing documents for each Benefit Plan or Policy. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a Change in Status event as described in Q-9 below. If you do not make an election during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. You may, however, be covered by certain Benefit Plans or Policies automatically (and be required to contribute with pre-tax dollars) even if you fail to make an election. These automatic Benefit Plans or Policies are called "Default Benefits" and will be identified in the enrollment material that you receive.

The election that you make during the Annual Enrollment Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a Change in Status event described in Q-9 below. A Participant who fails to complete, sign, and file a PDA during the Annual Enrollment Period as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and except for a Change in Status, will not be permitted to modify his election until the next Annual Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the Medical Care and Dependent Care Expense Reimbursement Plans, if offered under the Plan, must be made by submitting a PDA prior to the beginning of each Plan Year -- no deemed elections shall occur with respect to such benefits.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. What tax advantages are available through the Plan?

Suppose your monthly gross pay is $2,500 per month and your cost for coverage is $140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is $1,794. However, under the pre-tax premium plan, you will be considered to have received $2,360 gross pay rather than $2,500 for tax purposes with $140 contributed for medical coverage. This means your take home pay will be $1,825 with the pre-tax premium plan rather than $1,794 without it. Thus, you save $31 per month ($372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	With Cafeteria Plan	**Without Cafeteria Plan**
Gross Monthly Pay	$2,500	$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	2,360	2,500
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	--	140
Take Home Pay	1,825	1,794

Potential Monthly Savings: $31.00

Q-8. How are my contributions under the Benefit Plans or Policies made?

When you become a Participant, your share of the contributions for the elected Benefit Plan or Policy(ies) will be paid with Pre-tax Contributions elected on the PDA. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted (some state tax laws do not recognize Pre-tax Contributions). In addition, all or a portion of the cost of the Benefit Plans or Policies may, in the Employer's discretion, be paid with contributions made by the Employer on behalf of each Participant (these are called "Nonelective Contributions"). The amount of Nonelective Contribution that is applied towards the cost of the Benefit Plan(s) or

Policy(ies) for each Participant and/or level of coverage is subject to the sole discretion of the Employer, and it may be adjusted upward or downward in the Employer's sole discretion. The Nonelective Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your Dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable Compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may make available a certain amount of Nonelective Contributions and then allow you to allocate the Nonelective Contributions among the various Benefit Plan(s) or Policy(ies) that you choose (subject to restrictions described in the enrollment material).

Q-9. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution amounts although your election will terminate if you are no longer working for the Employer or no longer eligible under the terms of the Plan. Otherwise, you may change your elections for Pre-Tax Contributions only during the Annual Enrollment Period, and then, only for the coming Plan Year. There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator (or its designated claims administrator) within 30 days of any of the following events:

1. **Change in Status**. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

   - a change in your legal marital status (such as marriage, legal separation, annulment, or divorce or death of your Spouse);
   - a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
   - any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit (NOTE: The specific rules governing election changes when you take a leave of absence are described in Q-13 of this SPD);
   - an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student);
   - a change in your, your Spouse's or your Dependent's place of residence.
   - a change in your employment status such that you are no longer to average 30 hours or more per week each month but does not otherwise cause you to lose eligibility for group health benefits that provide minimum essential coverage; or
   - you are eligible to enroll in a Qualified Health Plan offered in the Marketplace during the Marketplace's special or annual enrollment period.

   If a Change in Status occurs and you want to make a corresponding election change, you must inform the Plan Administrator and complete a new election within 30 days from the date of the event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator with the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective.

   As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

   - *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage, and Medical Care Reimbursement Plan), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-Dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-Dependent coverage would be consistent with this Change in Status. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent child or yourself.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or Benefit Plan or Policy) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care Reimbursement Plan Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary)*. With respect to the Dependent Care Reimbursement Plan benefit (if offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a Dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund Dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the Dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the Dependent care program would be consistent with this Change in Status.

- *Ability to Procure Minimum Essential Coverage.* For a Change in Status in which you no longer average 30 hours or more per week each month but do not otherwise lose eligibility for group health benefits that provide minimum essential coverage, your election to revoke coverage under the Plan would correspond with that Change in Status only if you certify your intent to enroll yourself and any other dependents whose coverage is revoked in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

- *Gain of Coverage Eligibility in the Marketplace.* For a Change in Status in which you gain eligibility for coverage in a Qualified Health Plan in the Marketplace's special or annual enrollment period, your election to revoke coverage under the Plan would correspond with that Change in Status only if you certify your intent to enroll yourself and any other dependents whose coverage is revoked in new coverage under a Qualified Health Plan that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary).* For group term life insurance, disability income, and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

  Example: Employee Mike is married to Sharon, and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under

this Plan, you may change your election to provide coverage for the Dependent child identified in the order. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If you are notified that the cost of your Benefit Plan or Policy coverage under the Plan *significantly* increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Plan or Policy that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plans or Policies, however, your Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

   Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If you are notified that your Benefit Plan or Policy coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Plan or Policy that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

   Additionally, your election(s), may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law**.**

Q-10. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if my claim for benefits under this Plan is denied?

This SPD describes the basic features of the Plan. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedures applicable under the component Benefit Plan or Policy (see the plan summary for each of the Benefit Plans or Policies that you elect). However, if you are denied a benefit under this Plan, the claims procedure under this Plan will apply. You will be notified if your claim under the Plan is denied. The notice of denial will be furnished to you within 30 days after receiving your claim. However, if additional time is needed to process your claim you will be notified before the initial 30-day period has expired. The notice will explain why an extension is necessary and the date a decision is expected to be rendered. In no event will an extension go beyond 15 days after the end of the initial 30-day period. The notice of the denial will include the specific reasons for the denial and the relevant plan provisions on which the denial was based.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim, as set forth in the notice of denial, within 180 days after you receive notice of the denial. If there are two levels of appeal (as indicated in the notice of denial), you will have a reasonable amount of time in which to request a second review and such time period will be identified in the notice of denial. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. Within 60 days after the request for review is received, you will be notified in writing of the decision on review.

The notice of denial will indicate whether there are one or two levels of appeals and will contain the same type of information provided to you in the first notice of denial. If there are two levels of Plan appeals, the decisions on appeal will be made within 30 days after the request for each review is received. The Plan Administrator is the claims fiduciary for making the final decision under the plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-12. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-13. What happens if I take a leave of absence?

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Plans or Policies providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plans or Policies providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Plans or Policies providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plans or Policies are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Plan or Policy offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan or Policy, the election change rules in Q-9 of this SPD will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-14. Is there any other information that I should know about the Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name and address has also been provided in the Plan Information Summary.