THE CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

FOR

PEARL RIVER COMMUNITY COLLEGE

Introduction

Pearl River Community College (the "Employer") sponsors the Pearl River Community College Cafeteria Plan (the "Cafeteria Plan") that allows eligible Employees to choose from a menu of different benefits paid for with pre-tax dollars. (Such plans are also commonly known as "salary reduction plans" or "Section 125 plans").

This Summary Plan Description ("Summary") describes the basic features of the Cafeteria Plan, how it generally operates and how Employees can gain the maximum advantage from it.

PLEASE NOTE: This Summary is for general informational purposes only. It does not describe every detail of the Cafeteria Plan. If there is a conflict between the Cafeteria Plan documents and this Summary, then the Cafeteria Plan documents will control.

Cafeteria Plan

CAF Q-1. How do I pay for Pearl River Community College Cafeteria Plan benefits on a pre-tax basis?

You may elect to pay for benefits on a pre-tax basis by entering an election with the Employer. At the Employer's option, this may be done with a traditional "paper" salary reduction agreement or it may be done in electronic form. Whatever medium is used, it shall be referred to as an Salary Reduction Agreement for purposes of this Summary.

If you elect to pay for benefits on a "pre-tax" basis, you agree to a salary reduction to pay for your share of the cost of coverage with pretax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes.

Example CAF Q-1(a): Sally is paid an annual salary of $30,000. Sally's share of the costs for her elected benefits for the Plan Year totals $2,000, which will be deducted on a "pre-tax" basis. By doing so, she is electing to reduce her salary, and therefore also her taxable income, by $2,000 for the year to $28,000.

From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Example CAF Q-1(b): Using the same facts from Example Q-1(a), suppose Sally is paid 26 times a year (bi-weekly). Because she has elected $2,000 in benefits, she will have $76.92 deducted from each paycheck for the year ($2,000 divided by 26 paychecks equals $76.92).

CAF Q-2. What benefits may be elected under the Cafeteria Plan?

The Cafeteria Plan includes the following benefit plans:

The ***Premium Payment Component*** permits an Employee to pay for his or her share of contributions for insurance plans with pretax dollars. Under the Pearl River Community College Cafeteria Plan, these benefits may include Health, Vision, Dental, Group Term Life, Disability, Cancer, Accident, Critical Illness, HSA and Other Individual Voluntary Benefits.

The Employer may at its own discretion offer cash in lieu of benefits for participants who do not choose benefits. If the Employer does choose this option, participants will be informed through other communications.

The ***Health Flexible Spending Arrangement ("Health FSA")*** permits an Employee to use "pre-tax" dollars to pay for his or her qualifying Medical Care Expenses (defined in HFSA Q-7) that are not otherwise reimbursed by insurance.

The ***Dependent Care Assistance Program ("DCAP")*** permits an Employee to pay for his or her qualifying Dependent Care Expenses (defined in DCAP Q-7) with pre-tax dollars.

The ***Health Savings Account ("HSA")*** permits an Employee to make pre-tax contributions to an HSA established and maintained outside of the Plan with the Employee's HSA trustee/custodian. Benefits provided under the HSA consist solely of the ability to contribute to the HSA on a pre-tax salary reduction basis.

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you as necessary from time to time.

CAF Q-3. Who can participate in the Cafeteria Plan?

Employees who are working 20 or more hours per week are eligible to participate in the Cafeteria Plan following 0 calendar days of employment with the Employer, provided that the election procedures in CAF Q-5 are followed.

An "Employee" is any individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employees do not, however, include the following: any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer, any

individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer, any self-employed individual, any partner in a partnership, any more-than-2% shareholder in a Subchapter S corporation and any employee covered under a collective bargaining agreement.

CAF Q-4. What tax savings are possible under the Cafeteria Plan?

You may save both federal income tax and FICA (Social Security/Medicare) taxes by participating in the Pearl River Community College Cafeteria Plan.

Example CAF Q4(a): Suppose Sally pays 15% in federal income taxes for the year. With an annual salary of $30,000, that could mean as much as $4,500 in federal income taxes, plus $2,295 in FICA taxes (calculated at 7.65% of income). But by electing $2,000 of cafeteria plan benefits for the year, Sally lowers her taxable income by $2,000, meaning she is only taxed on $28,000. This comes out to $4,200 in income tax plus $2,142 in FICA tax. That's a $453 tax savings for the year.

(**Caution:** This example is intended to illustrate the general effect of "pre-taxing" benefits through a cafeteria plan. It does not take into account the effects of filing status, tax exemptions, tax deductions and other factors affecting tax liability. Furthermore, the amount of the contributions used in this example is not meant to reflect your actual contributions. It is also not intended to reflect specifically upon your particular tax situation. You are encouraged to consult with your accountant or other professional tax advisor with regard to your particular tax situation.)

CAF Q-5. When does participation begin and end in the Cafeteria Plan?

After you satisfy the eligibility requirements, you may enter the plan date of hire. You can become a Participant by electing benefits in a manner such as described in CAF Q-1. An eligible Employee who does not elect benefits will not be able to elect any benefits under the Cafeteria Plan until the next Open Enrollment Period (unless a "Change in Election Event" occurs, as explained in CAF Q-7).

An Employee continues to participate in the Cafeteria Plan until (a) termination of the Cafeteria Plan; or (b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. However, for purposes of pre-taxing COBRA coverage for Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See CAF Q-8 and CAF Q-12 for more information about this as information about how termination of participation affects your Benefits.

CAF Q-6. What is meant by "Open Enrollment Period" and "Plan Year"?

The "Open Enrollment Period" is the period during which you have an opportunity to participate under the Cafeteria Plan by electing to do so. (See Q-5.) You will be notified of the timing and duration of the Open Enrollment Period, which for any new Plan Year generally will occur during the quarter preceding the new Plan Year.

The Plan Year for the Pearl River Community College Cafeteria Plan is the 12 months beginning on January 1st and ending on December 31st.

CAF Q-7. Can I change my elections under the Cafeteria Plan during the Plan Year?

Except in the case of HSA elections, you generally cannot change your election to participate in the Cafeteria Plan or vary the salary reduction amounts that you have selected during the Plan Year (this is known as the "irrevocability rule"). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year.

However, there are several important exceptions to the irrevocability rule, many of which have to do with events in your personal or professional life that may occur during the Plan Year. Be advised, however, that there are very few exceptions applicable to Health FSAs.

Here are the exceptions to the irrevocability rule:

1. Leaves of Absence

(Applies to All Insurance Benefits, Health FSA, and DCAP Benefits.)

You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described in CAF Q-14.

2. Change in Status.

(Applies to All Insurance Benefits, to Health FSA Benefits as Limited Below, and to DCAP Benefits.)

If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

• a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);

• a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);

• any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Cafeteria Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

• an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or

• a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status—Other Requirements.

(Applies to All Insurance Benefits, to Health FSA Benefits as Limited Below, and to DCAP Benefits.)

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility(for DCAP Benefits, the event may also affect eligibility of Dependent Care Expenses (as defined in DCAP Q-7) for the dependent care tax exclusion).

Election changes may be made to reduce Health FSA coverage during a Period of Coverage or to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age).

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

• *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For accident and health benefits (here, the Medical Insurance Plan and the Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See CAF Q-12.

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

• *DCAP Benefits*. With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

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

4. Special Enrollment Rights. *(Applies to All Insurance Benefits, but Not to Health FSA or DCAP .)* In certain circumstances, enrollment for Insurance Benefits may occur outside the Open

Enrollment Period, as explained in materials provided to you separately describing the Insurance Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which was previously furnished to you. Contact the Human Resources Manager if you need another copy.) When a special enrollment right explained in those separate documents applies to your Insurance Benefits, you may change your election under the Cafeteria Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders. *(Applies to All Insurance Benefits and Health FSA Benefits, but Not to DCAP Benefits.)* If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Insurance Benefits or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. *(Applies to All Insurance Benefits and Health FSA Benefits as Limited Below, but Not to DCAP Benefits.)* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan, and/or your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Medical Insurance Benefits and/or Health FSA Benefits, as applicable).

