Plan Document

FlexSystem®

Article I: Table of Contents

Article II: Purpose

2.01 **Creation and Title.** The Employer adopts this Cafeteria Plan as indicated by the Employer signature in Article XI - 11.01, and creates this Cafeteria Plan under the terms and conditions set forth in this Plan Document as well as through the Enrollment Communications that are expressly incorporated by reference into this Plan Document and described in Article XI - 11.06.

2.02 **Effective Date.** The original Effective Date of this Cafeteria Plan and the Effective Date of this Plan Document are identified on the Plan Schedule, see Article XI.

2.03 **Purpose.** The Plan allows Participants to elect between cash Compensation or certain nontaxable Qualified Benefits Plans maintained by the Employer as identified on the Plan Schedule, see Article XI. The Employer intends that this Plan qualify as a Cafeteria Plan under Section 125 of the Internal Revenue Code. Notwithstanding any term in this Plan Document, if any term is found to be in conflict with federal or state law, the term will automatically be amended to comply with the federal or state law.

Article III: Definitions

3.01 **Change in Status Event.** A Change in Status Event allows a Participant to revoke or change his/her pre-tax election during the Plan Year, and outside of the scheduled open Enrollment period. The Employer allows all of the Change in Status Events published by the IRS for this type of Plan under 26 CFR 1.125-4, as amended. A Participant who becomes eligible under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") for coverage under an accident or health benefit offered by the Employer will be allowed to make a consistent election, or election change under this Plan.

3.02 **Code.** The Internal Revenue Code of 1986, as amended from time to time.

3.03 **Compensation.** All the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Internal Revenue Code.

3.04 **Dependent.** For the purpose of the tax advantages available under this Plan, a Dependent is an individual who is a dependent of a Participant within the meaning of Section 152(a) of the Internal Revenue Code, and any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). For the purposes of the tax advantages available under Qualified Benefit Plans that provide accident and health benefits as defined under Sections 105 and 106 of the Code, a Dependent is determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof and includes any child (as defined in Code § 152(f)(1)) of the Participant who at the end of the taxable year has not attained age 27.

3.05 **Effective Date.** The date specified in the Plan Schedule, see Article XI, on which the Plan was first effective, and the date that this Plan Document is in effect.

3.06 **Eligible Employee.** An Employee who is eligible to participate in the one or more Qualified Benefits Plans sponsored by the Employer, limited to Employees as defined below who meet the additional requirements in the Plan Schedule, see Article XI, and not including the following:

(a) Employees who are Non-Resident Aliens (within the meaning of Section 7701(b)(1)(B) of the Internal Revenue Code) who are deriving no earned income (within the mean ing of Section 911(d)(2) of the Code) from the Employer which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code); and,

(b) Employees who are self-employed individuals (as described in Section 401(c) of the Internal Revenue Code) including sole proprietors, partners in a partnership, or more than 2% owners of subchapter "S" Corporations. This exclusion applies to the Spouse, children, parents, and grandparents under the Code Section 318 attribution rules.

An Eligible Employee will also meet any additional conditions and terms as defined in the Enrollment Communication.

If an Employee is not eligible to participate in this Plan and allowed to participate under any Qualified Benefits Plan, then the Employee cost will be paid with taxable income, and the Compensation will not be reduced by the Employer.

3.07 **Employee.** An Employee is a person who is currently or hereafter employed by the Employer, or by any other Employer aggregated under Sections 414(b), (c), (m), (n), or (o) of the Internal Revenue Code and the regulations thereunder, including a leased Employee subject to Section 414(n) of the Code.

3.08 **Employer.** The Employer adopting this Plan under Article XI, and any affiliate or subsidiary that, with the consent of the Employer becomes an Employer, by adopting the Plan, or any successor business organization that assumes the obligations of the Employer.

3.09 **Enrollment Communication.** The Employer will provide a written Enrollment Communication at open Enrollment and during the Plan Year for midyear enrollees. The Enrollment Communication will provide the specific process for Enrollment in the Qualified Benefits Plans. The Enrollment Communication is expressly incorporated by reference into this Plan Document. Enrolling in a Qualified Benefits Plan will automatically enroll you in the Medical or Medical-Related Premium Plan. There is no separate Enrollment form for the Medical or Medical-Related Premium Plan.

3.10 **Participant.** Any person who has been or is an Eligible Employee and who qualifies to participate and enrolls in a Qualified Benefits Plan.

3.11 **Plan Year.** Commencing on the first day of the Plan Year and each anniversary thereof, except that the first Plan Year may include a period of fewer than twelve (12) consecutive months. The Plan Year is identified on the Plan Schedule, see Article XI.

3.12 **Qualified Benefits Plan.** Employer-sponsored plans that are allowed tax advantages under this Plan pursuant to Section 125(f) of the Internal Revenue Code.

3.13 **Spouse.** An individual who is legally married to a Participant but is not separated from a Participant or under a decree of legal separation.

Article IV: Administration

4.01 **Employer's Duties.** In addition to any rights, duties or powers specified in this Plan Document, the Employer will have the following rights, duties, and powers:

(a) to interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;

(b) to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the Plan, and from time to time, amend or supplement such rules and regulations;

(c) to determine the rights of any Participant, Spouse, or Dependent to benefits under the Qualified Benefit Plans;

(d) to develop appellate and review procedures for any Participant, Spouse, or Dependent denied benefits under the Plan;

(e) to maintain records it may require in connection with the proper administration of the Plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to correct any defect, supply any omission, or reconcile any inconsistency in the Plan in such a manner and to such extent as it shall be deemed expedient to administer the Plan;

(h) to amend or terminate this Plan.

4.02 **Information to be Provided to the Employer.** The Employer, or any of its agents, will collect employment records of Participants under the Plan. These records will include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the Employer may need for the proper administration of the Plan. A Participant will furnish the Employer the data the Employer reasonably requests to ensure the proper and efficient administration of the Plan, with documentation for items such as proof of relationship as needed.

4.03 **Interpreting Plan Terms.** Any interpretation of any provision of this Plan made in good faith by the Employer as to the terms of this Plan is final and will be binding upon the parties.

4.04 **Misstatements.** Any misstatement or other mistake of fact will be corrected as soon as reasonably possible upon notification to the Employer and any adjustment or correction attributable to such misstatement or mistake of fact will be made by the Employer as he considers equitable and practicable.

