ONEBRIDGE BENEFITS

CAFETERIA PLAN

WITH

FLEXIBLE SPENDING ACCOUNTS

AS ADOPTED BY
BENTON COUNTY PUD

PLAN DOCUMENT

AMENDED AND RESTATED EFFECTIVE AS OF THE
FIRST DAY OF ANY PLAN YEAR BEGINNING ON OR AFTER SEPTEMBER 1, 2020

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PREAMBLE. CAFETERIA PLAN

Effective as of the Effective Date, the Employer has established the Cafeteria Plan (the "Plan" or "Cafeteria Plan") for its Employees for purposes of providing eligible Employees with the opportunity to choose from the Benefit Options available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125.

In addition to the Cafeteria Plan, there are appendices attached to this Plan Document that describe the terms of the Health Flexible Spending Account and the Dependent Care Flexible Spending Account. To the extent either of these plans is adopted by the Employer, the appendix for that Plan is incorporated into and made a part of this Plan Document.

The **Summary Plan Description** or **SPD**, **Plan Information Summary**, and **Cardholder Agreement** delivered to Participants, collectively contain many of the actual terms and conditions of this Plan. Accordingly, the **SPD**, **Plan Information Summary**, and **Cardholder Agreement**, as amended from time to time, are incorporated into and made a part of this Plan Document and are collectively referred to as the Plan Documents. Note that, to the extent permitted by law, if there is a conflict between the terms of this Plan Document and any of the other Plan Documents incorporated herein, the specific terms of this Plan Document will control.

ARTICLE 1. DEFINITIONS

Capitalized terms that are used and not otherwise defined in this Plan Document or an applicable Appendix hereto are defined in the **SPD**.

"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).

"After-tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Election after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Options available under the Plan.

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

"Benefit Option(s)" means those Qualified Benefits available to a Participant under this Plan as set forth in the **Plan Information Summary**.

"Change in Status" means any of the events described in the **Summary Plan Description**, 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 **Summary Plan Description** for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

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

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

"Dependent" means any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a); however, that in the case of health benefits, a Dependent shall be defined as set forth in Code Section 105(b) and the regulations issued under Code Section 106. For purposes of Dependent Care FSA (if offered under the Plan) a Dependent shall also be defined as in Code Section 21(e)(5) (i.e., dependent of the parent with custody for the greatest portion of the year).

"Effective Date" of the Plan means the date that this Plan was adopted or established by formal action of the Governing Body of the Employer. The Effective Date is disclosed in the **Plan Information Summary.** If the Plan or this Plan Document is amended or restated from time to time, the effective date of such amendment or amended and restated Plan Document as set forth on the cover page of the amendment or amended and restated Plan Document.

"Eligibility Date" means, for any Employee who has satisfied the Employer's eligibility requirements for this Plan, the later to occur of the Employee's hire date or the date the Employee completes a Salary Reduction Election.

"Employee" means an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any of the following: (a) any leased employee (including, but not limited to, those individuals defined in Code § 414(n)); (b) an individual classified by the Employer as a contract worker or independent contractor; (c) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll; and (d) any individual who performs services for the Employer but who is paid by a temporary or

other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement, except as otherwise provided for in the collective bargaining agreement.

"Employer" means the Employer identified in the **Plan Information Summary** as the sponsoring employer and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Employer. Notwithstanding the previous sentence when the Plan provides that the Employer has a certain power (e.g., the appointment of a third party administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only the Employer identified as the Plan Sponsor. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

"Employer Contribution" 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 Dependents, if applicable, under one or more of the Benefit Option(s) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Option(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time at 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 **Summary Plan Description** or enrollment material, the Employer may make Employer Contributions available in the form of Flex Credits to allow Participants to allocate the Flex Credits among the various Benefit Options. In no event will any Employer Contribution or Flex Credit be disbursed to a Participant in the form of additional, taxable Compensation except as otherwise provided in the **Summary Plan Description** or enrollment material.

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

"Flex Credit" means Employer Contributions that are available to Participants and allow Participants to allocate the Flex Credits among the various Benefit Options offered under the Plan in a manner set forth in the Salary Reduction Election instructions or enrollment material. In no event will any Flex Credit be disbursed to a Participant in the form of additional, taxable Compensation except as otherwise provided in the enrollment material.

"Flexible Spending Account Plan" means either (1) the Health Flexible Spending Account Plan, the terms and conditions for which are described in the Health Flexible Spending Account Appendix hereto and in the Health FSA Summary set forth in the **SPD** or (2) the Dependent Care Flexible Spending Account Plan, the terms and conditions for which are described in the Dependent Care Flexible Spending Account Appendix hereto and in the Dependent Care FSA Summary set forth in the **SPD**.

"Governing Body" means the council, committee, board, or other governing body of the Employer. The Governing Body, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

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

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

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

"Plan" means this Cafeteria Plan, as set forth herein.

"Plan Administrator" means the person(s) or Committee identified in the **Summary Plan Description** 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.

"Plan Year" shall be the period of coverage set forth in the **Summary Plan Description**.

"Pre-tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Election before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Options available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Option 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).

"Qualified Benefit" means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 119 , 127, or 132 and any other benefit permitted by the Income Tax Regulations (i.e., any group-term 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, long-term care insurance is not a "Qualified Benefit."

"Qualified Reservist Distribution" means a distribution to an individual of all or a portion of the balance in such individual's Health Care Reimbursement Account if:

(i) while a Participant, such individual 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

(ii) such distribution is 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 Health Flexible Spending Account for the Plan Year which includes the date of such order or call.