7. Change in Cost. *(Applies to All Insurance Benefits and to DCAP Benefits as Limited Below, but Not to Health FSA Benefits.)* If the cost charged to you for your Insurance Benefits or DCAP Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage. (For these purposes, the Health FSA is not similar coverage with respect to the Medical Insurance Benefits, an HMO and a PPO are considered to be similar coverage (the Employer currently offers an PPO), and coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.) If the cost of Medical Insurance or DCAP Benefits significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes: (a) if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions; (b) if you are enrolled in another benefit package option (such as the HMO option under the Medical Insurance Plan), you may change your election on a prospective basis to elect the benefit package option that has decreased in cost (such as the PPO option under the Medical Insurance Plan); or (c) if you are otherwise eligible,

you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

The Plan Administrator generally will notify you of increases or decreases in the cost of Insurance benefits. You will have to notify the Plan Administrator of increases or decreases in the cost of DCAP benefits.

The change in cost provision applies to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

8. Change in Coverage. *(Applies to All Insurance Benefits and DCAP Benefits, but Not to Health FSA Benefits.)* You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Insurance Benefits or DCAP Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.) If your Insurance Benefits or DCAP Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Insurance Benefits coverage. You will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage.)

- *Addition or Significant Improvement of Cafeteria Plan Option.* If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

- *Intention or Need to Obtain Coverage through a Marketplace Established under the Affordable Care Act.* You may revoke your Health Insurance Benefits coverage mid-Plan Year if either one of the following applies:

    - You are seeking to enroll yourself and any other related individuals in coverage to be obtained through a Marketplace.

    - You have experienced a reduction of hours and reasonably expect to be working less than 30 hours for the foreseeable future and will seek coverage to be obtained through a Marketplace.

- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does.

For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.

- *DCAP Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

9. Change in HSA Elections. If you have enrolled in the Plan during Open Enrollment and have elected HSA Benefits, then you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. No other benefit package option election changes can be made as a result of a change in your HSA Benefits election unless permitted as a result of events otherwise described in this Attachment. For example, generally you would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described above for Health FSA Benefits otherwise applied (such as a change in status).

Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described

below. For details, see the various Change in Election Events headings below for the specific type of Change in Election Event:

Leaves of absence, including FMLA leave (defined in CAF Q-14); Changes in Status; Special Enrollment Rights;

Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note that the Change in Election Events do not apply for all Benefits—applicable exclusions are described under the relevant headings. In addition, as explained hereafter in this CAF Q-7, the Plan Administrator can change certain elections on its own initiative. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new election (depending on your employer's enrollment process, this may be either via a paper or electronic Salary Reduction Agreement), within 30 days after the occurrence. If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Cafeteria Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Cafeteria Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

CAF Q-8. What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Cafeteria Plan will cease and you will not be able to make any more contributions to the Cafeteria Plan for Insurance Benefits, Health FSA Benefits, HSA Benefits or DCAP Benefits.

See CAF Q-12 for information on your right to continued or converted group health coverage after termination of your employment.

For reimbursement of expenses from the Health FSA Account after termination of employment, see HFSA Q-9.
For reimbursement of expenses from the DCAP Account after termination of employment, see DCAP Q-9.
For information about obtaining distributions from your HSA at any time, including after termination of employment, contact the trustee/custodian of your HSA established and maintained outside of the Plan.
For purposes of pre-taxing COBRA coverage for Medical Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See CAF Q-12.

If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan, then you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, then your prior elections will be reinstated.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described in CAF Q-3 before again becoming eligible to participate in the Plan.

CAF Q-9. Will I pay any administrative costs under the Cafeteria Plan?

At the discretion of the employer, administrative costs may be borne by the Employer or the Employee. The Employer also reserves the right to offset these costs with available Cafeteria Plan forfeitures. A separate HSA trustee/custodial fee may be assessed by your HSA trustee/custodian for your HSA established and maintained by you outside of the Plan.

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

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

CAF Q-11. What happens if my claim for benefits is denied?

Insurance Benefits

The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which

generally is a prerequisite to bringing a suit in state or federal court). For more information about how to file a claim and for details regarding the medical insurance company's claims procedures, consult the claims procedure applicable under that plan or policy, as described in the plan document or summary plan description for the Insurance Plan.

Claims Under the Cafeteria Plan, Health FSA or DCAP.

If a claim for reimbursement under the Health FSA or DCAP Components of the Cafeteria Plan is wholly or partially denied, or you are denied a benefit under the Cafeteria Plan due to an issue germane to your coverage under the Cafeteria Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Cafeteria Plan document), then the claims procedure described below will apply:

If your claim is denied in whole or in part, you will be notified in writing by within 30 days after the date of the receipt of your claim. (This time period may be extended for an additional 15 days such as in cases where a claim is incomplete. You will be provided with written notice of any extension, including the reasons for the extension and the date by which a decision is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

• a specific reason or reasons for the denial;

• the specific Plan provision on which the denial is based;

• a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;

• appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

HSA Claims Not Involving Issues Relating to Salary Reductions.

Claims relating in any way to the HSA established and maintained by you outside of the Plan with your HSA trustee/custodian (for example, issues involving the investment or distribution of your HSA funds) shall be administered by your HSA trustee/custodian in accordance with the HSA trust or custodial document between you and such trustee/custodian.

Appeals.

If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the "Committee" (the Benefits Committee that acts on behalf of the Plan Administrator with respect to appeals). Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review.

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

• the specific reason(s) for the decision on review;

• the specific Plan provision(s) on which the decision is based;

• a statement of your right to review (upon request and at no charge) relevant documents and other information;

• if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

• a statement of your right to bring suit under ERISA § 502(a) (where applicable).

CAF Q-12. What is "Continuation Coverage" and how does it work?

COBRA.

For a discussion of your Continuation and Reinstatement rights please refer to Appendix A.

USERRA.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

CAF Q-13. How will participating in the Cafeteria Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable income, which may result in a decrease in your Social Security benefits and/or other benefits which are based on taxable income. However, the tax savings that you realize through Cafeteria Plan participation will often more than offset any reduction in other benefits. If you are still unsure, you are encouraged to consult with your accountant or other tax advisor.

CAF Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence.

NOTE: The following shall only apply if the Employer is subject to the federal Family and Medical Leave Act of 1993 (FMLA).

If you go on a qualifying leave under the federal Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your group health plan benefits, HSA Benefits, and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all group health plan benefits and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Insurance Benefits and Health FSA benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and, if applicable, vacation days (to pre-pay in advance, you must

make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue group health plan benefits and Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your group health plan benefits or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

If your Employer conducts an open enrollment during the time which you are on an FMLA leave, you will be eligible to participate in the open enrollment.

Non-FMLA Leaves of Absence.

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions

while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see the attachment entitled "When Can I Change Elections Under the Cafeteria Plan During the Plan Year?" found at the end of this Summary).

If your Employer conducts an open enrollment during the time which you are on a non-FMLA leave, you will be eligible to participate in the open enrollment.

CAF Q-15. Who is a "Spouse" under the Plan?

A "spouse" is any individual treated as a spouse for federal tax purposes, including but not limited to same-sex spouses legally married in a state recognizing same-sex marriages, regardless of the Participant's or the Spouse's current state of residence.

Premium Payment Benefits

PREM Q-1. What are "Premium Payment Benefits"?

As described in CAF Q-1, if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Insurance Benefits with pre-tax dollars by electing to do so. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See Q-4.

The Premium Payment Benefits offered under your Plan are for Health, Vision, Dental, Group Term Life, Disability, Cancer, Accident, Critical Illness, HSA and Other Individual Voluntary Benefits. The Medical Insurance Benefits are for major medical insurance, including a PPO options.

PREM Q-2. How are my Premium Payment Benefits paid?

As described in CAF Q-1 and in PREM Q-1, if you select a Medical Insurance Plan described in PREM Q-1, then you may be required to pay a portion of the contributions. When you complete the election (depending on your employer's enrollment process, this may be either via a paper or electronic Salary Reduction Agreement), if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Health FSA Benefits

HFSA Q-1. What are "Health FSA Benefits"?

As described in Q-2, a Health FSA permits eligible Employees to pay Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from an insurance plan.

As described in Q-1, if you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into a Salary Reduction Agreement with your Employer.

The Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

In the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, you may seek reimbursement from either the Health FSA or the HSA, but not both.

A general-purpose health FSA constitutes family coverage because it is available to pay or reimburse the qualified medical expenses of the employee and the employee's spouse and dependents. Consequently, if either spouse participates in a general-purpose health FSA, neither spouse will be eligible to contribute to an HSA either through the spouse's employer or individually through a bank. Likewise, the fact that an adult child's qualified medical expenses could be reimbursed by a parent's general-purpose health FSA (i.e., because the child is under age 27 as of the end of the taxable year) will prevent the adult child from being HSA-eligible.