4.05 **Review Procedures.** An Employee or his/her authorized representative can appeal a decision made to deny Enrollment in a Qualified Benefits Plan or a decision to disallow an election change by sending a written request for an appeal to the Employer within 60 days of the decision to deny Enrollment or an election change. The ap peal will be performed in a manner that does not afford deference to the initial determination and will be conducted by the Employer or designee. A Participant can request, free of charge, reasonable access to, and copies of, all documents and records relevant to the decision. Benefit appeals for denied claims are addressed in the Qualified Benefits Plan descriptions provided by the Employer.

4.06 **Rules Apply Uniformly.** The Employer will perform assigned duties in a reasonable manner and on a nondiscriminatory basis, and will apply uniform rules to all Participants similarly situated under the Plan.

4.07 **Facility of Payment.** Whenever a Participant who is entitled to receive a benefit under this Plan is under legal disability or is incapacitated to be unable to manage his/her financial affairs, the Employer may make payments to the Participant's legal representative, relative, or for the benefit of such Participant in such manner as the Employer considers advisable. Any such payment of a benefit in accordance with the provisions of this document shall be a complete discharge of any liability for the making of such payment under the provisions of this Plan.

4.08 **Information to be Furnished.** Participants shall provide the Employer with such information and evidence, and shall sign such documents, as may be requested reasonably from time to time for the purpose of administering the Plan.

4.09 **Medical Child Support Orders.** The Employer will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which complies with federal or applicable state law. The Employer will comply with the administrative requirements described under 29 USC Sec. 1169 relating to Qualified Medical Child Support Orders (QMCSO), including any federal regulations or state laws relating to the same. On the date coverage is provided as directed by a QMCSO the Employee-parent will become eligible to participate in this Plan in order to pay his/her share of the cost of the coverage on a pre-tax basis.

Article V: Eligibility and Participation

5.01 **Eligibility Requirements.** Each Employee who enrolls in a Qualified Benefits Plan must be eligible to participate in this Plan to receive the tax advantages made available under this Plan. The eligibility for this Plan is set forth in the Plan Schedule, see Article XI.

5.02 **Current Employees at the time of Plan inception.** At the time of Plan adoption, all non-excluded Employees who meet the eligibility requirements may participate.

5.03 **New Employees.** New Employees engaged for employment after the Plan adoption, who meet the eligibility requirements, may participate in the Plan the next following entry date as indicated in the Plan Schedule, see Article XI.

5.04 **Re-employment of Former Employees.** Unless the Employer provides differently in the Enrollment Communications, the treatment of re-employed former Employees shall be as follows. A Participant whose employment terminates and is subsequently re-employed within 30 days of his/her separation of service and within the same Plan Year will immedi ately rejoin the Plan with the same Benefit elections. Should the Participant return within 30 days of his/her separation of service during the following Plan Year, the Participant will be allowed to change elections through the Plan Enrollment process. A Participant whose employment terminates and who is subsequently re-employed with more than 30 days separation of service will need to re-satisfy Plan eligibility requirements to rejoin the Plan. Any unused reimbursement Benefits Account balance prior to the initial separation of service date will be forfeited.

5.05 **Becoming a Participant.** To become a Participant, an Eligible Employee shall enroll in a Qualified Benefits Plan by any application, agreements, or process as may be required by the Employer at the time of Enrollment. The Enrollment Communication provided by the Employer at the time of Enrollment will define the process for becoming a Participant. By completing the Enrollment process, the Employee shall be deemed for all purposes to have agreed to participate and to conform to the Plan requirements. An Employee, electing to participate in the Plan, is choosing to participate for the entire

Plan Year. The annualized sum of salary reduction benefit elections shall constitute a current obligation of the Employee to the Employer. Such obligation may be revoked or changed only when the Employee has experienced and documents a Change in Status Event, when the request is consistent with the event, and notice is provided to the Plan within 30 days.

5.06 **Notification to Employees.** The Employer will communicate (in writing) to all Participants the terms and conditions of this Plan through administrative communications at the time of Enrollment and as needed during the Plan Year. These communications are expressly incorporated by reference into this Plan Document.

5.07 **Termination of Participation.** A Participant will automatically cease to be a Participant on the earliest of the following dates:
(a) the date on which this Plan or any Qualified Benefits Plan is terminated by the Employer;
(b) the end of the Plan Year, unless the Participant enrolls in a Qualified Benefits Plan for the next Plan Year;
(c) the date on which the Participant fails to pay any required premium (including payment by salary reduction);
(d) when the Participant's employment with Plan Sponsor is terminated this Plan will terminate on the earlier of the day of the termination or the day using the rule stated in the SPD, whether termination is initiated by the Participant or the Plan Sponsor, however the Participants election can continue to be used for one or more of the Qualified Benefit Plans for the specified period of time communicated in the SPD. Participation under each Qualified Benefit Plan is described in the materials provided by the Employer; see Article XI Section 11.6 for a list of plans and literature available from the Employer.

5.08 **Family Medical Leave Act.** The Family & Medical Leave Act of 1993 (29 U.S.C. 2611) as amended, is referred to as FMLA. FMLA Leave will not be available to Employees for Plan Years in which the Employer has 50 or fewer Employees as counted in that Act. For Plan Years in which the Employer has more than 50 Employees, the Employer is required to make FMLA Leave available to Eligible Employees under circumstances that are prescribed by applicable federal law, including a period in which an Employee is off due to the FMLA shall be treated in accordance with the rules for a layoff or a leave of absence and provided to the extent required by the FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent the Participant opts to continue coverage). If the Employer is subject to the FMLA, a Participant may revoke or continue an election through the Plan upon commencement of the FMLA Leave, whether such leave is paid or unpaid. This provision applies in addition to any other right to revoke and reelect benefits under the Plan. Upon return from FMLA Leave, a Participant may be reinstated to all pre-leave elections.

5.09 **Uniformed Services Employment & Reemployment Rights Act (USERRA).** The Employer shall permit Participants to continue benefits elections as required under the Uniformed Services Employment & Reemployment Rights Act and shall provide such reinstatement rights as required by such law.

5.10 **Layoff, Leave of Absences, and Sabbaticals.** Continuation under the Plan may occur in one of the following ways:
(a) In the case of a planned layoff, an Employee may be able to pre-fund a Qualified Benefits Plan through the end of the planned leave or the end of the Plan Year.
(b) During the period which the Employee is off and receiving a salary, the pre-tax deductions may continue. If the Employee is not receiving a salary, he/she may continue to fund his/her election with after-tax dollars while on leave. (Payment schedule to be agreed upon between the Employer and Employee prior to the commencement of the leave.)