"Salary Reduction Election" means the means by which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Options with Pre-tax or After-tax Contributions and/or Flex Credits (if offered under the Plan) in accordance with Article III herein. A Salary Reduction Election includes any election change form by which an eligible Employee or Participant makes permitted changes to his or her original elections. If the Employer utilizes an interactive voice response (IVR) system or other, alternative web-based program or electronic medium for enrollment that requires a unique login or other form of personal identification number to serve as an electronic signature, the Salary Reduction Election may be completed using this medium. Elections made and directions received using such an alternative medium are enforceable as if such elections were made or directions provided in writing and signed by the Employee or Participant and may be maintained by or on behalf of the Plan Administrator on an electronic database in accordance with the **SPD** and all applicable federal and/or state laws.

"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 Spending Account 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.

"Summary Plan Description" or "SPD" means the OneBridge Benefits Cafeteria Plan with Flexible Spending Accounts **Summary Plan Description**, as adopted by the Employer, including all appendices and documents contained or referenced therein and incorporated into and made a part of the **SPD**, as amended from time to time. The **SPD** is incorporated by reference into and made a part of this Plan Document.

ARTICLE 2. ELIGIBILITY AND PARTICIPATION

2.01 Eligibility to Participate.

Each Employee who satisfies the eligibility requirements for the Plan shall be eligible to participate in this Plan as of Employee's Eligibility Date. Eligibility requirements for the Plan are determined pursuant to Employer policies, collective bargaining agreements or other legal or contractual obligations of the Employer and are summarized in the **Plan Information Summary.** Eligibility to participate in this Plan means only that the eligible Employee is entitled to contribute his share of the cost of applicable Benefit Options for which he is eligible with Pre-tax Contributions. Eligibility to make Pre-tax Contributions may be further subject to eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Options and the terms of eligibility and participation for the Benefit Option(s) offered under the Plan shall be subject to the requirements specified in the applicable governing documents for each Benefit Option.

By electing to participate in the Plan, using or claiming benefits under the Plan, or using the OneBridge Benefits Card for payment of benefits, a Participant is deemed to have agreed to abide by and be subject to the terms and conditions (including any limitations under the Plan) set forth in the Plan Documents. Participation in the Plan does not give any Participant the right to be retained in the employ of the Employer or any other right not specified in the Plan Documents.

2.02 Termination of Participation.

Participation in this Cafeteria Plan shall terminate or end on the earliest of the dates set forth in the **SPD**.

2.03 Qualifying Leave Under the Family and Medical Leave Act.

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 Options that provide health coverage (including Health Flexible Spending Account) 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, will be described in and administered in accordance with the FMLA, the **SPD**, and the regulations issued under Code Section 125.

2.04 Non-FMLA Leave.

If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Options 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** and implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Options chosen by the Participant, the election change rules in Section 3.04 will apply. If the Employer's 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 3. CONTRIBUTION ELECTIONS

3.01 Election of Contributions.

Participants may elect any combination of Pre-tax Contributions or After-tax Contributions (to the extent set forth in the enrollment material) to fund any Benefit Option 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 Flex Credits to one or more Benefit Options offered under the Plan and may also allow Participants to allocate their allotted share of Flex Credits among the various Benefit Options in a manner set forth in the Salary Reduction Election instructions and enrollment materials.

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 must complete a Salary Reduction Election 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 Salary Reduction Election 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 must complete a Salary Reduction Election during the Initial Election Period set forth in the **SPD** or the enrollment material. Participation will commence under this Plan on the Employee's Eligibility Date. Coverage under the component Benefit Options will be effective in accordance with the governing provisions of such Benefit Options.

(c) **Failure to Elect.** An eligible Employee who fails to complete a Salary Reduction Election 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 will have the right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan during the Annual Election Period. The date on which the Annual Election Period commences, and ends will be determined by the Plan Administrator. The consequences of failing to make an election during the Annual Election Period will be set forth in the **SPD** or the enrollment material.

3.04 Change of Elections.

A Participant may not make any changes to the Pre-tax Contribution amount, or where applicable, to the Participant's elected allocation of Flex Credits, except under the circumstances set forth in the **SPD** and for changes made during the Annual Election Period. 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, as determined by the Plan Administrator.

3.05 Impact of Termination of Employment on Election or Cessation of Eligibility.

If a Participant's employment with the Employer is terminated during the Plan Year or the Participant otherwise ceases to be eligible, the Employee's active participation in the Plan will *automatically* cease. If participation in the Plan ceases pursuant to 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 except as set forth in the **SPD**.

ARTICLE 4. PREMIUM PAYMENTS AND CREDITS AND DEBITS TO ACCOUNTS

4.01 Source of Benefit Funding.

The cost of coverage under the component Benefit Options shall be funded by Participant's Pre-tax and/or After-tax Contributions and/or any Employer Contributions or Flex Credits provided by the Employer. The required contributions for each of the Benefit Options offered under the Plan will be set forth in the applicable enrollment materials. Pre-tax or After-tax Contributions (as elected by the Employee on the Salary Reduction Election and permitted by the Employer) shall equal the aggregate cost of the Benefit Options elected by the Participant less any Employer Contributions allocated thereto by the Employer or Flex Credits allocated by the Participant for coverage 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.

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 any requirement or limitation imposed by the Code 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 Pre-tax Contribution election without the consent of such Employee.