HFSA Q-2. Can I participate in the Health FSA Benefit?

Eligibility requirements for the Health FSA Benefit are the same as the eligibility requirements described under CAF Q-3. After you satisfy the eligibility requirements, you may participate in the Health FSA by enrolling in the plan, as described under CAF Q-5.

HFSA Q-3. What is my "Health FSA Account"?

If you elect Health FSA Benefits, then an account called a "Health FSA Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account: it is not funded (that is, all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

Subject to the Employer's benefit offering, a Health FSA election may be for:

(a) General-Purpose Health FSA Coverage;

(b) Limited (Vision/Dental/Preventive Care) Health FSA Coverage; or

(c) Employee-Only Health FSA Coverage; or

(d) Employee-Plus-Children Health FSA Coverage.

Note: If you elect Health FSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect a Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option which is only available if offered by the employer. If you are married and elect the General-Purpose Health FSA Coverage Option, your spouse will also be ineligible to make HSA contributions.

HFSA Q-4. What is the maximum limit for the Health FSA Benefits that I may elect?

You may elect up to $2,750.00 in Health FSA benefits for the Plan year, and a minimum amount of $0.00.

Because of limitation on Health FSAs imposed by the Patient Protection and Affordable Care Act, for calendar years beginning January 1, 2018, you will only be able to elect up to $2,650 for the 2018 calendar year. Effective January 1, 2019, you will be able to elect up to $2,700 for any given calendar year, subject to any limits imposed by the Employer as defined above in this Section.

HFSA Q-5. How are my Health FSA Benefits paid for under the Cafeteria Plan?

When you complete a Salary Reduction Agreement during the benefit enrollment process, you will specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

HFSA Q-6. What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?

The full amount of Health FSA coverage that you have elected will be available to reimburse you for qualifying expenses incurred during the Plan Year (reduced by prior reimbursements made during the same Plan Year), regardless of the amount that you have contributed when you submitted the claim (so long as you continue participation).

Example HFSA Q-6(a): Sally elected $2,000 of coverage and contributed $307.69 to her Health FSA Account over the first four pay periods of the Plan Year ($2,000 divided by 26 pay periods equals $76.92 per pay period;. $76.92 multiplied by four pay periods equals $307.69), ending on February 23rd of the Plan Year. Sally has had no claims until February 25th, when she incurs $400 in expenses. The entire $400 is available for reimbursement to Sally even though she has contributed only $307.69 to her Health FSA Account to that point.

HFSA Q-7. What are "Medical Care Expenses" that may be reimbursed from the Health FSA?

The Employer offers the following Health FSA options:

• General-Purpose Health FSA Coverage;

• Limited (Vision/Dental/Preventive Care) Health FSA Coverage, if offered by the employer;

Each of these Health FSA coverage options is described in detail below. Note: You cannot elect HSA Benefits and Health FSA Benefits together unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. In addition, if you have an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option) that is in effect on the last day of a Plan Year, you cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in your Health FSA Account is $0 as of the last day of that Plan Year. For this purpose, your Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

The eligible "Medical Care Expenses" vary according to the type of Health FSA coverage option that is elected, as described below.

(a) *General-Purpose Health FSA Coverage Option.* For purposes of the General-Purpose Health FSA Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code § 213(d). Under the tax laws, "Medical Care Expenses" include expenses for OTC drugs and medicines as well as expenses for prescription drugs and menstrual products. However, as described above, only reasonable quantities of over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month.

Ask the Plan Administrator if you need further information about which expenses are—and are not— likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Since you derive tax benefits from this plan, you have responsibility for your compliance with tax laws.

(b) *Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option.*

According to rules set forth in Code § 223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses medical expenses as defined for a General-Purpose Health FSA in subsection (a) above. You may, however, be eligible to make/receive tax-favored contributions to a HSA and participate in a Health FSA if the Health FSA reimbursement is limited to the following unreimbursed Code § 213(d) expenses:

• Services or treatments for dental care (excluding premiums);

• Services or treatments for vision care (excluding premiums); or

•Services or treatments for "preventive care." Preventive care is defined in accordance with applicable rules and regulations under Code § 223(c)(2)(C). (This may include any prescription drugs to the extent that such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., a smoking cessation or weight-loss program). Preventive care does not include services or treatments that treat an existing condition.

Orthodontia Expenses. Orthodontia expenses will be reimbursed "as paid only". See below example.

Example: As paid only (i.e., in advance of services rendered, regardless of amount)
Rachel participates in a calendar-year health FSA in 2015, 2016, and 2017. In October 2015, she signs an agreement with an orthodontist to work on her son Ethan's teeth. During the first visit (November), Ethan is X-rayed and fitted for braces. During the second visit (December), the braces are installed. During 15 more monthly visits, the braces will be adjusted. Eventually (in 18 months, if everything goes as planned), the braces will be removed. For these services, the orthodontist charges $5,000. Rachel is required to pay a $2000 down payment and $200 for each month thereafter. She decides to pay the entire $5000 during the first visit to avoid any interest being charged. The entire $5000 will be reimbursable from her 2015 Health FSA.

PLEASE NOTE: "Down" payments for orthodontia are immediately reimbursable.

HFSA Q-8. When must the Medical Care Expenses be incurred for the Health FSA?

For expenses to be reimbursed to you from your Health FSA Account for the Plan Year, they must have been incurred during that Plan Year. The Plan Year for the Health FSA is the same as the Plan Year for the Cafeteria Plan—it is the 12-month period beginning on January 1st and ending on December 31st.
A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the Health FSA or the Cafeteria Plan became effective, before your Salary Reduction Agreement became effective, for any expense incurred after the close of the Plan Year , or after a separation from service (except for Continuation Coverage, as described in CAF Q-12).

HFSA Q-9. What must I do to be reimbursed for Medical Care Expenses from the Health FSA?

In cases where you do not use an electronic payment card or "debit" card to pay for your incurred expenses, you must submit a Health FSA Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form.

You will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15-day extension in certain instances—see CAF Q-11 for more information). Claims will be paid in the order in which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have 3 month(s) after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 3 month(s) after the date you ceased to be eligible in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible. You will be notified in writing if any claim for benefits is denied. (See CAF Q-11 for more information.)

To have your claims processed as soon as possible, please follow the instructions in CAF Q-11. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense—only for you to have incurred the expense (as defined in HFSA Q-8) and that it is not being paid for or reimbursed from any other source.

HFSA Q-10 Do I still have to submit claims if I use a debit card?

If the Employer implements an electronic payment card program (such as a debit card to pay expenses from the Health FSA, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents. You will receive more information from the Employer about what you must do to obtain reimbursement if such a system is implemented.

HFSA Q-11. Can I rollover my unused health FSA funds to the next Plan year?

Yes, you can rollover up to $550.00 of your unused health FSA funds to the next Plan Year. The actual amount of any such "unused" health FSA funds will be based upon the amount leftover after the run-out period for the current Plan Year ends. If you wish (for instance, to preserve HSA eligibility), you may waive your rights to this rollover but you must do so before the beginning of the next plan year. Unused health FSA funds above $550.00 shall be forfeited in accordance with the usual "use-or-lose" rule for health FSAs.

HFSA Q-12. What are the time limits that affect forfeiture of my Health FSA Benefits (and what happens to amounts that are forfeited)?

Subject to any rollover provisions in HFSA Q-11, you will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted by 3 month(s) after the close of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you may forfeit such amounts at an earlier date—see HFSA Q-9).

Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the Health FSA during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

HFSA Q-13. Will I be taxed on the Health FSA Benefits that I receive?

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in HFSA Q-4. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are

reimbursed for a claim that is later determined to not be for eligible Medical Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the Health FSA constitutes Medical Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

HFSA Q-14. Can I cover Dependents until they are 27 with my Health FSA?

Medical Care Expenses incurred for children of Participants who will have not attained age 27 by the end of any given taxable year may be reimbursed by the Health FSA.

DCAP Benefits

DCAP Q-1. What are "DCAP Benefits"?

As described in CAF Q-2, a DCAP permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse's DCAP).

As described in CAF Q-1, if you elect DCAP Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into a Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA taxes.

See CAF Q-4 for an example dealing with pre-tax payment of Health Insurance contributions.

DCAP Q-2. Reserved for future content

DCAP Q-3. What is my "DCAP Account"?