Article VI: Elections

6.01 **Available Benefits.** The Qualified Benefits Plans offered under this Plan are listed on the Plan Schedule; see Article XI. The option for an Employee to make after-tax contributions for certain Qualified Benefits Plans will be communicated by the Employer at the time of Enrollment.

6.02 **Election Maximum Amounts.** Each Participant shall elect any combination of the benefits made available. No Participant may choose available benefits costing more than the maximum amount, if any, as indicated in the Qualified Benefits Plan. The maximum election amounts will be included in the Enrollment Communication and the literature available for each Qualified Benefits Plan.

6.03 **Failure to Elect.** A Participant failing to complete the Enrollment process on or before the specified due date for the Plan Year, or a midyear enrollee during the Plan Year, shall be deemed to have elected to receive his full Compensation in cash. The Employer will communicate any applicable Enrollment deadlines in writing at the time of Enrollment.

6.04 **Effective Periods for Elections.** The election must be made by each Participant prior to the commencement of each Plan Year, and shall be irrevocable except as provided for in a Change in Status Event that would allow an election change. Participants may not carry over any unused contributions or available benefits from one Plan Year to a subsequent Plan Year unless the Plan Schedule indicates that the Plan has incorporated the Grace Period or the Plan document includes a limited Carryover for the Medical-Related Expense Reimbursement Benefit Plan. Further, Participants may not use any contributions from one Plan Year to purchase any available benefits that will be provided in a subsequent Plan Year.

6.05 **Change in Status Events.** No Participant in the Plan will be allowed to alter or discontinue the Participant's benefits elections during a Plan Year except when due to and consistent with a Change in Status Event. These Status Events include the Change in Status Events described in Notice 2014-55 that allow a Participant to revoke his/her election of coverage under the group health plan to enroll in Exchange coverage. Enroll ment requests must be made within 30 days of the Change in Status Event and be consistent with the event. Notwithstanding, an Employee can make a prospective change to a Health Savings Account (HSA) election under this Plan during the Plan Year without having a Change in Status Event.

A Change in Status Event allows a Participant to change his/her contribution election during the Plan Year, and outside of the scheduled open Enrollment period. The Employer has elected to allow all of the Change in Status Events published by the IRS for this type of plan. An unpermitted election change will cause the elected benefit to be included in a Participant's gross income and can disqualify the Plan from tax preferred status.

Upon the occurrence of a Change in Status Event, the Participant will notify the Employer within 30 days and complete the forms provided by the Employer. The Employer can require additional documentation for evidence of the event. The new election will be effective prospectively and will apply only to those benefits accruing to the Participant, the Participant's Spouse, or the Participant's Dependents after the effective date of the election change. With respect to an election change under the special Enrollment period provisions of HIPAA, "timely submitted" will mean submitted no later than the last day of such special Enrollment period.

6.06 **Non-Discrimination.** The Plan is not intended to discriminate in favor of highly compensated individuals or key Employees as to eligibility to participate or contributions and benefits as required by the Code. The Employer may exclude or limit certain highly compensated individuals from participation in the Plan, in the Employer's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules. The Employer can make necessary adjustments to Employee contributions during the Plan Year to assure that the Plan passes the required discrimination tests.

Article VII: Contributions

7.01 **Employer Contributions.** The Employer will contribute out of its general assets the amounts necessary to meet its obligations under the Plan. Unless the Employer provides differently in the Enrollment Communication or separate Plan Documents for the various Qualified Benefits Plans, there are no segregated funds established to collect or maintain the contributions. Contributions to the Plan for any Plan Year will be limited to the amounts necessary to pay for the Qualified Benefits Plans elected by the Participants.

The Employer may provide additional contributions in the way of cash or spending credits that can be used for any Qualified Benefits Plan, or used in a limited manner as defined by the Employer. The Employer may make defined contributions to specific Qualified Benefit Plans. The Enrollment Communications will include the amount of any Employer contribution, the rules defining how the Employer contributions can be used by the Participants, and any limitations on the use of Employer contributions. Employer contributions will continue to be provided while on approved FMLA Leave to the same extent provided to an Employee actively at work.

7.02 **Employee Salary Reductions.** The Participant shall agree to reduce his/her Compensation from the Employer by such amounts as are necessary to provide for those Qualified Benefits Plans which the Participant has elected. "Employee" salary reduction amounts are "Employer" contributions for purposes of Internal Revenue Code Section 125 and its applicable regulations. No Participant shall have, by virtue of the Plan, any interest in any specific asset or assets of the Employer. A Participant has only an unsecured contractual right to receive the benefits defined and limited by the Qualified Benefits Plans.

7.03 **Administrative Fees.** The Employer may charge the Employee reasonable cafeteria plan administrative fees. If any administrative fees are required, the Enrollment Communication will include the amount of the administrative fee and whether it is with held from the Employee's salary reduction.

7.04 **Increases or Decreases in Premium.** The Employer reserves the right to increase the Participant's share of any Premiums and decrease the Employer's share by a like amount. The Employer will notify Participants prior to raising the Participant's obligations. If the premium or required contribution for any Qualified Benefits Plan increases or decreases during the Plan Year, a Participant's contributions will increase or decrease automatically in an amount sufficient to pay for such increase or decrease. However, in the case of an increase in premium, if a similar benefit is offered under the Plan at the time of said increase, the Participant may select such similar benefit rather than pay the increase.

The Employer reserves the right to reduce the Participant's share of any Premiums and increase the Employer's share by a like amount. The duration of this "Premium Holiday" is at the Employer's discretion and will be communicated by the Employer. As this is considered to be temporary, Participants are not considered to have incurred a Change in Status should the Employer invoke this option.

Article VIII: Records and Reports

8.01 **Responsibility.** The Employer shall exercise authority and responsibility to comply with the Plan relating to Participant records, balances, and benefits payable under this Plan. The Employer also shall be responsible for all Plan reporting and disclosure requirements.

8.02 **Examination of Records.** The Employer will make each Participant's records under the Plan available for his/her examination at reasonable times and during normal business hours.

