KENOSHA COUNTY
CAFETERIA PLAN
BASIC PLAN DOCUMENT #125

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KENOSHA COUNTY
CAFETERIA PLAN
BASIC PLAN DOCUMENT
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KENOSHA COUNTY
FLEXIBLE BENEFIT PLAN

AMENDMENT

WHEREAS, Kenosha County (the "Company") maintains the Kenosha County Flexible Benefit Plan (the "Plan") for the benefit of certain of its employees; and

WHEREAS, Pursuant to Section 8.01 of the Plan, the Company desires to amend the Plan;

NOW, THEREFORE, the Plan is hereby amended by substituting the following in the Adoption Agreement, effective as of 07/01/2017:

D. PLAN OPERATIONS

Claims

1. Claims for reimbursement for an active Participant must be filed with the Plan Administrator (Section 6.01):
i. [X] within **90** days following the last day of each Plan Year.
ii. [ ] by _____.

2a. The Plan provides for an earlier deadline for claims submission for Terminated Participants:
[X] Yes [ ] No

2b. If **D.2a** is Yes, claims for reimbursement for a Terminated Participant must be filed with the Plan Administrator (Section 6.01):
i. [X] within **60** days following Termination of employment.
ii. [ ] by _____.

IN WITNESS WHEREOF, the Company has caused this Amendment to be executed this 21 day of June, 2017.

KENOSHA COUNTY:

Signature: Robert J. Riedl

Print Name: ROBERT J. RIEDL

Title/Position: H.R. DIRECTOR

ARTICLE 1
INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to qualify as a cafeteria plan within the meaning of Code section 125. To the extent provided in the Adoption Agreement, the Plan provides for the pre-tax payment of premiums and contributions to spending accounts that are excludable from gross income under Code section 125, reimbursement of certain medical expenses that are excludable from gross income under Code section 105(b), reimbursement of certain dependent care expenses that are excludable from gross income under Code section 129, and reimbursement of certain adoption expenses that are excludable from gross income under Code section 137.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Company on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Company whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2
DEFINITIONS

"Account" means the balance of a hypothetical account established for each Participant as of the applicable date. "Account" or "Accounts" shall include to the extent provided in the Adoption Agreement, a Premium Conversion Account, a Health Care Reimbursement Account, a Dependent Care Assistance Account, an Adoption Assistance Account and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

"Adoption Agreement" means the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

"Adoption Assistance Account" means the Account established with respect to the Participant's election to have adoption expenses reimbursed by the Plan pursuant to Section 4.04.

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

"Company" means the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

"Compensation" means the cash wages or salary paid to a Participant. If the Adoption Agreement indicates that the Plan is a simple cafeteria plan as defined in Code section 125(j), "Compensation" shall mean Section 414(s) Compensation (defined below).

"Contract" means an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. Contract shall not include any product which is advertised, marketed, or offered as long-term care insurance. As of January 1, 2014, "Contract" may not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employee's Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

"Dependent Care Assistance Account" means the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan pursuant to Section 4.03.

"Effective Date" shall have the meaning set forth in the Adoption Agreement.

"Eligible Employee" means any Employee employed by the Company, subject to the modifications and exclusions described in the Adoption Agreement. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Company is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Company in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by the Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the trade or business shall not become eligible to participate in the Plan until the Plan Sponsor specifically authorizes such participation.

"Employee" means any individual who is employed by the Employer. The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock of an S corporation.

"Employer" means the Company or any other employer required to be aggregated with the Company under Code sections 414(b), (c), (m) or (o); provided, however, that "Employer" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993 as amended from time to time.

"Health Care Reimbursement Account" means the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Section 4.02.

"Health Savings Account" or "HSA" means a health savings account established under Code section 223

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

"Participant" means an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

"Plan Administrator" means the person(s) designated pursuant to the Adoption Agreement and Section 7.01.

"Plan Sponsor" means the entity described in the Adoption Agreement.

"Plan Year" means the 12-consecutive month period described in the Adoption Agreement.

"Premium Conversion Account" means the Account established with respect to the Participant's election to have premiums reimbursed by the Plan pursuant to Section 4.01.

"Section 414(s) Compensation" means compensation as defined in Code section 414(s) and Treas. Reg. section 1.414(s)-1. The period used to determine an Employee's compensation for a Plan Year must be either the Plan Year or the calendar year ending within the Plan Year. Whichever period is selected by the Plan Administrator must be applied uniformly to determine the compensation of every eligible Employee under the Plan for that Plan Year. The Plan Administrator may, however, limit the period taken into account under either method to that portion of the Plan Year or calendar year in which the Employee was an eligible Employee, provided that this limit is applied uniformly to all eligible.