If you elect DCAP Benefits, an account called a "DCAP Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your DCAP Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer) and it does not bear interest.

DCAP Q-4. What are the maximum DCAP Benefits that I may elect under the Cafeteria Plan?

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the minimum reimbursement amount of $0.00 and the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual DCAP contribution equal to the coverage level that you have chosen (e.g., if you elect $3,000 in DCAP Benefits, you'll pay for the benefits with a $3,000 salary reduction).

The amount of Dependent Care Expense reimbursement that you choose cannot exceed the lower of the Employer's established maximum $5,000.00, statutory maximum of $5,000 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code § 129 when your election is made. The $5,000 maximum will apply to you if:

• you are married and file a joint federal income tax return;

• you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the DCAP); (2) you furnish over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of such household (i.e., your Spouse maintained a separate residence); or you are single or the head of the household for federal income tax purposes.

If you are married and reside with your Spouse but you file a separate federal income tax return, then the maximum DCAP Benefit that you may exclude from your income under Code § 129 is $2,500 for a calendar year. These maximums ($5,000 or $2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations, as described in DCAP Q-7 (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

DCAP Q-5 How are my DCAP Benefits paid for under the Cafeteria Plan?

When you complete your Salary Reduction Agreement, you specify the amount of DCAP Benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). If you pay all of your contributions, then your DCAP Account will be credited with the portion of your gross income that you have elected to give up through salary reduction. These portions will be credited as of each pay period.

For example, suppose that you have elected to be reimbursed for $5,000 per year for Dependent Care Expenses and that you have chosen no other benefits under the Cafeteria Plan. Your DCAP Account would be credited with a total of $5,000 by the end of the Plan Year. If you are paid biweekly, then your DCAP Account would reflect that you have paid $192.31 ($5,000 divided by 26) each pay period in contributions for the DCAP Benefits that you have elected.

DCAP Q-6. What amounts will be available for DCAP reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year.

Using the example in DCAP Q-5, suppose that you incur $1,500 of Dependent Care Expenses by the end of the third month of the Plan Year. Assuming you have had seven pay periods at that

point, your DCAP Account would only have been credited with $1,346.15 ($192.31 times seven pay periods), so only $1,346.15 would be available for reimbursement at the end of March (assuming that you had not received any prior reimbursements). You would have to wait to submit the remaining balance of your Dependent Care Expenses until after you had received the appropriate credits to your DCAP Account.

You may also be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year (See DCAP Q-8).

DCAP Q-7. What are "Dependent Care Expenses" that may be reimbursed?

"Dependent Care Expenses" means employment-related expenses incurred on behalf of a person who meets the requirements to be a "Qualifying Individual," as defined in the first bulleted item below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

• Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:

- a person under age 13 who is your "qualifying child" under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);

- your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or

- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child.

• No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account.

• The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.

• The expenses are incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care.

• The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.

If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least eight hours per day in your household.

If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

• The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child, or a person for whom you (or your Spouse) are entitled to a personal exemption under Code § 151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.

• The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.

Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

• your earned income for the calendar year (after your salary reductions under the Cafeteria Plan);

• the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of $250 ($500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care; or (b) a full-time student); or

• either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status, as described further in DCAP Q-4.

Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a DCAP, the maximum amount that you and your Spouse together can exclude from income is $5,000.

DCAP Q-8. When must the Dependent Care Expenses be incurred?

For Dependent Care Expenses to be reimbursed to you from your DCAP Account for the Plan Year, the expenses must have been incurred during that Plan Year. The Plan Year for the DCAP is the same as for the Cafeteria Plan—it is the 12-month period beginning on January 1 and ending on December 31.

In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year. Grace periods will begin immediately following the last day of the plan year and will end two months and fifteen days later.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the DCAP or Cafeteria Plan became effective, for any expenses arising before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except as described in DCAP Q-9).

DCAP Q-9. What must I do to be reimbursed for my Dependent Care Expenses?

Except in cases where an electronic payment card (or “debit card”) is used, when you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator (or Third Party Administrator, if applicable) on a DCAP Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses, along with the DCAP Reimbursement Request Form. Further details about what must be provided are contained in the DCAP Reimbursement Request Form.

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Request

Form (subject to a 15-day extension in certain instances—see CAF Q-11). If a claim is for an amount larger than that remaining in your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have 3 month(s) after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 3 month(s) after the date you ceased to be eligible in which to submit a claim for reimbursement for Dependent Care Expenses incurred prior to the date you ceased to be eligible. You will be notified in writing if any claim for benefits is denied. (See CAF Q-11.)

The following additional rules will apply to Dependent Care Expenses that are incurred during a grace period or are submitted after the close of the Plan Year in which they were incurred:

- Dependent Care Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that $200 remains in your DCAP Account at the end of the current Plan Year and that you have also elected $2,400 of DCAP coverage for the new Plan Year. If you submit a $500 Dependent Care Expense that was incurred on January 15, of the new Plan Year, $200 of your claim will be paid out of the unused amounts remaining in your DCAP Account from the current Plan Year and the remaining $300 will be paid out of the amounts that are available to reimburse you for Dependent Care Expenses incurred in the new Plan Year.
- Once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the $500 grace period expense, you discover $200 of 2009 Dependent Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2010 expenses. The Plan will not reprocess the $500 grace period expense so as to pay it entirely from your 2010 Dependent Care amounts. For this reason, if you also have Dependent Care coverage for the current year, you may want to wait to submit Dependent Care Expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.
- Expenses incurred during a grace period must be submitted by the 90 day(s) following the close of the Plan Year to which the grace period relates in order to be reimbursed from amounts remaining at the end of that Plan Year. (As discussed above, 90 days is also the deadline for submitting any claims for reimbursement of Dependent Care Expenses incurred during the preceding Plan Year.)

To have your claims processed as soon as possible, please read CAF Q-11. Note that it is not necessary for you to have actually paid the bill in an amount due for a Dependent Care Expense, only for you to have incurred the expense (as defined in DCAP Q-8) and that it is not being paid for or reimbursed from any other source.

If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Dependent Care Account, some expenses may be validated at the time the expense is incurred. For other expenses, the card payment is only conditional and you will still have to submit supporting documents. In addition, Dependent Care Expenses incurred during a Grace Period may need to be submitted manually in order to be reimbursed from unused amounts in your Dependent Care Account from the preceding Plan Year if the card is unavailable for such reimbursement.

DCAP Q-10. Is there any risk of losing or forfeiting the amounts that I elect for DCAP Benefits?

Yes. If the Dependent Care Expenses that you incur during the Plan Year or during the grace period immediately following the Plan Year (if you are eligible for the grace period—see DCAP Q-8) are less than the annual amount that you elected for DCAP Benefits, you will forfeit the rest of that amount—this is called the "use-or-lose" rule under applicable tax laws and it is one of the required trade-offs for the tax benefits gained. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year or its grace period (if applicable), even if amounts are still left in your DCAP Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the end of the time limits described in DCAP Q-11.

DCAP Q-11. What are the time limits that affect forfeiture of my DCAP Benefits?

You will forfeit any amounts in your DCAP Account that are not applied to DCAP Benefits for any Plan Year within 3 month(s) after the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within 3 month(s) after the date you ceased to be eligible—see DCAP Q-9). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the DCAP during the Plan Year and the subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

DCAP Q-12. Will I be taxed on the DCAP Benefits I receive?

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth in Q-4. However, the Employer cannot guarantee that specific tax consequences will flow from your

participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, for tax-free treatment, you will be required to file IRS Form 2441 ("Child and Dependent Care Expenses") with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

DCAP Q-13. If I elect DCAP Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit (see DCAP Q-14). For example, if you elect $3,000 in coverage under the DCAP and are reimbursed $3,000, but you had Dependent Care Expenses totaling $5,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more Qualifying Individuals.

DCAP Q-14. What is the Dependent Care Tax Credit?

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual Dependent Care Expenses. In determining what the tax credit would be, you may take into account $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one Qualifying Individual, or $2,100 for two or more Qualifying Individuals), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one Qualifying Individual, or $1,200 for two or more Qualifying Individuals). The maximum 35% rate is reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) by which your adjusted gross income exceeds $15,000.

For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). You may also wish to consult a tax advisor, as discussed below.

DCAP Q-15. Would it be better to include the DCAP Benefits in my income and claim the Dependent Care Tax Credit, instead of treating the reimbursements as tax free?