Article IX: Plan Termination

9.01 **Plan Termination.** The Plan or any portion of the Plan shall be subject to termination at any time by the Employer, provided however, that such termination shall not affect any right or claim arising under the Plan prior to termination. Any unclaimed funds shall become payable as the Employer may direct. Such direction may include, but not be limited to a continuation of the Plan in order to pay balances in accordance with elected benefits.

9.02 **Rights to Terminate.** In accordance with the procedures set forth in this section, the Employer may terminate the Plan at any time. In the event of a dissolution, merger consolidation, or reorganization of the Employer, the Plan shall terminate unless the Plan is adopted and continued by a successor to the Employer in accordance with the resolution of its Board of Directors.

Article X: Plan Construction

10.01 **Taxation.** The Employer intends that this Plan be in compliance with Section 125 of the Internal Revenue Code, and therefore, the Employer may deduct the amount paid for the benefits provided from federal income and employment taxes. This Plan has not been submitted to the Internal Revenue Service, and there is no assurance that the intended tax benefit under this Plan will be realized. Neither the Employer nor its designated representatives makes any commitment or guarantee that any amounts elected or paid for the benefit of a Participant will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax penalties and interest which may be imposed by the Internal Revenue Service with respect to these benefits.

10.02 **Adoption by Related Organizations.** Upon the approval of the Employer, this Plan may be adopted by any organization in affiliation with the Employer. For the purpose of this Plan affiliated organizations are described in Section 414(b), (c) or (m) of the Internal Revenue Code. The adopting organizations shall execute and deliver to the Employer a supplemental agreement providing for the adoption of this Plan and such other documents as the Employer deems necessary or desirable. The provisions of this Plan shall be applicable to such organization to the extent provided in the supplemental agreement.

10.03 **Uniform Exercise of Powers.** In the exercise of any of its powers, duties and discretion under this Plan, and within the scope of its authority, and in all of its acts, decisions, and determinations hereunder, the Employer shall at all times act in good faith and in a non-discriminatory manner and shall follow a consistent policy on comparable issues. All Employer actions and determinations shall be duly recorded. All such records, together with such other documents as may be necessary for the administration of this Plan, shall be preserved. Decisions regarding any Employer-disputed questions relative to the rights of a Participant hereunder and upon all matters within the scope of its authority shall be final and binding on all parties in interest.

10.04 **Construction.** No provision of this Plan shall be construed to conflict with any Treasury Department, Department of Labor, or Internal Revenue Service Regulation, Ruling, Release, or Proposed Regulation or other order which affect, or could affect, the terms of the Plan. This Plan will be in compliance with any changes related to the Internal Revenue Code. This 125 Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA); however the Qualified Benefits Plans offered by the Employer can be subject to ERISA. Refer to the Qualified Benefits Plan for details.

10.05 **Entire Document.** This document, including any appendices or supplements thereto, shall constitute the entire and complete document, and as such shall govern the rights, liabilities and obligations of the Plan, except as the Plan may be modified.

10.06 **Severability.** In the event any provisions of this document shall be held illegal or invalid for any reason by law or a court of competent jurisdiction, said illegality or invalidity shall not affect the remaining provisions included herein either initially, or beyond the date said provisions are first held to be illegal or invalid, provided the basic purposes hereof can be affected through the remaining valid and legal provisions.

10.07 **Benefits Provided through Third Parties.** In the case of any benefit provided through a third party, such as an insurance company, pursuant to a contract or policy with such third party, if any conflict or inconsistency exists between the description of benefits contained in this Plan and such contract or policy, then the terms of such contract or policy shall control.

10.08 **Rights Against the Employer.** Neither the establishment of the Plan, nor any modification thereof, nor any distribution hereunder, shall be construed as giving to any Participant or any person whomsoever any legal or equitable rights against the Employer, its shareholders, directors, or officers, as such, or as giving any person the right to be retained in the employ of the Employer.

10.09 **Successor-Businesses.** Unless this Plan be sooner terminated, a successor to the business of the Employer, by whatever form or manner resulting, may continue this Plan by appropriate supplemental agreement.

Article XI Plan Adoption and Schedule

11.01 **Employer Adoption.** By signing this Plan Document, the Employer identified below represents that it has formally adopted this Cafeteria Plan.

Employer: Buena Vista County

By: _____

Printed: _____

Title: _____

11.02 **Plan Year.** The Plan Year is from

January 1, 2018 to December 31, 2018.

There is a short Plan Year beginning

_____, 20 _____ and ending

_____, 20 _____.

(If left blank, there is no short Plan Year.)

11.03 **Effective Date.** This Cafeteria Plan was

originally effective on January 1, 2015.

This Cafeteria Plan has been

created or restated by this Plan Document

effective January 1, 2108.

11.04 **Eligible Employee.** An Employee who meets the definition of an Eligible Employee, 3.06, and the requirements in this part 11.04, can enroll in this Plan by completing the process outlined in the Enrollment Communications.

An Eligible Employee must be regularly scheduled to work 40 hours per week in order to enroll in this Plan. Part-time Employees working fewer hours are not Eligible Employees.

Description of Excluded Employees

Union. Employees who are included in the unit of Employees covered by a collective bargaining agreement between the Employer and Employee representatives, provided benefits were the subject of good faith bargaining and two percent or less of the Employees of the Employer who are covered pursuant to that agreement are professionals (as defined in Treasury regulation Section 1.410(b)-9). For this purpose, the term "Employee Representatives" does not include any organization more than half of whose members are Employees who are owners, officers, or executives of the Employer.

_____ Excluded
_____ Eligible
X Not applicable

Seasonal Employees regularly working less than

_____ months within a year.

_____ Excluded
_____ Eligible
X Not applicable

Employees under _____ years of age.

_____ Excluded
_____ Eligible
X Not applicable

11.05 **Commencement of Participation.** An Eligible Employee can enroll in this Plan at the annual open Enrollment period or upon completion of the employment requirement identified below:

_____ No wait, on the date of hire
_____ 30 days after the date of hire
_____ 60 days after the date of hire
_____ 90 days after the date of hire
_____ First of the month after the date of hire
_____ First of the month after 30 days of continuous employment
_____ First of the month after 60 days of continuous employment
X Other following 12 months of employment

_____

11.06 Qualified Benefits Plans. The Plan Documents and Summary Plan Descriptions identified in the chart below are expressly incorporated by reference into this Plan Document and provide specific description of each of the benefits available through the plan, including the periods during which the benefits are provided (the periods of coverage if different from the Plan Year for this Plan), and the Plan's rules governing participation.