"Termination" and "Termination of Employment" means any absence from service that ends the employment of the Employee with the Company.

ARTICLE 3
PARTICIPATION

Section 3.01 PARTICIPATION

Each Eligible Employee as of the Effective Date who was eligible to participate in the Plan immediately prior to the Effective Date shall be a Participant eligible to make benefit elections pursuant to Article 4 on the Effective Date. Each other Eligible Employee who was not a Participant in the Plan prior to the Effective Date shall become a Participant eligible to make benefit elections pursuant to Article 4 on the date specified in the Adoption Agreement; provided that he is an Eligible Employee on such date. Notwithstanding the foregoing, a Participant shall be eligible to make elections only for the Accounts as are specifically authorized in the Adoption Agreement.

Section 3.02 TRANSFERS

If a change in job classification or a transfer results in an individual no longer qualifying as an Eligible Employee, such Employee shall cease to be a Participant for purposes of Article 4 (or shall not become eligible to become a Participant) as of the effective date of such change of job classification or transfer; unless otherwise provided in the Adoption Agreement. Should such Employee again qualify as an Eligible Employee, he shall be eligible to participate as of the first day of the subsequent Plan Year; unless earlier participation is required by applicable law or permitted pursuant to the change of status provisions of Section 4.07(a). If an Employee who was not previously an Eligible Employee becomes an Eligible Employee, he shall be eligible to participate on the first entry date following the later of the effective date of such subsequent change of status or the date the Employee meets the eligibility requirements of this Article 3.

Section 3.03 TERMINATION AND REHIRES

(a) Participants. If a Participant has a Termination of Employment, such Employee shall cease to be a Participant for purposes of Article 4 as of his Termination of Employment. The Plan Administrator may continue participation for purposes of Article 4.01 until the end of the calendar month coincident with or next following his Termination of Employment or other timeframe according to established Plan Administrator procedures. Unless otherwise provided in the Adoption Agreement, if an individual who has satisfied the applicable eligibility requirements set forth in Article 3 as of his Termination date, and who is subsequently reemployed by the Company as an Eligible Employee, shall resume or become a Participant as of the later of the first day of the subsequent Plan Year or the first entry date following reemployment. Notwithstanding the foregoing and if so provided in the Adoption Agreement, the Plan Administrator shall automatically reinstate benefit elections for Terminated Participants who are rehired within 30 days of Termination and permit new benefit elections for Terminated Participants who are rehired more than 30 days after Termination.

(b) Non-Participants. An Eligible Employee who has not satisfied the applicable eligibility requirements set forth in Article 3 on his Termination date, and who is subsequently reemployed by the Company as an Eligible Employee, shall be eligible to participate on the first entry date following the later of the effective date of such reemployment or the date the individual meets the eligibility requirements of this Article 3.

Section 3.04 PROCEDURES FOR ADMISSION

The Plan Administrator shall prescribe such forms and may require such data from Participants as are reasonably required to enroll a Participant in the Plan or to effectuate any Participant elections made pursuant to Article 4.

ARTICLE 4
BENEFITS

Section 4.01 PREMIUM CONVERSION ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Premium Conversion Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Premium Conversion Account described in Subsection (b). The amount of such contributions to and the premiums that may be reimbursed from the Premium Conversion Account shall not exceed the employee-paid portion of premiums payable under the Contracts specified in the Adoption Agreement. If a Contract is offered in conjunction with a Company-sponsored benefit plan, a Participant shall be eligible to make contributions to the Premium Conversion Account with respect to that Contract only if he or she is also eligible to participate in the applicable Company-sponsored plan. The Account established under this Section 4.01 is intended to qualify under Code Sections 79 and 106(a) to the extent so indicated in the Adoption Agreement and shall be interpreted in a manner consistent with such Code sections. Elections for Code section 79 coverage shall be made on an after-tax basis to the extent that the premiums relate to coverage in excess of the limit described in Code section 79(a).

(b) Premium Conversion Account. Each Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for amounts applied to employee-paid portion of applicable premiums. However, the Plan Administrator will not direct the Company to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

(c) Conflicts. In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions which must be satisfied to become covered, if any, the benefits Participants are entitled to and the circumstances under which coverage terminates.