For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a DCAP will be only marginally better.) Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 ("Child and Dependent Care Expenses") to help you.

HSA Benefits

HSA Q-1. What are "HSA Benefits"?

As described in CAF Q-2, an HSA permits Employees to make pre-tax contributions to an HSA established and maintained outside the Plan with the Employee's HSA trustee/custodian. For purposes of this Cafeteria Plan, HSA Benefits consist solely of the ability to make such pre-tax contributions under this Cafeteria Plan.

As described in CAF Q-1, if you elect HSA Benefits, then you will be able to provide a source of pre-tax contributions by entering into a Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA taxes. See CAF Q-4 for an example dealing with pre-tax payment of insurance contributions.

To participate in the HSA Benefits, you must be an "HSA-Eligible Individual." This means that you are eligible to contribute to an HSA under the requirements of Code § 223 and that you have elected qualifying High Deductible Health Plan coverage offered by the Employer and have not elected any disqualifying non- High Deductible Health Plan coverage offered by the Employer. ("High Deductible Health Plan" means the high deductible health plan offered by your Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials that will be provided separately to you by the Employer.) If you elect HSA Benefits, you will be required to certify that you meet all of the requirements under Code § 223 to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage—and you should be aware that coverage under a Spouse's plan could make you ineligible to contribute to an HSA. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 ("Health Savings Accounts and Other Tax-Favored Health Plans").

In order to elect HSA Benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian and you must provide sufficient identifying information about your HSA to facilitate the forwarding of your pre-tax Salary Reductions through the Employer's payroll system to your designated HSA trustee/custodian. If you elect Health FSA Benefits, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. In the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, you may seek reimbursement from either the Health FSA or the HSA, but not both. (If your Employer ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the Health FSA must pay first.)

HSA Q-2. What is my "HSA"?

The HSA is not an employer-sponsored employee benefit plan—it is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code § 223. Your HSA is administered by your HSA trustee/custodian. Consequently, an HSA trustee/custodian, not the Employer, will establish and maintain your HSA. Your Employer's role is limited to allowing you to contribute to your HSA on a pre-tax Salary-Reduction basis. The HSA trustee/custodian will be chosen by you, as the Participant, and not by the Employer. Your Employer may, however, limit the number of HSA providers to whom it will forward pretax Salary Reductions, a list of whom will be provided upon request. Any such list of HSA trustees/custodians, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular HSA trustee/custodian. Your Employer has no authority or control over the funds deposited in your HSA.
The Plan Administrator will maintain records to keep track of HSA contributions that you make via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

HSA Q-3. What are the maximum HSA Benefits that I may elect under the Cafeteria Plan?

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect. The amount you elect must not exceed the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. (Note: $3,500 for single and $7,000 for family are the statutory maximum contribution limits for 2019; $3,550 for single and $7,100 for family are the statutory maximum contribution limits for 2020; $3,600 for single and $7,200 for family are the statutory maximum contribution limits for 2021.) An additional catch-up contribution ($1,000) may be made if you are age 55 or older (you must certify your age to your Employer).

Note that if you are an HSA-Eligible Individual for only part of the year but you meet all of the requirements under Code § 223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family). However, any contributions in excess of your annual contribution under the Plan for HSA benefits (as described above), but not in excess of the applicable full statutory maximum amount, must be made outside the Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of Code §223 during the following year, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 10% penalty (exceptions apply in the event of death or disability).

HSA Q-4. How are my HSA Benefits paid for under the Cafeteria Plan?

When you complete the Salary Reduction Agreement, you specify the amount of HSA Benefits that you wish to pay for with your salary reduction. From then on, you make a contribution for

such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

For example, suppose that you have elected to contribute up to $2,000 per year for HSA Benefits and that you have chosen no other benefits under the Cafeteria Plan. If you pay all of your contributions, then our records would reflect that you have contributed a total of $2,000 during the Plan Year. If you are paid biweekly, then our records would reflect that you have paid $76.92 ($2,000 divided by 26) each pay period in contributions for the HSA Benefits that you have elected. Such contributions will be forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld.

In addition, the maximum annual contribution shall be: (a) reduced by any matching (or other) Employer contribution made on your behalf (there are currently no such Employer contributions (other than pre-tax Salary Reductions) made under the Plan); and (b) pro-rated for the number of months in which you are an HSA-Eligible Individual.
As described in HSA Q-2, your Employer has no authority or control over the funds deposited in your HSA.

HSA Q-5. Will I be taxed on the HSA Benefits that I receive?

You may save both federal income taxes and FICA taxes by participating in the Cafeteria Plan. However, very different rules apply with respect to taxability of HSA Benefits than for other Benefits offered under this Plan. For more information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of your HSA see the communications materials provided by your HSA trustee/custodian and see IRS Publication 969 (“Health Savings Accounts and Other Tax-Favored Health Plans”).

The Employer cannot guarantee that specific tax consequences will flow from your participation in the Cafeteria Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA Benefits. Remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

HSA Q-6. Who can contribute to an HSA under the Cafeteria Plan?

Only Employees who are HSA-Eligible Individuals can participate in the HSA Benefits. As described in HSA Q-3, an HSA-Eligible Individual means an individual who meets the eligibility requirements of Code §223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage. The terms of the High Deductible Health Plan that has been selected by your Employer will be further described in materials that will be provided separately to you by the Employer.

HSA Q-7. Can I change my HSA Contribution under the Cafeteria Plan?

Unlike the other benefits offered under the Cafeteria Plan, you may increase, decrease, or revoke your HSA contribution election at any time during the plan year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change. Your ability to make pre-tax contributions under this Plan to the HSA identified above ends on the date that you cease to meet the eligibility requirements. See CAF Q-8.

HSA Q-8. Where can I get more information on my HSA and its related tax consequences?

For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA trust or custodial agreement and other documentation associated with your HSA and provided to you by your HSA trustee/custodian. You may also want to review IRS Publication 969 ("Health Savings Accounts and Other Tax-Favored Health Plans").

Miscellaneous

MISC Q-1.Reserved
MISC Q-2. What other general information should I know?

This MISC Q-2 contains certain general information that you may need to know about the Plan. Note: This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan documents and the separate Summary Plan Description for the Medical Insurance Plan. Neither does this Summary Plan Description describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

General Plan Information

Official Name of the Plan: Pearl River Community College Cafeteria Plan

Plan Number: 501

Effective Date: October 18, 2019.

Plan Year: January 1 to December 31. Your Plan's records are maintained on this period of time.

Type of Plan: Welfare plan providing Medical Insurance Benefits, Health FSA Benefits, and DCAP Benefits

Employer/Plan Sponsor Information

Name and Address:
Pearl River Community College
101 Highway 11 North
Poplarville, MISSISSIPPI 39470

Federal employee tax identification number (EIN): 64-6000960.

Plan Administrator Information

Name, address, and business telephone number:
Pearl River Community College
101 Highway 11 North
Poplarville, MISSISSIPPI 39470
Attention: Human Resources

Telephone Number: (601) 403-1489

Funding Medium and Type of Plan Administration.

The Health FSA Component is a group health plan. The Health FSA is self-funded by the Employer. It is a contract administration plan. A third-party administrator processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.

Named Fiduciary

The named fiduciary for the Health FSA Component is:

Pearl River Community College
101 Highway 11 North
Poplarville, MISSISSIPPI 39470
Telephone Number: (601) 403-1489

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process is:
Pearl River Community College
101 Highway 11 North
Poplarville, MISSISSIPPI 39470
Attention: Benefits Committee

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Insurance Plan and HSA Documents and Information

This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan document and the separate Summary Plan Description for the Medical Insurance Plan. Neither does this Summary Plan Description describe many aspects of the HSA

Component (e.g., with respect to claims and reimbursement under the HSA). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

Appendix A

CONTINUATION COVERAGE RIGHTS UNDER COBRA Pearl River Community College Cafeteria Plan (the "Plan")

Introduction

The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The Plan may have one or more of the following group health components: Medical, Dental, Vision and/or Health FSA. You may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan (the Medical, Dental, and Health FSA components) and not to any other benefits offered under the Plan or by Pearl River Community College. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

You May Have Other Options Available to You When You Lose Group Health Coverage

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

COBRA coverage may become available to "qualified beneficiaries"

After a qualifying event occurs and any required notice of that event is properly provided to Pearl River Community College, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA Coverage Under the Health FSA Component

COBRA coverage is offered only in limited circumstances

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

Health FSA COBRA coverage lasts only until the end of the plan year

COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by the reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year.