The following Plans are offered under this Cafeteria Plan:

Check if offered under this Plan:	Qualified Benefits Plans	Available Plan Documents or Summary Plan Description (SPD)
X	Medical or Medical-Related Premium for a group health plan. (This can include an imbedded or standalone dental/vision plan.)	A Medical or Medical-Related Premium SPD will be provided by the Employer within 90 days of Enrollment and upon request.
_____	Health Savings Account (HSA)*	Details will be provided in the Enrollment Communication.
_____	Non-Employer-Sponsored Premium Account Plan for individual health plans (NESP).	See Appendix A.
X	Medical or Medical-Related Expense Reimbursement Benefit (Health FSA).	See Appendix B. A Medical or Medical-Related Expense Reimbursement Benefit SPD will be provided by the Employer within 90 days of Enrollment and upon request.
_____	Non-Excepted Medical or Medical-Related Expense Reimbursement Benefit (Health FSA)	See Appendix D. A non-excepted Medical or Medical-Related Expense Reimbursement Benefit SPD will be provided by the Employer within 90 days of enrollment and upon request.
X	Dependent Care Benefit.	See Appendix C.
X	Supplemental Insurance (Voluntary Indemnity Plans).	Details will be provided in the Enrollment Communication.
X	Disability Insurance Premium (Employee Only) - Pre-taxing Employee contributions will make benefits paid taxable compensation.	Details will be provided in the Enrollment Communication.
X	Voluntary/Group Term Life Insurance **	Details will be provided in the Enrollment Communication.

NOTES

* A Participant is required to make an election before the start of the Plan Year, or before the first day of his/her coverage, showing the amount contributed to an HSA tax free under this Plan. A Participant will be able to change his/her HSA election for any month in the Plan Year regardless of whether the Employee can show a Change in Status Event.

** The cost of excess coverage as determined in Table I, published by the IRS, a will be imputed income. Excess coverage is any amount over a $50,000 benefit.

COBRAToday COBRA Administration
DirectPay Health Reimbursement Arrangements (HRA)
FlexSystem Flexible Spending Accounts (FSA)
ERISAEdge ERISA Compliance
FMLAMatters FMLA Administration
Form 5500 Preparation
Funded HRA
GiveBack
HIPAA Compliance
Health Savings Accounts (HSA)
Medicare Part D
Non-Discrimination Testing
PayPath Payroll Services
PCORI

Total Administrative Services, Inc.

2302 International Lane, Madison, WI 53704-3140
800.422.4661

Plan Document: Appendix B

Medical or Medical-Related Expense Reimbursement Benefits Plan (Health Flexible Spending Account, or FSA)

All terms and conditions stated in the Plan Document and Appendix B are applicable to this Medical or Medical-Related Expense Reimbursement Benefits Plan (Health FSA) unless specifically changed by this Appendix B.

All capitalized terms in this Appendix B are defined exactly as in the Plan Document, Article III, Definitions.

This Plan is intended to provide reimbursement for certain medical expenses incurred by Participants and not otherwise covered by insurance or by the Employer. The Employer intends that the Plan qualify as an accident and health plan under Section 105 and 106 of the Internal Revenue Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participant incomes under Section 105(b) of the Code.

The Health FSA is an Employer Sponsored Welfare Plan as defined by ERISA (Employee Retirement Income Security Act of 1974) and is subject to ERISA. The Employer will provide a Summary Plan Description within 90 days of enrollment or on request. The Summary Plan Description will identify the Plan Administrator for this Plan.

Maximum Contribution. The maximum salary reduction that a Participant can make per Plan Year will be communicated in the Enrollment Communications that are provided to each Eligible Employee at open enrollment or at the time a new or existing Employee becomes eligible for enrollment in the Plan. Beginning Plan Years on and after January 1, 2013, a Participant's salary reduction cannot exceed the greater of these two: either the maximum salary reduction communicated in the Enrollment Communications or the maximum limit per Code Section 125(i), indexed for inflation.

Qualified Expenses. A medical expense incurred during a Plan Year by a Participant, the Participant's Spouse, or the Participant's Dependents while the Participant is covered under this Plan. Medical expenses are reimbursable only to the extent allowed as a medical expense under Section 213(d) of the Internal Revenue Code. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

Benefits. Benefits are provided from the Employer's general assets. There are no segregated funds established for this Plan. The amount of the Participant's annual election is available on each day of the Plan Year in which the Employee is a Participant.

A Participant is entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's annual election, and Employer contributions, if any. The amount of a Participant's annual election will be uniformly available during the Plan Year.

Claims. A claim under this Health FSA can be reimbursed only if the Participant provides a written statement from an independent third party stating that the medical expense has been incurred, the amount of the expense, and that the medical expense has not been reimbursed nor is it reimbursable under any other health plan coverage. If claims are submitted electronically, the Participant will sign a certification upon Enrollment or acceptance of an electronic card that claims submitted under the card have not been reimbursed by any other insurance or self-insured plan, and that the Participant is not seeking reimbursement under any other insured or self-insured plan.

Each claim will be substantiated by the submission of a third-party statement that shows that the claim is for a Qualified Benefits Expense, or by automated means that comply with guidelines established under IRS Rev. Rul. 2003-43.

Services purchased under a prefunded debit card can be automatically substantiated as allowed under IRS Notice 2006-69, including claims that are automatically substantiated using the Inventory Information Approval System (IIAS), amounts that are a multiple of a health plan copayment (up to five multiple copayments).

Death of Participant. In the event of the death of the Participant prior to the payment of any claims, payment will be made in the following priority:

(a) Executor of the Estate of the deceased Participant,

(b) Spouse, or,

(c) Family member held responsible for payment of deceased's medical bills.

Amounts Paid in Error. Upon any benefits payment made in error, the Plan Sponsor will inform the Participant that they are required to repay the amount that has been paid in error to or on the behalf of a Participant. This includes and is not limited to amounts exceeding the Participant's annual election, amounts for services that are determined not to be Qualified Expenses, or amounts that are not substantiated (as when a Participant does not provide adequate documentation to substantiate a claim upon request). The Employer may take reasonable steps to recoup such an amount, including reducing the amount of future benefits reimbursements by the amount paid in error.