ARTICLE 5. BENEFITS

5.01 Qualified Benefits.

The maximum amount of Compensation contributed by a Participant as Pre-tax Contributions shall not exceed the aggregate cost of the Benefit Options elected by the Participant, less the aggregate amount of Employer Contributions allocated thereto by the Employer and Flex Credits allocated thereto by the Participant.

5.02 Cash Benefit.

To the extent that a Participant does not elect to have the maximum amount of his Compensation permitted to be 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 Employer Contributions or Flex Credits may not be received in the form of cash compensation, except as otherwise provided for in the **SPD** or the enrollment material.

ARTICLE 6. 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. 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 the Plan Administrator 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 the Plan Administrator 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 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 the Plan Service Provider and shall be identified in the **SPD**;

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

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

6.02 Provision for Third-Party Plan Service Providers.

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons, as it may deem necessary or desirable, in connection with the operation of the Plan, and may rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Such entity will be identified in the **SPD** as the Plan Service Provider. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

6.03 Fiduciary Liability.

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

6.04 Compensation of Plan Administrator.

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but the Employer shall pay all reasonable expenses incurred in the performance of his or her duties.

6.05 Bonding.

Unless otherwise determined by the Employer, or unless required by any federal or state law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan and any Flexible Spending Account Plan offered as a Benefit Option.

6.06 Payment of Administrative Expenses.

Unless otherwise indicated in the **SPD**, the Employer currently pays all reasonable expenses incurred in administering the Plan.

6.07 Funding Policy.

The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefit Options offered under the Plan and to replace any of such

insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by, the Employer. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this plan. Such limitation shall include, but not be limited to, losses or obligations that pertain to the following:

(a) Once insurance is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;

(b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other losses which result from such failure;

(c) The Employer will not be liable for the payment of any insurance premium or any loss that may result from the failure to pay an insurance premium if the benefits available under this plan are not enough to provide for such premium cost at the time it is due. In such circumstances, the Employee will be responsible for, and see to, the payment of such premiums. The Employer will undertake to notify a Participant if available benefits under this plan are not enough to provide for an insurance premium, but will not be liable for any failure to make such notification;

(d) When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this plan, and the Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

ARTICLE 7. CLAIM PROCEDURES

The Plan has established procedures for reviewing claims denied under the Flexible Spending Account Plans and those claims review procedures are set forth in the **SPD**. The Plan's claim review procedures set forth in the **SPD** shall apply only to claims for benefits under the Flexible Spending Account Plans. 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 Plan Document) shall be determined at the discretion of the Plan Administrator.

ARTICLE 8. AMENDMENT OR TERMINATION OF PLAN

8.01 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 8.02 and 8.03, 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.

8.02 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 the normal procedures of its Governing Body for transacting business or by the Plan Administrator or such other delegee pursuant to the delegation authority of the Governing Body. Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Option 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.

8.03 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.

8.04 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.

ARTICLE 9. GENERAL PROVISIONS

9.01 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.

9.02 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 Employer's primary domicile to the extent not preempted by federal law.

9.03 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.

9.04 Multiple Functions.

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

9.05 Tax Effects.

Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any Pre-tax Contributions 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 are 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.

9.06 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.

9.07 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.

9.08 Incorporation by Reference.

The actual terms and conditions of the separate component Benefit Options 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 respective individual plan document and this Plan Document 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. In addition, the **Summary Plan Description** or **SPD**, **Plan Information Summary**, and the Cardholder Agreement relating to your OneBridge Benefits Card[1], collectively contain many of the actual terms and conditions of this Plan. Accordingly, the **SPD**, **Plan Information Summary**, and Cardholder Agreement, as amended from time to time, are incorporated into and made a part of this Plan Document and are collectively referred to as the Plan Documents. Note that, except as set forth above with respect to the individual plan document for any individual Benefit Option and to the extent permitted by law, if there is a conflict between the terms of this Plan Document and any of the other Plan Documents incorporated herein, the specific terms of this Plan Document will control.

9.09 Severability.

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

9.10 Effect of Mistake.

In the event of a mistake as to the eligibility or participation of an Employee, or 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 Plan Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

[1] The OneBridge Visa® Benefits Card is issued by the Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card can be used for qualified expenses wherever Visa Debit Cards are accepted. See cardholder agreement for details.

APPENDIX A TO THE CAFETERIA PLAN. HEALTH FLEXIBLE SPENDING ACCOUNT

PREAMBLE. HEALTH FSA

If identified as a Benefit Option is the Plan Information Summary, the Employer has established a Health Flexible Spending Account Plan (the Health FSA) to help provide full and complete medical care for those Employees who participate in the Employer's Cafeteria Plan ("Plan") and who, pursuant to the election procedures set forth in the Plan, choose to contribute to a Health FSA established pursuant to this document. This Health FSA is intended to provide reimbursement of certain Eligible Medical Expenses incurred by the Participant and his eligible Dependents. The Employer intends that the Health FSA qualify as a Code Section 105 self-insured medical reimbursement plan, and that the benefits provided under the Health FSA be eligible for exclusion from the Participant's income for federal income tax purposes under Section 105(b) of the Code. This Health FSA is a component of, and incorporated by reference into, the Cafeteria Plan, and the terms and conditions of the Cafeteria Plan Document apply also to this Health FSA.

This Health Flexible Spending Account Appendix only applies if a Health FSA has been identified as a Benefit Option in the **Plan Information Summary**.