All qualified beneficiaries are covered together under the Health FSA unless otherwise elected

Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Pearl River Community College for more information.

No Health FSA open enrollment

Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Who Is Entitled to Elect COBRA?

We use the pronoun “you” in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

Qualifying events for the covered employee

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens: • your hours of employment are reduced; or • your employment ends for any reason other than your gross misconduct.

Qualifying events for the covered spouse

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

• your spouse dies;

• your spouse's hours of employment are reduced;

• your spouse's employment ends for any reason other than his or her gross misconduct; or

• you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Qualifying events for dependent children

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

• your parent-employee dies;

• your parent-employee's hours of employment are reduced;

• your parent-employee's employment ends for any reason other than his or her gross misconduct;

• you stop being eligible for coverage under the Plan as a "dependent child."

Electing COBRA after leave under the Family and Medical Leave Act (FMLA)

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact Pearl River Community College or the third party COBRA administrator for more information about these special rules.

Special second election period for certain eligible employees who did not elect COBRA

Certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second

opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost). If you are an employee or former employee and you qualify for TAA or ATAA,

CONTACT Pearl River Community College PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE ANY RIGHT THAT YOU MAY HAVE TO ELECT COBRA DURING A SPECIAL SECOND ELECTION PERIOD.

Contact Pearl River Community College for more information about the special second election period.

When Is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify Pearl River Community College of any of these qualifying events.

Caution:

You stop being eligible for coverage as dependent child whenever you fail to satisfy any part of the plan's definition of dependent child.

You must notify the plan administrator of certain qualifying events by this deadline

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify Pearl River Community College in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

No COBRA election will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form"

(you may obtain a copy of this form from Pearl River Community College at no charge, **and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to Pearl River Community College during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA. Electing COBRA Coverage**

How to elect COBRA

To elect COBRA, you must complete and return the Election Form in the manner outlined in the Plan's COBRA election notice.

(An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from Pearl River Community College.

Deadline for COBRA election

If mailed, your election must be postmarked (or if hand-delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Independent election rights

Each qualified beneficiary will have an independent right to elect COBRA.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Special Considerations in Deciding Whether to Elect COBRA

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods.

COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred—see the section above entitled "COBRA Coverage Under the Health FSA Component."

COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Death, divorce, legal separation, or child's loss of dependent status

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the Plan's Medical and Dental components can last for up to a total of 36 months.

If the covered employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical and Dental components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Termination of employment or reduction of hours

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical and Dental components generally can last for only up to a total of 18 months.

Extension of Maximum Coverage Period (Not Applicable to Health FSA Component)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Pearl River Community College of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances. These extension opportunities also do not apply to a period of COBRA coverage

resulting from a covered employee's death, divorce, or legal separation or a dependent child's loss of eligibility.)

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify Pearl River Community College in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You must notify Pearl River Community College of a qualified beneficiary's disability by this deadline

The disability extension is available only if you notify Pearl River Community College in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

• the date of the Social Security Administration's disability determination;

• the date of the covered employee's termination of employment or reduction of hours; and

• the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

No disability extension will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" (you may obtain a copy of this form from Pearl River Community College at no charge, **and you must follow the notice procedures specified in the section below entitled "Notice Procedures."**

If these procedures are not followed or if the notice is not provided to Pearl River Community College during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

You must notify Pearl River Community College of a second qualifying event by this deadline

This extension due to a second qualifying event is available only if you notify Pearl River Community College in writing of the second qualifying event within 60 days after the date of the second qualifying event.

No extension will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from Pearl River Community College at no charge, **and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to Pearl River Community College during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

• any required premium is not paid in full on time;

• a qualified beneficiary becomes covered, after electing COBRA, under another group health plan;

• a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;

• the employer ceases to provide any group health plan for its employees; or

• during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate). For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period(Not Applicable to Health FSA Component)."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify Pearl River Community College if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage

You must notify Pearl River Community College in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form" (you may obtain a copy of this form from Pearl River Community College at no charge, and you must follow the notice procedures specified below in the section entitled "Notice Procedures." In addition, if you were already entitled to Medicare before electing COBRA, notify Pearl River Community College of the date of your Medicare entitlement at the address shown in the section below entitled "Notice Procedures."

You must notify Pearl River Community College if a qualified beneficiary ceases to be disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify Pearl River Community College of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form entitled **"Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form"** (you may obtain a copy of this form from Pearl River Community College at no charge, and you must follow the notice procedures specified below in the section entitled "Notice Procedures."

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan

participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Payment for COBRA Coverage

How premium payments must be made

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When premium payments are considered to be made

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

First payment for COBRA coverage

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled “Electing COBRA Coverage.”

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue’s employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.)

You are responsible for making sure that the amount of your first payment is correct. You may contact Pearl River Community College using the contact information provided below to confirm the correct amount of your first payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly payments for COBRA coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Pearl River Community College will not send periodic notices of payments due for these coverage periods (that is, **we will not send a bill to you for your COBRA coverage—it is your responsibility to pay your COBRA premiums on time).**

Grace periods for monthly COBRA premium payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during a period of COBRA coverage

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA

coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Pearl River Community College during the covered employee's period of employment with Pearl River Community College is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Are There Other Coverage Options Besides COBRA Coverage?

Yes. Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.HealthCare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

NOTICE PROCEDURES

Pearl River Community College Welfare Benefits Plan (the Plan)

Warning
If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms

Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this SPD, and you may obtain copies from Pearl River Community College without charge. Oral notice, including notice by telephone, is not acceptable.

How, When, and Where to Send Notices

You must mail or hand-deliver your notice to:

Human Resources Manager
Pearl River Community College
101 Highway 11 North
Poplarville, MISSISSIPPI 39470

However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand-deliver your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from Pearl River Community College).

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You must notify the plan administrator of certain qualifying events by this deadline," "You must notify Pearl River Community College of a qualified beneficiary's disability by this deadline," and "You must notify Pearl River Community College of a second qualifying event by this deadline.")

Information Required for All Notices

Any notice you provide must include (1) the name of the Plan (Pearl River Community College Welfare Benefits Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying Pearl River Community College that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation,

your notice must include evidence satisfactory to Pearl River Community College that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability

Any notice of disability that you provide must include (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event

Any notice of a second qualifying event that you provide must include (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices

The covered employee, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

PEARL RIVER COMMUNITY COLLEGE CAFETERIA PLAN

ARTICLE I. Introductory Provisions

Pearl River Community College ("the Employer") hereby establishes the Pearl River Community College Cafeteria Plan ("the Plan") effective October 18, 2019 ("the Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to allow an Eligible Employee to pay for his or her share of Contributions on a pre-tax salary reduction basis under the Premium Component, to an account for reimbursement of certain Medical Care Expenses (Health FSA Account), to an Employee's health savings account (HSA) and to an account for reimbursement of certain Dependent Care Expenses (DCAP Account).

This Plan is intended to qualify as a "cafeteria plan" under Code § 125 and the regulations issued thereunder. The terms of this document shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a "self-insured medical reimbursement plan" under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b). The DCAP Component is intended to qualify as a "dependent care assistance program" under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a). Although reprinted within this document, the different components of this Plan shall be deemed separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed on such components by the Code. The Health FSA Component, if any, shall also be deemed a separate plan for purposes of applicable provisions of HIPAA and COBRA.

ARTICLE II. Definitions

"Account(s)" means the Health FSA Accounts and the DCAP Accounts described in Section 7.5 for Health FSAs and Section 8.5 for DCAPs. In some contexts, the term "Account(s)" may also include the record of HSA Contributions described in Section 9.4.

"Benefits" means the Premium Payment Benefits, the Health FSA Benefits, the HSA Benefits and the DCAP Benefits offered under the Plan.

"Benefit Package Option" means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

"Change in Status" has the meaning described in Section 4.6.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

"Contributions" means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, Section 8.2 for DCAP Benefits and Section 9.2 for HSA Benefits.

"Committee" means the Benefits Committee appointed by the Board of Directors of Pearl River Community College

"Compensation" means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

"DCAP" means dependent care assistance program.

"DCAP Account" means the account described in Section 8.5.

"DCAP Benefits" has the meaning described in Section 8.1.