Change in Enrollment. No Participant in the Plan will be allowed to alter or discontinue the Participant's elections during a Plan Year except when due to and consistent with a Change in Status Event. Change In Status enrollment requests must be made within 30 days of the Change In Status Event and be consistent with the actual Change in Status.

The new Benefits Enrollment Form, if determined by the Employer to be submitted in a timely fashion and consistent with the Status Change, will be effective prospectively and will apply only to those Benefits accruing to the Participant, the Participant's Spouse or the Participant's Dependents after the effective date of the new Benefits Enrollment Form. With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" will mean submitted no later than the last day of such special enrollment period. The Employer will determine if the new Benefits Enrollment Form has been timely submitted consistent with the nature of the Change in Status.

Limited Coverage under this Plan (Spouse covered under an HSA). Section 1201 of the Medicare Prescription Drug, Improvement & Modernization Act of 2003, added Section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning on or after December 31, 2003. In order to allow an Employee's Spouse to contribute to an HSA Account, an Employee is required to submit a written request to the Benefits Coordinator requesting "single" or "Parent and Child(ren)" enrollment in this Health FSA. Qualified Expenses are limited to covered services or supplies provided to the Employee and Dependents that are not covered under the Spouse's HSA. No claims for family members covered under the HSA can be submitted under this Plan.

Nondiscrimination. The Plan is not intended to discriminate in favor of highly compensated individuals regarding eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated employees from participation in the Plan or adjusting elections midyear, if in the Employer's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

Carryover. The Allowed Carryover Maximum will be communicated in the Enrollment Communications provided to each Eligible Employee at open enrollment or when a new or existing Employee becomes eligible for enrollment in the Plan. The Carryover Maximum will be the lessor of the amount communicated in the Enrollment Communications or $500.

The Allowed Carryover will be the lesser of the Allowed Carryover Maximum or the unused benefit balance at the end of the Runout Period. A Runout Period immediately follows the end of a Plan Year during which a Participant may request reimbursement of expenses incurred for qualified benefits during the Plan Year. The duration of any Runout Periods will be detailed in the Summary Plan Description provided by the Employer.

The amount carried over has no effect on the ability to elect the maximum salary reduction allowed under the Plan for the new Plan Year. If a Participant elects the maximum salary reduction allowed under the Plan then the amount carried over will be in addition to that election.

Forfeiture (Use-it-or-lose-it Rule) and Runout Period. Participant forfeits any unused amount in excess of the Allowed Carryover Maximum that remains unused at end of the Plan Year's Runout Period.

Participants who terminate coverage under this Plan during the Plan Year forfeit any amount of their annual elections that exceeds claims reimbursed during any Plan Year.

A Participant who is covered through the end of the Plan Year will have a Runout Period in which to submit eligible claims. A Participant who terminates coverage during the Plan Year has a Runout Period in which to submit eligible claims. The duration of these Runout Periods will be provided in the Summary Plan Description provided by the employer.

Upon such forfeiture, the Participant's accrual will be reduced to zero. Forfeiture of Plan benefit amounts may be (a) reallocated to existing Participants in any reasonable manner (reallocation must in no way relate to prior claims history) or (b) applied towards the cost of administering the Plan.

COBRA Continuation Coverage. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, does not apply to any group health plan of the Employer for any calendar year if all employers maintaining the Plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Any Participant eligible for COBRA continuation coverage under this Plan, shall be allowed to continue to participate in the Plan until the end of the Plan Year in which the qualifying event occurred, as long as such Participant complies with the provisions set out in COBRA. A Participant is eligible for COBRA coverage only when the cost to continue to the end of the Plan Year exceeds the remaining benefit.

The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Internal Revenue Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

Plan Administrator's Duties. The Plan Administrator, identified in the Summary Plan Description, will have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member). The Plan Administrator's decision will be final, binding, and conclusive on all parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude all individuals who are not considered Employees for purposes of the Employer's payroll system, and the Plan Administrator is authorized to do so, despite the fact that its decision may result in the loss of the Plan's tax qualification.

In addition, the Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefits determinations as it may determine at its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations regarding whether any individual is eligible and entitled to receive any benefits under the Plan.

The Plan Administrator is responsible for the administration of the Plan. In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator will have the following rights, duties and powers:

(a) to interpret the Plan; to determine the amount, manner, and time for payment of any benefits under the Plan; and to construe or remedy any ambiguities, inconsistencies, or omissions under the Plan;

(b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;

(c) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;

(d) to develop appellate and review procedures for any Participant, Spouse, Dependent, or beneficiary denied benefits under the Plan;

(e) to provide the Employer with such tax or other information it may require in connection with the Plan;

(f) to employ any agents, attorneys, accountants or other parties (who may also be Employees of the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year pertinent information regarding the administration of the Plan, to report any significant problems as to the administration of the Plan, and to make recommendations for modifications regarding procedures and benefits, or any other change which might ensure the efficient administration of the Plan.

The Privacy Rule. Protected Health Information ("PHI") is defined as information that is created or received by the Employer which relates to the past, present, or future physical or mental health or condition of a Participant; or, the provision of healthcare to a Participant; or the past, present, or future payment

for the provision of healthcare to a Participant; and that identifies the Participant. The test is whether there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

Access to PHI: The Employer's access to PHI is restricted to the minimum information necessary to administer the Health FSA. This includes obtaining Participant elections and reimbursements for payroll administration. The Employer has access to PHI submitted for claims reimbursement when that claim is on an appeal from an adverse decision. Only the Benefits Coordinator and Employees trained in the federal privacy rule will have access to the PHI.

Permitted And Required Uses And Disclosures of PHI By The Employer: The Employer may use and disclose PHI for Plan administration functions only as permitted and required by this Plan Document, or as required by law. The Employer will not use or disclose PHI for employment-related actions or in connection with any other Employee benefits plan. When necessary, the Benefits Coordinator will disclose the PHI to consultants and experts as required by the Department of Labor for a full and fair review or to perform Plan non-discrimination testing as required by law.

Complaints: If a Participant has any complaints regarding the way in which the Employer has handled PHI said Participant may complain to the Benefits Coordinator. No response from the Benefits Coordinator is required. A copy of this complaint procedure shall be provided to the Participant upon request. The Benefits Coordinator will keep a copy of the complaint, applicable documentation, and disposition if any, for a period of 6 years from the end of the Plan Year in which the act occurred.

No Retaliation: No Employee will intimidate, threaten, coerce, discriminate against, or take other retaliatory action against Participants for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under the federal Privacy Rule.