Section 4.02 HEALTH CARE REIMBURSEMENT ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Health Care Reimbursement Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Health Care Reimbursement Account described in Subsection (b). The amount of such salary reduction contributions to the Health Care Reimbursement Account shall not exceed the maximum annual limit described in the Adoption Agreement. The Account established under this Section 4.02 is intended to qualify as a health flexible spending arrangement under Code Sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

(b) Health Care Reimbursement Account. Each Participant's Health Care Reimbursement Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for expenses described in Subsection (c). The entire annual amount elected by the Participant on the salary reduction agreement for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Reimbursement Account provided that the amounts elected in the salary reduction agreement have been paid as provided in the salary reduction agreement.

(c) Eligible Expenses. Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Health Care Reimbursement Account for expenses that are: (i) incurred in the Plan Year (except as provided in Section 4.05(c)), (ii) incurred while the Participant participates in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses that are not covered, paid or reimbursed from any other source.

(1) For purposes of Code section 105(b), unless otherwise provided in the Adoption Agreement, dependents shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

(2) For purposes of Code section 105(b), unless otherwise provided in the Adoption Agreement, expenses for a child (as defined in section 152(f)(1)) of the Participant may be covered until his or her 26th birthday although the Plan Administrator may extend coverage until the end of the calendar year in which the child turns age 26.

(3) Effective January 1, 2011, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(d) Qualified Reservist Distributions.

(1) If the Plan allows Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his Health Care Reimbursement Account specified in the Adoption Agreement provided that such amount was in existence on or after June 18, 2008. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days 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 Plan for the Plan Year which includes the date of such order or call. A Participant ordered or called to active duty before June 18, 2008 is eligible for a Qualified Reservist Distribution if the Participant's period of active duty continues after June 18, 2008 and meets the duration requirements of IRS Notice 2008-82. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(2) The Plan shall permit a Participant to submit Health Care Reimbursement Account claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Company shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(3) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 4.03 DEPENDENT CARE ASSISTANCE ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Dependent Care Assistance Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Dependent Care Assistance Account described in Subsection (b). The Account established under this Section 4.03 is intended to qualify as a dependent care assistance program under Code Section 129 and shall be interpreted in a manner consistent with such Code section which provisions are incorporated herein by reference.

(b) Dependent Care Assistance Account. Each Participant's Dependent Care Assistance Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for expenses described in Subsection (c). However, the Plan Administrator will not direct the Company to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Dependent Care Assistance Account.

(c) Eligible Expenses.

(1) In General. A Participant may be reimbursed from his or her Dependent Care Assistance Account to the extent that such reimbursement: (i) is incurred in the Plan Year (except as provided in Section

4.05(c), (ii) is incurred while the Participant participates in the Plan, and (iii) qualifies as dependent care expenses; provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the same expenses.

(2) Dependent Care Expenses. Dependent care expenses are defined as expenses incurred for the care of a qualifying individual. A qualifying individual is either: (i) a dependent who is under age 13, or (ii) the Participant's spouse or dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are dependent care expenses only if they allow the Participant to be gainfully employed. Dependent care expenses include expenses for household services and expenses for the care of a qualifying individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the qualifying individual stays overnight. Expenses described in this Subsection which are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least 8 hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

(3) Limits. The maximum amount of expense that may be contributed/reimbursed in any taxable year for the Dependent Care Assistance Account is $5,000 ($2,500 if the Participant is married and filing a separate return). The amount payable may also not be greater than the amount of the Participant's earned income or the earned income of his or her spouse. In the case of a spouse who is a student or a qualifying individual, Code section 21(d)(2) shall apply in determining earned income.

(d) If the Plan allows Employees that cease to be Participants in the plan to spend down unused Dependent Care Assistance Account expenses, Employees that cease to Participate in the Plan (due to Termination or any other reason) may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of Participation occurs (or grace period if provided in the Plan) to the extent the claims do not exceed the balance of the Dependent Care Assistance Account.

Section 4.04 ADOPTION ASSISTANCE ACCOUNTS

(a) In General. To the extent that the Adoption Agreement authorizes Adoption Assistance Accounts, each Participant may choose to receive his or her full Compensation for any Plan Year in cash or to have a portion of such Compensation applied by the Company toward the Adoption Assistance Account described in Subsection (b). The Account established under this Section 4.04 is intended to qualify as an adoption assistance program under Code Section 137 and shall be interpreted in a manner consistent with such Code section which provisions are incorporated herein by reference.

(b) Adoption Assistance Account. Each Participant's Adoption Assistance Account will be credited with amounts withheld from the Participant's Compensation and amounts paid by the Company pursuant to Section 4.09; and will be debited for reimbursements described in Subsection (c). However, the Plan Administrator will not direct the Company to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Adoption Assistance Account.