ARTICLE 1A. DEFINITIONS

Unless otherwise specified, terms that are capitalized in this Appendix A have the same meaning as the defined terms in the Cafeteria Plan Document or **SPD**. The definitions of terms defined in this Appendix A, but not defined in the Cafeteria Plan or the **SPD**, shall be applicable only with respect to this Appendix A. To the extent a term is defined both in the Cafeteria Plan Document (or **SPD**) and in this Appendix A, the term as defined in the Cafeteria Plan Document shall govern the interpretation of the Cafeteria Plan and the term as defined in this Appendix A shall govern the interpretation of this Health FSA.

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code Section 105(b).

"Eligible Medical Expenses" means those expenses that are eligible for reimbursement under this Health FSA as set forth in the **SPD**.

"Health Care Reimbursement" shall have the meaning assigned to it by Section 4.01A of this Health FSA.

"Health Care Reimbursement Account" is defined in the **SPD**.

"Highly Compensated Individual" means an individual defined under Code Section 105(h) or 125(e), as amended, as a "highly compensated individual" or a "highly compensated employee."

ARTICLE 2A. ELIGIBILITY AND PARTICIPATION

2.01A Eligibility to Participate. Each Employee who satisfies the Employer's eligibility requirements shall be eligible to participate in this Health FSA as of the Employee's Eligibility Date.

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

2.03A Qualifying Leave Under the Family and Medical Leave Act. Notwithstanding any provision to the contrary in this Health FSA, 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 coverage under this Health FSA 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.

2.04A Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Health FSA, 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** and implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Health FSA, the election change rules in Section 3.03A of this Health FSA 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 3A. ELECTION TO PARTICIPATE

Salary reductions made with respect to the Plan for a Plan Year for Health Care Reimbursement (under all Health Flexible Spending Accounts) shall not exceed the maximum amount permitted by law per Participant or such lower amount as set forth in the Plan **SPD** or Plan enrollment materials. In the event of a short Plan Year for all Participants, the maximum amount permitted hereunder shall be pro-rated.

3.01A Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Health FSA as of the Effective Date must complete a Salary Reduction Election during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Health FSA in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Election shall be effective, subject to Section 3.02A, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Health FSA's Waiting Period**. An Employee who becomes eligible to become a Participant in this Health FSA after the Effective Date must complete a Salary Reduction Election during the Initial Election Period set forth in the **SPD** or the enrollment material. Participation will commence under this Health FSA as set forth in the **SPD** (but in no event prior to the election).

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Election 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 3.02A or 3.03A.

3.02A Annual Election Period. Each Employee who is a Participant in this Health FSA or who is eligible to become a Participant in this Health FSA will have the to become a Participant in this Health FSA, to continue participation in this Health FSA, or to modify or to cease participation in this Health FSA during the Annual Election Period. The date on which the Annual Election Period commences and ends will be determined by the Plan Administrator. The consequences of failing to make an election during the Annual Election Period will be set forth in the **SPD**.

3.03A Change of Elections. A Participant may not make any changes to his or her election except for election changes permitted under the **SPD**, and for changes made during the Annual Election Period. 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, as determined by the Plan Administrator.

3.04A Impact of Termination of Employment or Cessation of Eligibility on Election. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Election. Except as provided below, if revocation occurs under this Section 3.04A, no new election with respect to the Health FSA may be made during the remainder of the Plan Year except as set forth in the **SPD**.

3.05A Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Health FSA may fail to satisfy any requirement or limitation imposed by the Code or on Pretax Contributions allocated by 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 an action

may include, without limitation, a modification or revocation of a Highly Compensated Individual's election without the consent of such Employee.

ARTICLE 4A. REIMBURSEMENTS

4.01A Health Care Reimbursement. Each Participant's Health Care Reimbursement Account will be credited for Health Care Reimbursement with amounts withheld from the Participant's Compensation and any Employer Contribution or Flex Credits allocated thereto by the Employer or where applicable, the Participant. The Health Care Reimbursement 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 Salary Reduction Election as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed to the Participant for Eligible Medical Expenses incurred during the Plan Year shall be available to the Participant at any time during the Plan Year without regard to the amounts withheld from the Employee's Compensation (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 Health FSA. In no event will the amount of Health Care Reimbursements in any Plan Year exceed the annual amount specified for the Plan Year in the Salary Reduction Election for Health Care Reimbursement. Any amount credited to the Health Care Reimbursement Account shall be forfeited by the Participant applied by the end of the run-out period set forth in the **SPD** to provide Health Care Reimbursement for expenses incurred during the Plan Year, or has not been used to make a Qualified Reservist Distribution as set forth in the **SPD**. Notwithstanding the foregoing, the Employer has the discretion to establish a grace period following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Eligible Medical Expenses incurred during the grace period. In no event can the grace period exceed the time period permitted by applicable law.

In lieu of a grace period, the Employer may also elect to carryover any unused Health Care Reimbursement Account balance at the end of the Plan Year to the next Plan Year up to the maximum amount permitted by applicable law. The Employer may require or allow participants who elect Health Savings Account compatible coverage for the next Plan Year to carryover unused Health Care Reimbursement Account balances to a limited-purpose Health FSA coverage as set forth in the **SPD**. In addition, the Plan Administrator may permit an individual to decline or waive any carryover of an unused Health Care Reimbursement Account balance to the next Plan Year before the beginning of that next Plan Year.

If a grace period or carryover is adopted, all amounts allocated to the Health FSA during a Plan Year that are not used to reimburse Eligible Medical Expenses incurred during the Plan Year and/or the grace period or not carried over (or used to make a Qualified Reservist Distribution), shall be forfeited. 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 Health FSA, including the amount of the carryover (if any), shall be set forth in the **SPD**. The Employer may establish a minimum annual reimbursement amount as set forth in the **SPD**.