"DCAP Component" means the Component of this Plan described in Article VIII.

"Dependent" means: (a) for purposes of accident or health coverage and to the extent funded for purposes of the Health FSA Component and under the Premium Payment Component , 1) any individual who is a tax dependent of the Participant as defined in Code § 105(b), 2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year) ; and (b) for purposes of the DCAP Component, a dependent means a Qualifying Individual as defined in Section 8.3(c).

The Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent." Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Dependent Care Expenses" has the meaning described in Section 8.3.

"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 (a) any amounts received pursuant to any DCAP established under Code § 129; or (b) any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity or pursuant to workers' compensation.

"Effective Date" of this Plan has the meaning described in Article 1.

"Election Form/Salary Reduction Agreement" means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Premium Payment Benefits, Health FSA Benefits, HSA Benefits and DCAP Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 3.1.

"Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: exclude any leased employee; exclude any temporary employee; exclude any self-employed individual; exclude any partner in a partnership; exclude any more-than-2% shareholder in a Subchapter S corporation;

and exclude any employee of a collective bargaining agreement The term “Employee” does include “former Employees” for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

“Employer” means Pearl River Community College, and any Related Employer that adopts this Plan with the approval of Pearl River Community College. Related Employers that have adopted this Plan, if any, are listed in Appendix A of this Plan. However, for purposes of Article XIV and Section 15.3, “Employer” means only Pearl River Community College.

“Employment Commencement Date” means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

“FMLA” means the Family and Medical Leave Act of 1993, as amended.

“General-Purpose Health FSA Option” has the meaning described in Section 7.3(b).

“Grace Period” means the period that begins immediately following the close of a Plan Year and ends on the day that is two months plus 15 days following the close of that Plan Year.

“Health FSA” means health flexible spending arrangement, which consists of four options (if applicable): the General- Purpose Health FSA Option; the Limited (Vision/Dental/Preventive Care) Health FSA Option; the Employee- Only Health FSA Option; and the Employee-Plus-Children Health FSA Option.

“Health FSA Account” means the account described in Section 7.5.

“Health FSA Benefits” has the meaning described in Section 7.1.

“Health FSA Component” means the Component of this Plan described in Article VII.

“High Deductible Health Plan” means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials provided separately by the employer. The High Deductible Health Plan may or may not be the sole Medical Insurance Plan eligible for pre-tax Salary Reduction funding hereunder.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“HMO” means the health maintenance organization Benefit Package Option under the Medical Insurance Plan.

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45. The Employer does not currently offer an HRA.

"HSA" means a health savings account established under Code § 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

"HSA Benefits" has the meaning described in Section 9.1.

"HSA-Eligible Individual" means an individual who is eligible to contribute to an HSA under Code § 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.

"Limited (Vision/Dental/Preventive Care) Health FSA Option", if offered by the employer, has the meaning described in Section 7.3(b).

"Medical Care Expenses" has the meaning defined in Section 7.3.

"Medical Insurance Benefits" means the Employee's Medical Insurance Plan coverage for purposes of this Plan.

"Medical Insurance Plan" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies (with PPO options). The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

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

Reimbursement Accounts offered under the Plan in a manner set forth in the SPD of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.

"Open Enrollment Period" with respect to a Plan Year means the month preceding the Plan Year, or such other period as may be prescribed by the Administrator.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Insurance Benefits, Health FSA Benefits, DCAP Benefits, HSA Benefits, and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under the Medical Insurance Plan (if any) with after-tax dollars outside of this Plan and who have not elected any Health FSA Benefits, DCAP Benefits or HSA Benefits.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

"Plan" means the Pearl River Community College Cafeteria Plan as set forth herein and as amended from time to time.

"Plan Administrator" means Pearl River Community College. The contact person is the Human Resources Manager or the equivalent thereof for Pearl River Community College, who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 13.1.

"Plan Year" means the 12-month period commencing January 1 and ending on December 31.

"PPO" means the preferred provider organization Benefit Package Option under the Medical Insurance Plan.

"Premium Payment Benefits" means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

"Premium Payment Component" means the Component of this Plan described in Article VI.

"Qualifying Dependent Care Services" has the meaning described in Section 8.3.

"Qualifying Individual" has the meaning described in Section 8.3.

"Related Employer" means any employer affiliated with Pearl River Community College that, under Code § 414(b), § 414(c), or § 414(m), is treated as a single employer with Pearl River Community College for purposes of Code § 125(g)(4).

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

"Spouse" means an individual who is treated as a spouse for federal tax purposes. Notwithstanding the foregoing, for purposes of the DCAP Component the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"Student" means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual: (a) is an Employee; (b) is working 20 or more hours per week; and (c) has been employed by the Employer for 0 consecutive calendar days, counting his or her Employment Commencement Date as the first such day. Eligibility for Premium Payment Benefits may also be subject to the additional requirements, if any, specified in the Medical Insurance Plan. To participate in the HSA Component, the individual must be an HSA-Eligible Individual and shall also be subject to the additional requirements, if any, specified in the High Deductible Health Plan. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective date of hire, or for any subsequent Plan Year, in accordance with the procedures described in Article IV.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

• the termination of this Plan; or

• the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Insurance Benefits and Section 7.8 for Health FSA Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 8.8 for DCAP Benefits. Distributions from a Participant's HSA (whether before or after termination of employment) and all other matters relating to a Participant's HSA are outside of this Plan and are to be handled by the Participant and his or her trustee/custodian in accordance with the agreement between them—see Article IX.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination.

3.4 FMLA Leaves of Absence

Under FMLA, the provisions of this section shall not be available to Eligible Employees for such Plan Years in which the Employer has 50 or fewer Employees. For Plan Years in which the Employer has more than 50 Employees, the Employer must make FMLA leave available to Eligible Employees for up to 12 weeks in connection with the birth or adoption of a child, or to care for a close relative, or because of a serious health condition of the Employee.

(a) *Health Benefits*. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Insurance Benefits, HSA Benefits, and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions. The Participant shall also be eligible to participate in an Employer's open enrollment, if any, while on leave.

An Employer may require participants to continue all Insurance Benefits and Health FSA Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (for instance, on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Insurance Benefits and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

• with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

• with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

• under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up"

amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Insurance Benefits and Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Insurance Benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Insurance Benefits or Health FSA Benefits, as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Insurance Benefits or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon

by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules detailed in Article IV will apply.

Notwithstanding any provision to the contrary in this Plan, the Participant shall also be eligible to participate in an employer's open enrollment, if any, while on leave.

ARTICLE IV. Method and Timing of Elections; Irrevocability of Elections

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in Article IV.

Benefits shall be subject to the additional requirements, if any, specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in Article IV.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described in Article IV.

For the Premium Only Plan only, if an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Medical Insurance Benefits and has made an effective

election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described in Article IV), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article IV), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

Unless otherwise noted in this section, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding: participation in this Plan;

• Salary Reduction amounts; or

• election of particular Benefit Package Options(including the various Health FSA Options).

Notwithstanding the foregoing, an election to make a Contribution to an HSA can be changed at any time on a prospective basis.

4.5 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election.* Except for new elections made pursuant to a loss in coverage under Medicaid or a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act, a Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.6 or 4.7, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.7(d) through 4.7(i), within 30 days after the events described in such Sections).

A Participant who experiences a loss in coverage under Medicaid or a state children's health insurance program (SCHIP) may make a new election within 60 days of the occurrence.

Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 4.5 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.7(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components see Section 7.4 and Section 8.4 respectively.

4.6 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 4.7, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee

switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

4.7 Other Events Permitting Exception to Irrevocability Rule for Other Benefits (Except as Otherwise Indicated) Other than HSA Benefits

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

(a) *Open Enrollment Period (Applies to Premium Payment, Health FSA, and DCAP Benefits)* A Participant may change an election during the Open Enrollment Period.

(b) *Termination of Employment (Applies to Premium Payment, Health FSA, and DCAP Benefits)* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.2 and 3.3, as applicable.

(c*) Leaves of Absence (Applies to Premium Payment, Health FSA, and DCAP Benefits)* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) *Change in Status (Applies to Premium Payment, Health FSA as Limited Below, and DCAP Benefits as Limited Below)* A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.6), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may be made to reduce Health FSA coverage during a Period of Coverage or to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it

would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for: (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(3) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if: (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

(e) *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, but Not to Health FSA or DCAP Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by

HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

• a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

• a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of this Section 4.7(e), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) *Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits).* If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid (Applies to Premium Payment and Health FSA Benefits as limited below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

(h) *Change in Cost (Applies to Premium Payment Benefits, DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* For purposes of this Section 4.7(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical

Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions (Sections 4.7 (h)(1) through 4.7(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(d)(2)(A) through (G), incorporating the rules of Code §§ 152(f)(1) and 152(f)(4).