(c) Eligible Expenses.

(1) In General. A Participant may be reimbursed from his or her Adoption Assistance Account to the extent that such reimbursement is (i) incurred in the Plan Year (except as provided in Section 4.05(c), (ii) incurred while the Participant participates in the Plan, and (iii) qualifies as adoption assistance; provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the same expenses.

(2) Adoption Assistance. Adoption assistance is defined as reasonable and necessary adoption fees, court costs, attorney fees and other expenses which are (i) directly related to the legal adoption of an eligible child by the Participant and (ii) not incurred in violation of state or federal law or in carrying out any

surrogate parenting arrangement. An eligible child includes a child under age 18 or a child who is physically or mentally incapable of caring for himself/herself. However, an eligible child does not include a child of the Participant's spouse. In the case of an adoption of a child who is not a citizen or resident of the United States, any adoption expense with respect to such adoption is not reimbursable until such adoption becomes final.

(3) Limits. The maximum amount of expense that may be contributed/reimbursed for the Adoption Assistance Account for any Plan Year beginning in a calendar year is the maximum amount permitted by federal tax law for that calendar year. The annual limit shall be reduced for adoption assistance expenses incurred any prior Plan Year.

Section 4.05 FORFEITURES/TRANSFERS

(a) Forfeitures. Any balance remaining in a Participant's Account at the end of any Plan Year that is above the carryover amount limit to the extent a carryover applies to the Plan (or after the grace period if Subsection (c) applies) shall be forfeited and shall remain the property of the Company. Except as expressly provided herein, any balance remaining in a Participant's Account on his date of Termination shall be forfeited and shall remain the property of the Company. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within the time period specified in Section 6.01(b).

(b) Transfers. Amounts may not be transferred between Accounts.

(c) Grace Period. If the Adoption Agreement provides for a 2-1/2 month grace period, effective for grace periods beginning on or after the date specified in the Adoption Agreement and notwithstanding anything to the contrary in the Plan, the unused contributions that remain in a Participant's Account at the end of a Plan Year may be used to reimburse expenses that are incurred during the grace period. The grace period shall commence on the first day of the subsequent Plan Year and shall end on the fifteenth day of the third calendar month of the subsequent Plan Year. Unless otherwise provided in the Adoption Agreement, the grace period shall apply to all Accounts in which the Participant is eligible to Participate. Payment or reimbursement of unused benefits shall be subject to the following terms and conditions:

(1) Same Account. Unused contributions remaining at the end of a Plan Year relating to a particular Account may only be used to reimburse expenses incurred with respect to that Account.

(2) No Cash Out. Unused contributions remaining at the end of a Plan Year may not be cashed-out or converted to any other taxable or nontaxable benefit.

(3) No Carryforward. Except as provided in Section 4.05(d), any unused contributions remaining at the end of a Plan Year that exceed the expenses for a particular Account that are incurred during the grace period may not be carried forward to any subsequent period (including any subsequent Plan Year) and shall be forfeited.

(4) Construction. This Section 4.05(c) is to be construed in accordance with IRS Notice 2005-42 and any superseding guidance.

(d) Carryovers. To the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year up to $500 of any amount remaining unused as of the end of the Plan Year in a Participant's Health Care Reimbursement Account. The amount remaining unused as of the end of the Plan Year is the amount unused in the Health Care Reimbursement Account after all eligible Health Care Reimbursement Account expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible Health Care Reimbursement Account expenses incurred during the entire Plan Year to which it is carried over. Any unused amount remaining in the Health Care Reimbursement Account in excess of $500 (or a lower amount specified in the Adoption Agreement) is forfeited.

Section 4.06 ELECTIONS

(a) New Participants. The Plan Administrator shall provide, where possible, an election form to a Participant before such Participant meets the eligibility requirements of Article 3. In order to participate in the Plan in the initial Plan Year, the Participant must return the completed election form to the Plan Administrator on or before such date as specified by the Plan Administrator. However, any election shall not be effective until a pay period following the later of such Participant's effective date of participation pursuant to Article 3 or the date of the receipt of the election form by the Plan Administrator and shall be limited to the expenses incurred after the effective date of the election.