If adopted by the Employer, the Employer will make Qualified Reservist Distributions as described in the **SPD** to the extent that the Participant satisfies all election requirements established in accordance with applicable law and the Employer's internal policies and procedures.

4.02A Receiving Health Care Reimbursement. Payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Dependents while he is a Participant during the Plan Year (or during the grace period to the extent adopted by the Employer) for which the Participant's election is effective provided that the substantiation requirements of Section

4.03A herein are satisfied. However, if the Employer so chooses, the participant may choose to make payment for eligible medical expense with an electronic payment card arrangement. The terms of the electronic payment card arrangement, if applicable, will be set forth in the **SPD**.

4.03A Substantiation of Expenses. Each Participant must submit an expense for reimbursement in accordance with the terms of the **SPD** and provide the required substantiation set forth in the **SPD** or as otherwise requested by the Plan Administrator (or its designee).

4.04A Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been substantiated by such Participant during the Plan Year as required by Section 4.03A herein or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the excess reimbursements may be recouped as set forth in the **SPD**.

If, as of the end of the period for making a Qualified Reservist Distribution, it is determined that a Participant has received a distribution under this Plan that exceeds the amount allowable for a Qualified Reservist Distribution for the applicable Plan Year, 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.

4.05A Reimbursement Following Cessation of Participation. Participants in the Health FSA may submit claims for reimbursement for Eligible Medical Expenses incurred during the Plan Year and before the date of participation in the Health FSA ceases as set forth in the **SPD**.

4.06A Coordination of Benefits Under the Health FSA. The Health FSA is intended to pay benefits solely for otherwise unreimbursed medical expenses (subject to Qualified Reservist Distributions, if adopted by the Employer). 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.

4.07A Disbursement Reports. The Plan Administrator shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Health FSA.

4.08A Timing of Reimbursements. Reimbursements shall be made as soon as administratively feasible after the Plan Administrator or its designee has received the required forms.

4.09A Statements. The Plan Administrator, or its designated third party administrator, may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Health Care Reimbursement under the Health FSA.

4.10A Post-Mortem Payments. Any benefit payable under the Health FSA after the death of a Participant shall be paid to his surviving Spouse, or if no spouse, 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.

4.11A Non-Alienation of Benefits. Except as expressly provided by the Plan Administrator, no benefit under the Health FSA 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

Health FSA shall in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person.

4.12A Mental or Physical Incompetency. Every person receiving or claiming benefits under the Health FSA 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.

4.13A 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 Health FSA, because he cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to locate such person, such payment and all subsequent payments otherwise due to such Participant, or other person, shall be forfeited after a reasonable time after the date any such payment first became due.

4.14A Tax Effects of Reimbursements. Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any reimbursements or Qualified Reservist Distributions made under the Health FSA 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 are 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 Health FSA is designed, and is intended to be operated, as a self-insured medical reimbursement plan under Section 105 of the Code.

4.15A Forfeiture of Unclaimed Health FSA Benefits. Any Health Flexible Spending Account benefit payments that are unclaimed (e.g., uncashed benefit checks) within 180 days following the close of the plan year shall be forfeited.

ARTICLE 5A. FUNDING AGENT

The Health FSA shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Elections, and/or Employer Contributions and Flex Credits provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, out of its general assets to pay for the welfare benefits provided herein as soon as administratively feasible and to the extent applicable, shall comply with all applicable regulations promulgated by the DOL, taking into consideration any enforcement procedures adopted by the DOL.

ARTICLE 6A. CLAIM PROCEDURES

The Plan has established procedures for reviewing claims denied under this Health FSA, and those claims review procedures are set forth in the **SPD**.

ARTICLE 7A. CONTINUATION COVERAGE UNDER COBRA

The **SPD** includes COBRA continuation of coverage provisions that shall be applicable to the Health FSA to the extent the plan sponsor is subject to COBRA (as it amended ERISA, the Code, and the Public Health Service Act).

ARTICLE 8A. HIPAA PRIVACY AND SECURITY

8.01A Scope and Purpose. The Health FSA is a Health Plan (as defined below), and as such will use protected health information ("PHI") to the extent of, and in accordance with, the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Health FSA will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations as set forth below.

8.02A Definitions. For purposes of this Article, the following definitions shall apply:

"Breach" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule that compromises the security or privacy of the PHI. A Breach does not include:

(i) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure;

(ii) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or

(iii) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

"Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media.

"Enrollment/Disenrollment Information" means information of the Employer that is held on behalf of the Employer by the Plan Administrator and other Plan Service Providers. Enrollment/disenrollment information shall include, without limitation, name, employee ID or social security number, contribution history, account balance information, age, employment status (active, retired, separated), limited account status, account preferences (e-communication, etc.) or other information necessary to determine, verify, or assist with eligibility, enrollment or disenrollment of an Employee or Participant. Enrollment /disenrollment Information held at any time by or on behalf of the Employer is held in its capacity as an Employer and is not PHI.