Firewall: The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of the group health plan; and ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information. Employer will do the following: (1) Ensure that any subcontractors or agents to whom the Plan Sponsor provides PHI agree to the same restrictions described above, (2) report to the health plan any use or disclosure that is inconsistent with this Plan Document or the federal Privacy Rule, (3) make the PHI information accessible to the Participants, (4) allow Participants to amend their PHI, (5) provide an accounting of its disclosures of PHI as required by the Privacy Rule, (6) make its practices available to the Secretary of Health and Human Services for determining compliance, and, (7) return and destroy all PHI when no longer needed, if feasible.

The Federal Security Rule. This rule is intended to bring the Plan into compliance with the "HIPAA Security Rule" as published on February 20, 2003 by the United States Department of Health and Human Services (HHS), and amended, including the final Security Standards under the Health Insurance Portability and Accountability Act of 1996 and the HITECH Act (Health Information Technology for Economic and Clinical Health Act) of the 2009.

The Electronic Media contemplated by the HIPAA Security Rule includes the following:

(a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

In order to send and receive Protected Health Information ("PHI" as defined in the Plan Document) necessary for Plan administration by Electronic Media, the Employer will do the following:

(a) implement reasonable and appropriate safeguards for electronic PHI created, received, maintained or transmitted to or by the Employer on behalf of the group health plan;

(b) ensure that electronic "firewalls" are in place to secure the electronic PHI;

(c) ensure that all agents and subcontractors with access to electronic PHI comply with the security requirements; and

(d) report to the group health Plan any security incident of which it becomes aware.

Employee Retirement Income Security Act (ERISA). The Health FSA is defined as a welfare benefits Plan subject to the ERISA Reporting requirements.

Summary Plan Description. The SPD informs Employees of their rights under the Plan. It must be provided to all Participants of all welfare benefits plans, regardless of size. New Participants must receive the SPD within 90 days of becoming Participants or receiving benefits.

Summary of Material Modification. The SMM informs Employees of any changes to the Plan. Participants must receive a SMM reflecting any such changes. However, a SMM is not required if a change is described in the SPD and is redistributed.

Summary Annual Report. A SAR is the highlight of the financial information detailed on IRS Form 5500. The SAR is to be distributed to Plan Participants within nine months following the end of the Plan Year. Unfunded Plans with fewer than 100 Participants at the beginning of the Plan Year are exempt from the SAR distribution rules.

IRS Form 5500. Form 5500 is required under ERISA Section 104, applicable to welfare benefits plans. Unfunded plans with fewer than 100 Participants are exempt from the filing requirement if Plan assets are not held in trust.

Plan Document: Appendix C

Dependent Care Benefits Plan

All terms and conditions stated in the Plan Document and Appendix C are applicable to this Dependent Care Benefits Plan unless specifically changed by this Appendix C.

All capitalized terms in this Appendix C are defined exactly as in the Plan Document, Article III, Definitions.

This Plan is intended to provide reimbursement for certain Dependent Care Expenses incurred by Participants. The Employer intends that the Plan qualify as a dependent care assistance plan under Section 129(d) of the Internal Revenue Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participant incomes under Section 129 of the Code. This Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Maximum Contribution. A Participant can defer the lesser of $5000, their earned income, or the Spouse's earned income, per plan Year. If a Spouse is disabled or a full-time student with no income, then the Spouse is deemed to have a monthly income of $250, if one dependent, $500 if two or more dependents. A married Participant who files a separate tax return is limited to $2,500 per year. Contributions to the Plan are made and limited in accordance with the Participant's annual election.

Maximum Benefit. A Participant can never withdraw more funds than actually contributed on the date a claim is submitted. If a Participant fails to use his/her entire election at the end of the Plan Year or upon other termination of the Plan, the unused election cannot be cashed out and becomes the property of the Employer.

Dependent Care Expenses. Expenses incurred by a Participant for the care of a Qualified Person or for related household services which would be considered employment-related expenses under Section 21(b)(2) of the Internal Revenue Code.

Qualifying Person - All child and Dependent Care Expenses must be for the care of one or more Qualifying Persons. A Qualifying Person is defined as the following:

(a) A child whom is claimed as the Participant's Dependent and who was under the age of 13 when the care was provided;

(b) A Participant's Spouse who was physically or mentally unable to care for himself/herself and lived with the Participant for more than half of the year;

(c) A person who was physically or mentally unable to care for himself or herself and lived with the Participant for more than half of the year, and either of the following:

  (1) Was the Participant's Dependent; or

  (2) Would have been the Participant's Dependent without the occurrence of one of the following:

    i) He or she received gross income equal to or in excess of the exemption amount for Dependents under Internal Revenue Code § 151(d);

    ii) He or she filed a joint tax return;

    iii) The Participant, or the Participant's Spouse if filing jointly, could be claimed as a Dependent on someone else's federal tax return.

Child of divorced or separated parents: Even if a Participant cannot claim a child as a Dependent, he or she is treated as a Qualifying Person if one of the following applies.

(a) The child was under the age of 13 or was physically or mentally unable to care for himself/herself; or

(b1) The Participant was the child's custodial parent (the parent with whom the child lived for the greater part of the calendar year), and

(b2) The non-custodial parent is entitled to claim the child as a Dependent under the special rules for a child of divorced or separated parents.

If this applies, the non-custodial parent cannot treat the child as a Qualifying Person.

Benefits and Claims - Benefits are provided only for the reimbursement of a Qualified Person's Dependent Care Expenses that are incurred during the Plan Year and during the period in which the Employee was a Participant. Benefits are limited to the amount that has actually been withheld from the Participant's Compensation on the date the claim is processed.

Reimbursement will be made under the Plan only on the basis of Dependent Care Expenses incurred for the care of a Qualified Person, as presented on a written form specific for requesting reimbursement from the Plan. Dependent Care Expenses requested for reimbursement will be reviewed for eligibility prior to reimbursement from a Participant's dependent care reimbursement benefits account. If it is determined that an expense is a Dependent Care Expense subject to reimbursement, the Participant will be reimbursed for the Dependent Care Expense within a reasonable time. To make the determination that a Dependent Care Expense subject to reimbursement has been incurred, proper evidence of any or all of the following may be required:

(a) the name of the Qualified Person for whom the expenses have been incurred;

(b) the nature of the services incurred;

(c) the date the services were incurred;

(d) the amount of the requested reimbursement; and,

(e) that the expenses have not been otherwise paid through a program offered by the Employer or any other employer, or reimbursed from any other source.