(b) Continuing Participants. Prior to the commencement of each Plan Year, the Plan Administrator shall provide an election form to each Participant and to each other individual who is expected to become a Participant at the beginning of such Plan Year. In order to participate in the Plan in the applicable Plan Year, the Participant must return the completed election form to the Plan Administrator on or before such date specified in the Adoption Agreement, which date shall be no later than the beginning of the first pay period for which the individual's Compensation reduction agreement will apply.

(c) Failure to Return Election Form. The failure of a Participant described in Subsection (a) to return a completed election form to the Plan Administrator on or before the specified due date shall constitute an election to receive his or her full Compensation in cash for the remainder of the Plan Year. The failure of a Participant described in Subsection (b) to return a completed election form to the Plan Administrator on or before the specified due date shall constitute an election not to participate for the applicable Plan Year unless a default election is otherwise specified in the Adoption Agreement or under Subsection (d).

(d) Premium Conversion Special Election Rules. If elected in the Adoption Agreement, a Participant shall be deemed to elect to contribute the entire amount of any premiums payable by the Participant for the benefits described in Section 4.01 unless he or she affirmatively elects otherwise before such date specified by the Plan Administrator. If elected in the Adoption Agreement, a Participant's election for benefits described in Section 4.01 shall be automatically adjusted for any change in the cost of premiums pursuant to the terms of Treas. Reg. 1.125-4.

(e) Form of Elections. All elections shall be made in written form unless the Plan Administrator provides procedures for such elections to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(f) Leave of Absence/FMLA/USERRA. If the Plan is subject to FMLA or the Plan Administrator determines that the Plan is subject to FMLA, the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law unless otherwise specified in the Adoption Agreement. To the extent provided in the Adoption Agreement, the Plan Administrator shall also permit a Participant taking unpaid Non-FMLA leave to continue the benefits specified in the Adoption Agreement. Participants continuing participation pursuant to the foregoing shall pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave. The Plan Administrator shall also permit Participants to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

(g) COBRA. If the Plan is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan is subject to COBRA, a Participant shall be entitled to continuation coverage as prescribed in Code Section 4980B (and the regulations thereunder) or such applicable state statutes.

(h) Procedures. A Participant shall make the elections described in this Section in such form and manner as may be prescribed by the Plan Administrator and at such time in advance as the Plan Administrator may

require. Such procedures may include, without limitation, a minimum annual and per-pay period contribution amount, a maximum contribution per pay-period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

Section 4.07 REVOCATION OF ELECTIONS

(a) By Participant. Any election made under this Article 4 shall be irrevocable by the Participant during the Plan Year unless revocation is required by the provisions of the Federal Family and Medical Leave Act or other applicable law and is permitted under Treas. Reg. 1.125-4, IRS Notice 2014-55 and the provisions of the Adoption Agreement.

(b) If the Adoption Agreement provides that elections may be modified at any time permitted under Treas. Reg. section 1.125-4, elections may be modified upon the occurrence of any of the following events:

(1) HIPAA Special Enrollment Rights. Participant may revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f).

(2) Change in Status. A Participant may revoke an election during a period of coverage with respect to a qualified benefits plan (as defined in Treas. Reg. 1.125-4(i)(8)) and make a new election for the remaining portion of the period if, under the facts and circumstances: (i) a change in status described in Subsections (A)-(F) occurs; and (ii) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under a qualified benefits plan.

(A) Legal Marital Status. Events that change a Participant's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.

(B) Number of Dependents. Events that change a Participant's number of dependents, including the following: birth; death; adoption; and placement for adoption.

(C) Employment Status. Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite and, the extent permitted in Treas. Reg. 1.125-4 and Section 3.03, change in employment status resulting in gaining or losing eligibility under the Plan.

(D) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. Events that cause a Participant's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(E) Residence. A change in the place of residence of the Participant, spouse, or dependent.

(F) Adoption Assistance. For purposes of adoption assistance provided through Section 4.04 of the Plan, the commencement or termination of an adoption proceeding.

(3) Judgment, Decree, or Order. A Participant may modify an election pursuant to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant; provided that the modification:

(A) changes the Participant's election to provide coverage for the child if the order requires coverage for the child under the Plan; or

(B) cancels coverage for the child if the order requires the spouse, former spouse, or other individual to provide coverage for the child; and that coverage is, in fact, provided.

(4) Entitlement to Medicare or Medicaid. A Participant may modify an election for benefits attributable to a Company-sponsored accident or health plan if the Participant, spouse, or dependent becomes entitled to coverage under Medicare or Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines). The Participant may make a prospective election change to cancel or reduce coverage of that Participant, spouse, or dependent under the accident or health plan. Corresponding rights to commence or increase benefits under the accident or health plan shall be granted in the case of loss of coverage under Medicare or Medicaid.