"Health Care Operations," as defined under 45 C.F.R. Section 164.501, means any of the following activities to the extent that they are related to the Health Plan's covered functions:

(i) Conducting quality assessment and improvement activities; population-based activities related to health improvement, reduction of health care costs, case management and care coordination; contacting health care providers and patients regarding treatment alternatives; and related functions that do not include treatment;

(ii) Reviewing competence or qualifications of health care professionals and evaluating provider and Health Plan performance;

(iii) Underwriting and other activities that relate to the creation, renewal or replacement of a contract of health insurance or health benefits; and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance);

(iv) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(v) Business planning and development, such as cost-management and planning-related analysis related to managing and operating the Health Plan, and development or improvement of coverage policies; and

(vi) Business management and general administrative activities, including, but not limited to: (A) management activities related to implementation of and compliance with the requirements of the Privacy Rule; (B) customer service, including the provision of data analyses for the Health Plan sponsor, provided that PHI is not disclosed to the Health Plan sponsor; (C) resolution of internal grievances; (D) due diligence related to the sale, transfer, merger or consolidation of all or part of the Health Plan with another entity directly regulated under the Privacy Rule, or an entity that, following such activity, will be subject to the Privacy Rule; and (E) consistent with applicable requirements of the Privacy Rule, creating de-identified information, as defined in 45 C.F.R. Section 164.514(b)(2), or a limited data set, as defined under 45 C.F.R. Section 164.514(d)(2).

"Health Plan" means each "group health plan," as defined in 45 C.F.R. Section 160.103, sponsored by the Employer to provide health care benefits for its employees, former employees and dependents, including this Plan. The Plan Administrator intends this Plan to form part of an Organized Health Care Arrangement, as defined in 45 C.F.R. §160.103, along with any other benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Employer.

"Payment," as defined under 45 C.F.R. Section 164.501, means activities undertaken by the Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care. Such activities include, but are not limited to:

(i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
(ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
(iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance) and related health care data processing;
(iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;
(v) Utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services; and

(vi) Disclosure to consumer reporting agencies of necessary information relating to collection of premiums or reimbursement.

"Privacy Policy" means the Employer's internal HIPAA privacy and security policies and procedures.

"Protected Health Information" or "PHI" means individually identifiable health information that (i) relates to the past, present or future physical or mental condition of a current or former Participant, provision of health care to a Participant, or payment for such health care; (ii) can either identify the Participant, or there is a reasonable basis to believe the information can be used to identify the Participant; and (iii) is received, created, maintained or transmitted by or on behalf of the Health Plan. Notwithstanding the foregoing, for purposes of identifying information permitted to be shared by the Health Plan and an Employer or its Responsible Employees, Enrollment/Disenrollment Information shall not be considered PHI.

"Responsible Employee" means an employee (including a contract, temporary or leased employee) of the Health Plans or of the Employer whose duties (A) require that the employee have access to PHI for purposes of Health Plan Payment or Health Care Operations; or (B) make it likely that he will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 8.03A. A Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates, receives, maintains or transmits PHI on behalf of the Health Plan, even though his duties do not (or are not expected to) include creating, receiving, maintaining or transmitting PHI. Responsible Employees are within the Employer's HIPAA firewall when they perform Health Plan functions.

"Security Incident" as defined under 45 C.F.R. Section 164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

"Security Rule" means the regulations issued under HIPAA concerning the security of Electronic PHI.

8.03A Responsible Employees. Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a Health Plan. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health Plan administration functions that the Employer performs on behalf of a Health Plan pursuant to Section 8.04A; provided, however, enrollment and disenrollment functions performed by an Employer or its Responsible Employees are performed on behalf of Employees, Participants, and their Dependents and are not considered Health Plan administration functions:

(a) Employer employees who perform the following functions on behalf of the Health Plans are Responsible Employees:

(i) claims determination and processing functions;

(ii) Health Plan vendor relations functions;

(iii) benefits education and information functions;

(iv) Health Plan administration activities;

(v) legal department activities;

(vi) Health Plan compliance activities;

(vii) information systems support activities;

(viii) internal audit functions; and

(ix) human resources functions.

(b) In addition to those individuals described in subsection (a), the Plan Administrator who performs claims appeals and other decision-making functions on behalf of the Health Plans, the Health Plans' HIPAA privacy officer and security official, and Employer employees to whom the Health Plans' HIPAA privacy officer and security official has delegated any of the following responsibilities shall also be Responsible Employees:

(i) implementation, interpretation and amendment of the Privacy Policy;

(ii) Privacy Rule or Security Rule training for Employer employees;

(iii) investigation of and response to complaints by Participants and/or employees;

(iv) preparation and maintenance of the Health Plans' privacy notice;

(v) distribution of the Health Plans' privacy notice;

(vi) response to requests by Participants to inspect or copy PHI;

(vii) response to requests by Participants to restrict the use or disclosure of their PHI;

(viii) response to requests by Participants to receive communications of their PHI by alternate means or in an alternate manner;

(ix) amendment and response to requests to amend Participants' PHI;

(x) response to requests by Participants for an accounting of disclosures of their PHI;

(xi) response to requests for information by the Department of Health and Human Services;

(xii) approval of disclosures to law enforcement or to the military for government purposes;

(xiii) maintenance of records and other documentation required by the Privacy Rule or Security Rule;

(xiv) negotiation of Privacy Rule and Security Rule provisions and/or reasonable security provisions into contracts with third party service providers;

(xv) maintenance of Health Plan PHI or Electronic PHI security documentation; or

(xvi) approval of access to Electronic PHI.