The Employer will make the final determination of what constitutes a Dependent Care Expense subject to reimbursement under the Plan.

In the event of the death of the Participant prior to the payment of any claims, payment will be made in the following priority:

(a) Executor of the Estate of the deceased Participant,

(b) Spouse of decedent.

Amounts Paid in Error - Upon any benefit payment made in error, the Employer will inform the Participant that they are required to repay the amount that has been paid to or on the behalf of a Participant in error. This includes and is not limited to amounts over the Participant's annual election, amounts for services that are determined not to be Dependent Care Expense, or when a Participant does not provide adequate documentation to substantiate a claim upon request. The Employer may take reasonable steps to recoup such an amount including reducing the amount of future benefit reimbursements by the amount paid in error.

Forfeiture (Use-it-or-lose-it Rule) - A Participant forfeits any amount of his/her annual election that exceeds of the amount of claims reimbursed during any Plan Year. A Participant who terminates coverage during the Plan Year has a run out period in which to submit eligible claims. A Participant who is covered through the end of the Plan Year will have a run out period in which to submit eligible claims. The duration of these run out periods will be provided in the Summary Plan Description provided by the Employer.

Upon such forfeiture, the Participant's accrual will be reduced to zero. Forfeited funds can be retained by the Employer, or at the discretion of the Employer, forfeitures of benefits under the Plan can be reallocated to Participants in any reasonable manner that has no relation to prior claims history. Forfeitures of benefits also may be applied towards the cost of administering the Plan. Forfeitures of benefits will become the sole property of the Employer.

Change in Enrollment. No Participant in the Plan will be allowed to alter or discontinue the Participant's elections during a Plan Year except when due to and consistent with a Change in Status. Change in Status Event enrollment requests must be made within 30 days of the Change in Status Event and be consistent with the actual Change in Status, as defined by the IRS.

The new Benefits Enrollment Form, if determined by the Employer to be submitted in a timely fashion and consistent with the Status Change, will be effective prospectively and apply only to those Benefits accruing to the Participant, the Participant's Spouse, or the Participant's Dependents after the effective date of the new Benefits Enrollment Form.

Nondiscrimination. The Plan is not intended to discriminate in favor of highly compensated individuals regarding eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. The Employer may take such actions as excluding certain highly compensated employees from participation in the Plan or adjusting elections midyear, if in the Employer's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

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Plan Document: Grace Period Amendment

Amendment to the Dependent Care Benefits Plan

All terms and conditions stated in the Plan Document and Appendix C are applicable to this Amendment unless specifically stated in this Amendment.

All capitalized terms in this Amendment are defined exactly as in the Plan Document, Article III, Definitions, or as defined in Appendix C.

Grace Period. The Dependent Care Benefits Plan allows reimbursement for Dependent Care Expenses, when the services are rendered during the Grace Period. The Grace Period extends two and one half months after the last day of your Plan Year. The last day of this Grace Period is the fifteenth day of the third month following the end of the Plan Year. Services that are rendered after the last day of this Grace Period will not be considered for reimbursement under the prior Plan Year.

You must be enrolled on the last day of the Plan Year in order for this Grace Period to apply.

Order of payment. Dependent Care Expenses rendered during the Grace Period will be reimbursed using any balance in your prior Plan Year annual election first, and then reimbursed from any new Plan Year annual election.

Participants who terminate before the end of the Plan Year. If you terminate coverage for any reason prior to the end of the last day of the Plan Year, then you may not submit any claims for services that were rendered after your date of termination. The Grace Period rules described above will not be available.

Forfeiture (Use-it-or-lose-it Rule) and run out period for submitting claims. A Participant forfeits any amount of his/her annual election that exceeds the amount of claims reimbursed for Qualified Expenses rendered during any Plan Year or applicable Grace Period.

A Participant who terminates coverage during the Plan Year has a run out period in which to submit eligible claims. The duration of the run out period will be provided in the Summary Plan Description provided by the Employer.

A Participant who is covered through the end of the last day of any Plan Year will have a run out period in which to submit eligible claims. The duration of the run out period will be provided in the Summary Plan Description provided by the Employer.

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Plan Document: Heart Act Amendment

Heart Act Amendment to the Medical or Medical-Related Expense Reimbursement Benefits Plan (Health FSA)

All of the terms and conditions stated in the Plan Document and Appendix B continue in effect unless specifically changed by the terms of this Amendment. All capitalized terms in this Amendment have the same meaning as defined in Article III, Definitions, in the Plan Document or as defined in Appendix B.

Military Cash Out Option. A Participant in the Plan will receive a Qualified Reservist Distribution upon written request provided to the Employer. A Qualified Reservist Distribution means a distribution to a Participant of all or a portion of the Balance in the employee's account under the Plan, if:

(a) a Participant was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code)) ordered or called to active duty for a period of 180 days or more, or for an indefinite period; and,

(b) the distribution is requested and made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year in which the Participant received the order or call.

The Balance that can be distributed is limited to the amount of the Participant's actual payroll deductions made as of the date of the request, less any amount that has already been disbursed for valid claims submitted. A request for a Qualified Reservist Distribution after the period defined under Paragraph B will be denied.

Plan Document: Carryover Opt-Out Amendment

To the Medical or Medical-Related Expense Reimbursement Benefits Plan (Health FSA)

All terms and conditions stated in the Plan Document and Appendix B are applicable to this Health FSA Amendment unless specifically stated in this Amendment.

All capitalized terms in this Amendment are defined as in Article III, Definitions, in the Plan Document, or as defined in Appendix B.

This Amendment removes the Carryover terms for the Medical or Medical-Related Expense Reimbursement Benefits (Health FSA). The Carryover terms stated in Appendix B are hereby deleted in their entirety.

Forfeiture (Use-it-or-lose-it-Rule) and Runout Period for submitting claims. A Participant forfeits any election balance that exceeds claims reimbursed for Qualified Expenses rendered during any period of time the Participant was covered under the Plan and submitted before the end of the Runout Period.

A Participant who is covered through the end of the Plan Year will have a Runout Period in which to submit eligible claims. A Participant who terminates coverage during the Plan Year has a Runout Period in which to submit eligible claims. The duration of these Runout Periods will be provided in the Summary Plan Description provided by the employer.

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