(5) Significant Cost or Coverage Changes. A Participant may modify an election for benefits, other than those provided in Section 4.02, as a result of changes in cost or coverage pursuant to Treas. Reg. section 1.125-4.

(6) FMLA. A Participant taking leave under the FMLA may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

(c) If the Adoption Agreement permits Participants to revoke an election of coverage under a group health plan due to reduction in hours of service, the following conditions must be met:

(1) The Participant must have been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in the Participant's status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under a group health plan; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked. The Plan Administrator may rely on the reasonable representation of the Participant that the Participant has enrolled or intends to enroll in the other plan.

This Section shall be interpreted consistent with IRS Notice 2014-55 and any superseding guidance.

(d) If the Adoption Agreement permits Participants to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through a marketplace established under Code section 1311, the following conditions must be met:

(1) The Participant is eligible for a special enrollment period to enroll in a qualified health plan through the marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a qualified health plan through a marketplace during the marketplace's annual enrollment period; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a qualified health plan through a marketplace for new coverage that is effective no later than the day immediately following the last day of the original coverage that is revoked. The Plan Administrator may rely on the reasonable representation of the Participant that the Participant has enrolled or intends to enroll in the other qualified health plan.

This Section shall be interpreted consistent with IRS Notice 2014-55 and any superseding guidance.

(e) By Plan Administrator. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Subsection shall be carried out in a uniform and non-discriminatory manner.

(f) Automatic Termination of Election. Any election made under this Section shall automatically terminate on the date specified in Sections 3.02 or 3.03.

(g) Plan Administrator Discretion. The Plan Administrator reserves the right to determine whether a Participant has experienced an event that would permit an election change under this Section 4.07 and whether the Participant's requested election change is consistent with such event.

Section 4.08 HEALTH SAVINGS ACCOUNT CONTRIBUTIONS

(a) In General. Notwithstanding anything in the Plan to the contrary, this Section 4.08 shall apply to the extent that the Adoption Agreement allows an Eligible Employee to can elect to make contributions on a pre-tax basis to the Employee's HSA Account that is established and maintained outside the Plan by a trustee/custodian to which the Company will forward contributions to be deposited ("HSA Contributions").

(b) The annual HSA Contributions for a Participant are equal to the annual benefit amount elected by the Participant, but in no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's high deductible health plan coverage limit for the calendar year in which the HSA Contribution is made ($3,350 for single and $6,650 for family for 2015) plus any applicable catch-up contributions adjusted for time as an HSA eligible individual.

(c) Modifications of Elections. A Participant who elects to make HSA Contributions may prospectively start, stop, increase or decrease the election at any time. The Plan Administrator may, in a uniform and nondiscriminatory manner, establish a procedure placing additional restrictions on the election of HSA Contributions.

(d) HSA Nondiscrimination Rules. Any contribution to an HSA from the Plan shall comply with the nondiscrimination rules of Code section 125, Treas. Reg. section 1.125-7 and any superseding guidance.

(e) HSA Comparability Rules. HSA Contributions shall comply with Treas. Reg. section 54.4980G-5 and any superseding guidance.

Section 4.09 EMPLOYER CONTRIBUTIONS

The Company may contribute to the Plan to the extent provided in the Adoption Agreement. Such contributions shall be credited to the applicable Account at such time as determined by the Company.

ARTICLE 5
LIMITATIONS ON CONTRIBUTIONS

Section 5.01 NONDISCRIMINATION

If the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the following nondiscrimination requirements of Code sections 125(b), 79(d), 105(h) and 129(d)(2), (3), (4), and (8) shall be treated as met during such year.

(a) Cafeteria Plan. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 125(e)) as to benefits provided or eligibility to participate.

(b) Group Term Life. The Plan may not discriminate in favor of key employees (within the meaning of Code section 416(i)(1)) as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 4.01.

(c) Health Care Reimbursement Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 105(h)(5)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.02.

(d) Dependent Care Assistance Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 414(q)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.03.

(e) Adoption Assistance Accounts. The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 414(q)) as to benefits provided or eligibility to participate with respect to the Account described in Section 4.04.

Section 5.02 LIMITATIONS ON CONTRIBUTIONS

(a) Cafeteria Plan. Key employees (within the meaning of Code section 416(i)(1)) may not receive more than 25% of the aggregate benefits provided for all employees under the Plan.