8.04A Permitted Uses and Disclosures. Responsible Employees may access, request, receive, use, disclose, create and/or transmit PHI only to perform certain permitted and required functions on behalf of the Health Plan, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health Plans' own Payment and Health Care Operations functions;

(b) uses and disclosures for another Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 C.F.R. Section 160.103, for the health care provider's treatment activities;

(d) disclosures to the Employer, acting in its role as Plan Sponsor, of (i) summary health information for purposes of obtaining health insurance coverage or premium bids for the Health Plan or for making decisions to modify, amend or terminate the Health Plan; or (ii) enrollment or disenrollment information;

(e) disclosures of a Participant's PHI to the Participant or his personal representative, as defined under 45 C.F.R. Section 164.502(g);

(f) disclosures to a Health Plan for the other Health Plan's Payment or Health Care Operations activities;

(g) disclosures to a Participant's family members or friends involved in the Participant's health care or payment for the Participant's health care, or to notify a Participant's family in the event of an emergency or disaster relief situation;

(h) uses and disclosures to comply with workers' compensation laws;

(i) uses and disclosures for legal and law enforcement purposes, such as to comply with a court order;

(j) disclosures to the Secretary of Health and Human Services to demonstrate the Health Plan's compliance with the Privacy Rule or Security Rule;

(k) uses and disclosures for other governmental purposes, such as for national security purposes;

(1) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(m) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;

(n) uses and disclosures required by other applicable laws; and

(o) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 C.F.R. Section 164.508.

Notwithstanding anything in the Plan to the contrary, the use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal or replacement of a contract of health insurance.

8.05A Certification Requirement. Through its execution of this Plan Document, the Employer hereby certifies that, with respect to any PHI received from or disclosed by the Health Plan to the Employer or its Responsible Employees, the Employer and its Responsible Employees will:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to take reasonable steps to ensure that any agents, including subcontractors, to whom the Employer provides PHI or Electronic PHI, received from the Health Plan agree:

(i) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and

(ii) implement reasonable and appropriate security measures to protect such Electronic PHI.

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Health Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 8.04A, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 C.F.R. Section 164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;

(h) to make its internal practices, books and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with the Privacy Rule or the Security Rule;

(i) if feasible, to return or destroy all PHI and Electronic PHI, received from the Health Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI when no longer needed for the purpose for which disclosure was made,

except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible and Electronic PHI;

(j) to take reasonable steps to ensure that there is adequate separation between the Health Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic PHI that the Employer creates, receives, maintains or transmits on behalf of the Health Plan.

8.06A Mitigation. In the event of non-compliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document his investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

8.07A Breach Notification. Following the discovery of a Breach of unsecured PHI, the Health Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 C.F.R. Section 164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 C.F.R. Section 164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, Health Plan shall notify the media in accordance with 45 C.F.R. Section 164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

APPENDIX B TO THE CAFETERIA PLAN. DEPENDENT CARE FLEXIBLE ACCOUNT

PREAMBLE. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If identified as a Benefit Option in the **Plan Information Summary**, the Employer has established a Dependent Care Flexible Spending Account (the Dependent Care FSA) to help provide dependent care assistance for those Employees who participate in the Employer's Cafeteria Plan ("Plan") and who, pursuant to the election procedures set forth in the Plan, choose to make contributions to this Dependent Care FSA. This Dependent Care FSA is intended to provide reimbursement of certain Eligible Dependent Care Expenses incurred by the Participant for care of a Qualifying Individual. The Employer intends that the Dependent Care FSA qualify as a Code Section 129 dependent care assistance plan, and that the benefits provided under the Dependent Care FSA be eligible for exclusion from the Participant's income for federal income tax purposes under Section 129 of the Code. This Dependent Care FSA is a component of, and incorporated by reference into, the Cafeteria Plan **("**Cafeteria Plan"), and the terms and conditions of the Cafeteria Plan Document apply also to this Dependent Care FSA.

This Dependent Care Flexible Spending Account Appendix only applies if a Dependent Care FSA has been identified as a Benefit Option in the **Plan Information Summary**.

ARTICLE 1B. DEFINITIONS

Unless otherwise specified, terms that are capitalized in this Appendix B have the same meaning as the defined terms in the Cafeteria Plan Document or **SPD**. The definitions of terms defined in this Appendix B, but not defined in the Cafeteria Plan or the **SPD**, shall be applicable only with respect to this Appendix B. To the extent a term is defined both in the Cafeteria Plan Document (or **SPD**) and in this Appendix B, the term as defined in the Cafeteria Plan Document shall govern the interpretation of the Cafeteria Plan and the term as defined in this Appendix B shall govern the interpretation of this Dependent Care FSA.

"Dependent" means any individual who is a tax dependent of the Participant as defined the **Summary Plan Description** for the Dependent Care FSA.

"Dependent Care Reimbursement" means amounts used to reimburse Eligible Dependent Care Expenses.

"Dependent Care Reimbursement Account(s)" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Dependent Care Reimbursement. 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 Plan 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).

"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 includible in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code Section 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

"Eligible Dependent Care 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 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 the Qualifying Individual's parent; or

(c) a child (as defined in Code Section 152(f)(1)) of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

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

"Qualifying Individual" means a person as described in the **SPD** for whom an Eligible Dependent Care Expense may be reimbursed under this Dependent Care FSA.

"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 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

ARTICLE 2B. ELIGIBILITY AND PARTICPATION

2.01B Eligibility to Participate.

Each Employee who satisfies the Employer's eligibility requirements shall be eligible to participate in this Dependent Care FSA as of the Employee's Eligibility Date.

2.02B Termination of Participation.

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

2.03B Qualifying Leave Under the Family and Medical Leave Act.

Notwithstanding any provision to the contrary in this Dependent Care FSA, 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 coverage under this Dependent Care FSA in accordance with the **SPD**. 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.