(b) Dependent Care Assistance Accounts. Shareholders or owners owning more than 5% of the capital or profits interest of the Employer may not receive more than 25% of the aggregate benefits provided for all employees under the Plan with respect to the Account described in Section 4.03. The average benefits provided under Section 4.03 to Participants who are not highly compensated employees must be at least 55 percent of the average benefits provided to highly compensated employees of the Company.

(c) Adoption Assistance Accounts. Shareholders or owners owning more than 5% of the capital or profits interest of the Employer may not receive more than 5% of the aggregate benefits provided for all employees under the Plan with respect to the Account described in Section 4.04.

ARTICLE 6
REIMBURSEMENTS

Section 6.01 PROCEDURES FOR REIMBURSEMENT

(a) Benefits Provided by Contracts. All claims for benefits that are provided under Contracts shall be made by the Participant to the company issuing such contract.

(b) Timing of Claims. Reimbursements and/or payments shall only be made for expenses incurred in the applicable Plan Year while the Participant participates in the Plan. Except as otherwise expressly provided herein, no reimbursement and/or payment shall be made for any expenses relating to services rendered before participation or after Termination of Employment for any reason. All claims for reimbursement and/or payment must be made within the time periods specified in the Adoption Agreement.

(c) Documentation. A Participant or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

(d) Payment. To the extent that the Plan Administrator approves the claim, the Company shall: (i) reimburse the Claimant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Accounts established hereunder. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.

(e) Coordination with HRA. A Participant who is also eligible to participate in a Code section 105 health reimbursement arrangement ("HRA") sponsored by the Company shall not be entitled to payment/reimbursement under the Health Care Reimbursement Account for expenses that are reimbursable under both the Health Care Reimbursement Account and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the Health Care Reimbursement Account if before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the Health Care Reimbursement Account have been paid.

(f) Death. If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her dependents or a representative of the Participant's estate. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

(g) Form of Claim/Notice. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(h) Refunds/Indemnification. If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Company for any liability the Company may incur for making such

payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (ii) offset other benefits payable hereunder.

(i) Debit, Credit or Other Stored Value Cards. To the extent provided in the Adoption Agreement, the Company may enter into an agreement with a financial institution to provide a Participant with a debit, credit or other stored value card to provide immediate payment of reimbursements available under Section 4.02 and/or Section 4.03 provided that the use of such card complies with IRS Revenue Ruling 2003-43 (to the extent not superseded by IRS Notice 2006-69), IRS Notice 2006-69, IRS Notice 2007-2, IRS Notice 2008-104, IRS Notice 2010-59, IRS Notice 2011-5 and any superseding guidance. A Participant may obtain benefits under Sections 4.02 and 4.03 without the use of the card.

(j) HSA Coordination. Except as otherwise provided in the Adoption Agreement, benefits under this Plan shall not be coordinated with coverage in a high deductible health plan to facilitate participation in Health Savings Accounts.

(k) Plan Administrator Procedures. The Plan Administrator may establish procedures regarding the documentation to be submitted in a claim for reimbursement and/or payment and may also establish any other procedures regarding claims for reimbursement and/or payment provided that the procedures do not violate ERISA section 503 if the Adoption Agreement indicates the plan is subject to ERISA. Such procedures may include, without limitation, requirements to submit claims periodically throughout the Plan Year.

Section 6.02 CLAIMS PROCEDURE FOR HEALTH CARE REIMBURSEMENT ACCOUNT

(a) A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) This Section 6.02(b) shall apply for any claim for benefits under the Health Care Reimbursement Account.

(1) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(2) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA, and (E): (I) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule,

guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (II) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

(4) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) Exhaustion of Remedies. Before a suit can be filed in federal court, claims must exhaust internal remedies.

(c) Additional Internal and External Claims Procedure for Health Care Reimbursement Account.

(1) Applicability. This Section shall apply for any claim for benefits under the Health Care Reimbursement Account if (A) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (B) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(2) Effective Date. This Section shall be effective the later of the first plan year beginning after September 23, 2010 or the date the Plan is no longer a grandfathered health plan under the Patient Protection and Affordable Care Act.

(3) Internal Claims Process. The requirements under Section 6.02(b) shall apply as the internal appeals process except as modified below. This section is intended to satisfy the requirements of DOL Reg. 2590.715-2719 and any superseding guidance.

(A) Adverse Benefit Determination. An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

(B) Full and Fair Review. A Claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

(C) Notice. A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(4) Deemed Exhaustion of Internal Claims Process. If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the claimant may initiate an external review under Section 6.02(c)(5) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

(5) External Claims Process.

(A) State External Claims Process. If the Adoption Agreement specifies that the Plan is not subject to ERISA and the State external claims process includes at a minimum the consumer protections in the NAIC Uniform Model Act then the plan must comply with the applicable State claims review process.

(B) Federal External Claims Process. The plan must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance if Subsection (c)(5)(A) above is not applicable.

(d) Notwithstanding anything to the contrary, if the Adoption Agreement specifies that (1) the Plan is not subject to ERISA and (2) the Plan does not constitute a group health plan as defined in Treas. Reg. section 54.9801-2 or the Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Company and any other applicable law.

Section 6.03 CLAIMS PROCEDURES FOR NON-HEALTH BENEFITS

(a) This Section 6.03 shall apply for any claim for benefits under Accounts other than the Health Care Reimbursement Account.

(b) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the

Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(c) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

(d) Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

(f) Notwithstanding anything to the contrary, if the Adoption Agreement specifies that the Plan is not subject to ERISA, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Company and any other applicable law.

Section 6.04 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

Section 6.05 MISSING PAYEE

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

ARTICLE 7
PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA (if the Adoption Agreement provides that the Plan is subject to ERISA), and as such shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 6;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(viii) to determine all questions of the eligibility of Employees and of the status of rights of Participants;

(ix) to adjust Accounts in order to correct errors or omissions;

(x) to determine the validity of any judicial order;

(xi) to retain records on elections and waivers by Participants;

(xii) to supply such information to any person as may be required;

(xiii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Company.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 7.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Company shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA to the extent that the Adoption Agreement provides the Plan is subject to ERISA.

Section 7.03 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

If the plan is not subject to ERISA any applicable law related to qualified medical child support orders or National Medical Support Notices shall apply and the Plan Administrator shall follow any required procedures under such law.

Section 7.04 HIPAA PORTABILITY RULES

In the event the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan shall comply with the requirements of Code section 9801 et. Seq. including the requirement to cover children until at least the attainment of age 26 if the Plan makes dependent coverage of children available.

ARTICLE 8
AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor.

Section 8.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the Company reserves the right to terminate its participation in this Plan. Each such entity constituting the Company shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Company, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company.

ARTICLE 9
MISCELLANEOUS

Section 9.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan.

Section 9.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Company and the Participant, or as a right of any Employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its Employees, with or without cause.

Section 9.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Company to provide benefits hereunder shall remain part of the general assets of the Company and all payments of benefits under the Plan shall be made solely out of the general assets of the Company.

(b) The Company shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Company may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any Account other than as expressly authorized in the Plan.

Section 9.04 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 9.05 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 9.06 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 9.07 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 9.08 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

ARTICLE 10
HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article 10 shall only apply in the event that the Health Care Reimbursement Account under the Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy and security rules. The Plan will comply HIPAA as set forth below.

Section 10.01 Definitions. For purposes of this Article 10, the following terms have the following meanings:

(a) "Business Associate" means any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) "Group Health Benefits" means the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

(c) "Individual" means the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.

(d) "Notice of Privacy Practices" means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) "Plan Administration Functions" means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) "Protected Health Information ("PHI")" means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan or the Plan Sponsor;

(2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and

(3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) "Summary Health Information " means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

(1) names;

(2) any geographic information which is more specific than a five digit zip code;

(3) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated

into a single category of age 90 and older);

(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) facial photographs or biometric identifiers (e.g., finger prints); and

(6) any other unique identifying number, characteristic, or code.

Section 10.02 HIPAA Privacy Compliance. The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;

(B) for auditing claims payments made by the Plan;

(C) to request proposals for services to be provided to or on behalf of the Plan; and

(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.

(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

(3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.

(3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.

(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the

Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

(f) Rights of Individuals.

(1) Notice of Privacy Practices. The Plan Sponsor will provide a Notice of Privacy Practices to the Participant in accordance with HIPAA.

(2) Right to Request Restrictions. Each Individual has the right to request that the Plan restrict its uses and disclosures of the Individual's PHI.

(3) Right to Access. Each Individual has the right to obtain and inspect its PHI held by the Plan.

(4) Right to Amend. Each Individual has the right to ask the Plan to amend its PHI.

(5) Right to an Accounting. Each Individual has the right to request an accounting of disclosures of PHI made by the Plan for purposes other than treatment, payment or health care operations.

Section 10.03 HIPAA Security Compliance. To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

(c) 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; and

(d) Report to the Plan any security incident of which it becomes aware.