ARTICLE 3B. ELECTION TO PARTICIPATE

3.01B Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Dependent Care FSA as of the Effective Date must complete a Salary Reduction Election during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Dependent Care FSA in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Election shall be effective, subject to Section 3.02B, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied the Dependent Care FSA's Waiting Period**. An Employee who becomes eligible to become a Participant in this Dependent Care FSA after the Effective Date must complete a Salary Reduction Election during the Initial Election Period set forth in the **SPD** or the enrollment material. Participation will commence under this Dependent Care FSA as set forth in the **SPD** (but in no event prior to the election).

(c) **Failure to Elect.** An eligible Employee who fails to complete a Salary Reduction Election 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 3.02B or 3.03B.

3.02B Annual Election Period.

Each Employee who is a Participant in this Dependent Care FSA, or who is eligible to become a Participant in this Dependent Care FSA will have the right to become a Participant in this Dependent Care FSA, to continue participation in this Dependent Care FSA, or to modify or to cease participation in this Dependent Care FSA during the Annual Election Period. The date on which the Annual Election Period commences and ends will be determined by the Plan Administrator. The consequences of failing to make an election during the Annual Election Period will be set forth in the **SPD**.

3.03B Change of Elections.

A Participant may not make any changes to his or her election except for election changes permitted under the **SPD**, changes made during the Annual Election Period. All election changes shall be effective on a prospective basis only, as determined by the Plan Administrator.

3.04B Impact of Termination of Employment on Election or Cessation of Eligibility.

Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Election. Except as provided below, if revocation occurs under this Section 3.04B, no new election with respect to the Dependent Care FSA may be made during the remainder of the Plan Year except as set forth in the **SPD**.

3.05B Reduction of Certain Elections to Prevent Discrimination.

If the Plan Administrator determines, before or during any Plan Year, that the Dependent Care FSA may fail to satisfy any requirement or limitation imposed by the Code on Pre-tax Contributions allocated by 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 or a Highly Compensated Individual's election without the consent of such Employee.

ARTICLE 4B. REIMBURSEMENTS

4.01B Dependent Care Reimbursement.

To the extent offered under the Plan, each Participant's Dependent Care FSA will be credited for Dependent Care Reimbursement with amounts withheld from the Participant's Compensation, and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Dependent Care Reimbursement 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 Dependent Care Reimbursement 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 Reimbursement Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Reimbursement Account for any Plan Year. Any amount allocated to the Dependent Care Reimbursement Account shall be forfeited by the Participant and restored to the Employer if it has not been applied by the end of the run-out period set forth in the **SPD** to provide Dependent Care Reimbursement for Eligible Dependent Care Expenses incurred during the Plan Year. The Employer has the discretion to establish a grace period following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Eligible Dependent Care Expenses incurred during the grace period. In no event can the grace period exceed the maximum amount permitted by law. All amounts allocated to the Dependent Care FSA that are not used to reimburse Eligible Dependent Care Expenses incurred during the Plan year and/or the grace period shall be forfeited. 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 be set forth in the **SPD**. The Employer may establish a minimum annual reimbursement amount as set forth in the **SPD**.

4.02B Receiving Dependent Care Reimbursement.

Payment shall be made to the Participant in cash as reimbursement for Eligible Dependent Care Expenses incurred by him while a Participant, during the Plan Year (or the grace period, if adopted by the Employer) for which the Participant's election is effective, provided that the substantiation requirements of Section 4.03B herein are satisfied.

4.03B Substantiation of Expenses.

Each Participant must submit an expense for reimbursement in accordance with the terms of the **SPD**.

4.04B Repayment of Excess Reimbursements.

If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Dependent Care FSA that exceed the amount of Eligible Dependent Care Expenses that have been substantiated by such Participant during the Plan Year as required by Section 4.03B herein, the excess reimbursements may be recouped as set forth in the **SPD**.

4.05B Reimbursement Following Cessation of Participation.

Participants in the Dependent Care FSA may submit claims for reimbursement for Eligible Dependent Care Expenses incurred during the Plan Year and before the date of participation in the Dependent Care FSA ceases as set forth in the **SPD**.

4.06B Disbursement Reports.

The Plan Administrator shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Dependent Care FSA.

4.07B Timing of Reimbursements.

Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan Administrator or its designee.

4.08B Statements.

The Plan Administrator, or its designated third party administrator, may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Dependent Care Reimbursement under the Dependent Care FSA.

4.09B Post-Mortem Payments.

Any benefit payable under the Dependent Care FSA after the death of a Participant shall be paid to his surviving Spouse, 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.

4.10B Non-Alienation of Benefits.

Except as expressly provided by the Plan Administrator, no benefit under the Dependent Care FSA 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 Dependent Care FSA shall in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person.

4.11B Mental or Physical Incompetency.

Every person receiving or claiming benefits under the Dependent Care FSA 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.

4.12B 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 Dependent Care FSA because he 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 after a reasonable time after the date any such payment first became due.

4.13B Tax Effects of Reimbursements.

Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any reimbursements made under the Dependent Care FSA 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 are 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 Dependent Care FSA is designed and is intended to be operated as a dependent care assistance plan under Section 129 of the Code.

4.14B Forfeiture of Unclaimed Benefits.

Any Dependent Care FSA benefit payments that are unclaimed (e.g., uncashed benefit checks) within 180 days following the close of the plan year shall be forfeited.

ARTICLE 5B – FUNDING AGENT

The Dependent Care FSA shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Elections, and/or Employer Contributions and Flex Credits provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits out of its general assets provided herein as soon as administratively feasible and shall comply with all applicable regulations.

ARTICLE 6B – CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Dependent Care FSA and those claims review procedures are set forth in the **SPD**.