(i) *Change in Coverage (Applies to Premium Payment and DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* The definition of "similar coverage" under Section 4.7(h) applies also to this Section 4.7(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's

Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 4.7(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

• a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

• a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

• any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or

significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(5) *DCAP Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

(6) *Revocation of Medical Coverage Due to Reduction in Hours.* A participant may revoke his or her major medical coverage, along with that of any related individuals, if the Participant experiences a reduction of hours such that he or she will be reasonably expected to work fewer than 30 hours a week on a regular basis and the Participant intends to enroll, along with any

such related individuals, in another medical plan no later than the first day of the second full month following the revocation.

(7) *Revocation of Medical Coverage for Purposes of Enrolling in Marketplace Coverage.* A participant may revoke his or her major medical coverage if he or she is seeking to enroll, along with that of any related individuals who cease coverage due to such revocation, in Marketplace coverage (either during the Marketplace's annual open enrollment period or during a special enrollment period) immediately after the revoked coverage ends.
A Participant entitled to change an election as described in this Section 4.7 must do so in accordance with the procedures described in Section 4.5.

4.8 Election Modifications for HSA Benefits May Be Changed Prospectively at Any Time

As set forth in Section 9.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed. No Benefit Package Option election changes can occur as a result of a change in HSA election except as otherwise described in this Article IX. For example, a Participant generally would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described in Section 4.7 for Health FSAs otherwise applied (such as for change in status).

A Participant entitled to change an election as described in this Section 4.7 must do so in accordance with the procedures described in Section 4.5.

4.9 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions (including Salary Reductions for HSA Benefits) for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

- Premium Payment Benefits, as described in Article VI;
- Health FSA Benefits, as described in Article VII. The Health FSA election may be for:
    - General-Purpose Health FSA Option;
    - Limited (Vision/Dental/Preventive Care) Health FSA Option
- HSA Benefits as described in Article IX;
- DCAP Benefits, as described in Article VIII .

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. In addition, a Participant who has an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA Account is $0 as of the last day of that Plan Year. For this purpose, a Participant's Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

In no event shall Benefits under the Plan be provided in the form of deferred compensation. Notwithstanding the foregoing, amounts remaining in a Participant's Health FSA and DCAP Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year as provided in Article VII. In addition, a Participant's Salary Reductions during a Plan Year under the Premium Payment Component may be applied by the Employer to pay the Participant's share of the Contributions for Insurance Benefits that are provided to the Participant during the Grace Period immediately following the close of that Plan Year.

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* For Participants who elect Insurance Benefits described in Article VI, the Employer will contribute a portion of the Contributions as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement.

The Employer may, but is not required to allocate Nonelective Contributions to one or more Reimbursement Accounts and to the extent set forth in the SPD or enrollment material, may allow a Participant to allocate his allotted share of Nonelective Contributions among the various Reimbursement Accounts in a manner set forth in the SPD or enrollment material.

(b) *Participant Contributions.* Participants who elect any of the Insurance Benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing an Election Form/Salary Reduction Agreement. Participants who elect Health FSA Benefits, HSA Benefits or DCAP Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, Section 9.2 for HSA Benefits, and Section 8.2 for DCAP Benefits, as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the Health FSA Component, HSA Component or DCAP Component to the extent permitted under Section 4.7, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 4.7, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

(b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits, Health FSA Benefits, HSA Benefits, and the DCAP Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

(d) *After-Tax Contributions for Premium Payment Benefits.* For those Participants who elect to pay their share of the Contributions for any of the Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits, as described in Section 6.2; and (b) as described under Section 7.4(b) for Health FSA Benefits, Section 8.4(b) for DCAP Benefits, and Section 9.2 for HSA Benefits

ARTICLE VI. Premium Payment Component

6.1 Benefits

The only Insurance Benefits that are offered under the Premium Payment Component are benefits under the Health, Vision, Dental, Group Term Life, Disability, Cancer, Accident, Critical Illness, HSA and Other Individual Voluntary Benefits Plan. The Medical Insurance Benefits are for major medical insurance (with PPO options). Notwithstanding any other provision in this Plan, the Medical Insurance Benefits are subject to the terms and conditions of the Medical Insurance Plan, and no changes can be made with respect to such Medical Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Insurance Benefits on a pretax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and to pay for his or her share of the Contributions, if any, for Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Article IV), such election is irrevocable for the duration of the Period of Coverage to which it relates.

At its discretion, the Employer may offer cash in lieu of benefits.

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Medical Insurance Benefits Provided Under the Medical Insurance Plan

Medical Insurance Benefits will be provided by the Medical Insurance Plan, not this Plan. The types and amounts of Medical Insurance Benefits (here, major medical insurance), the requirements for participating in the Medical Insurance Plan, and the other terms and conditions of coverage and benefits of the Medical Insurance Plan are set forth in the Medical Insurance Plan. All claims to receive benefits under the Medical Insurance Plan shall be subject to and governed by the terms and conditions of the Medical Insurance Plan and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical Insurance Plan the day before the qualifying event for the periods prescribed by COBRA.

Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Medical Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Medical Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article IV), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

7.2 Contributions for Cost of Coverage of Health FSA Benefits

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant and any Nonelective Contributions allocated thereto by the Employer, subject to the dollar limits set forth in Section 7.4(b). (For example, if the maximum $2,750.00 annual benefit amount is elected, then the annual Contribution amount is also $2,750.00.)

7.3 Eligible Medical Care Expenses for Health FSA

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.
(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) *Medical Care Expenses.* "Medical Care Expenses" will vary depending on which Health FSA coverage option the Participant has elected.

• General-Purpose Health FSA Option. For purposes of this Option, "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan.

If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this

Article VII.

Orthodontia Expenses. Orthodontia expenses will be reimbursed “as paid only”. See below example.

Example: As paid only (i.e., in advance of services rendered, regardless of amount)
Rachel participates in a calendar-year health FSA in 2015, 2016, and 2017. In October 2015, she signs an agreement with an orthodontist to work on her son Ethan's teeth. During the first visit (November), Ethan is X-rayed and fitted for braces. During the second visit (December), the braces are installed. During 15 more monthly visits, the braces will be adjusted. Eventually (in 18 months, if everything goes as planned), the braces will be removed. For these services, the orthodontist charges $5,000. Rachel is required to pay a $2000 down payment and $200 for each month thereafter. She decides to pay the entire $5000 during the first visit to avoid any interest being charged. The entire $5000 will be reimbursable from her 2015 Health FSA.

PLEASE NOTE: “Down” payments for orthodontia are immediately reimbursable.

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. In addition, a Participant who has an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant’s Health FSA Account is $0 as of the last day of that Plan Year. For this purpose, a Participant’s Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

7.4 Maximum and Minimum Benefits for Health FSA

(a*) Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant’s Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8 . Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses

incurred during the Period of Coverage for which the Participant's election is effective , provided that the other requirements of this Article VII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $2,750.00, subject to the terms of Section 7.5(c). The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $0.00. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

Changes Made by Employer and/or Mandated by the Patient Protection and Affordable Care Act (PPACA). For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. Furthermore, in accordance with PPACA mandates, effective January 1, 2018, and notwithstanding anything else in this document to the contrary, at no time shall any Participant be able to salary-reduce more than $2,650 for the 2018 calendar year with regard to the Health FSA. Beginning January 1, 2019, at no time shall any Participant be able to salary-reduce more than $2,700 for any calendar year, subject only to any increases to such limit declared by the Internal Revenue Service in future years. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article IV (other than under Section 4.7(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to

the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 4.7(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose.

The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) *Crediting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period .

(c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage (or during the Grace Period, if applicable); it is not based on the amount credited to the Health FSA Account at a particular point in time . Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Unused Funds

(a) *Rollover of Unused Funds.*

If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage (including any reimbursements made during a run-out period), then any such balance up to $550.00 shall be carried over to reimburse the Participant for Medical Care Expenses incurred during the subsequent Plan Year, provided that the Participant has not exercised his or her right to waive any right to any such carryover and provided that the Employer does not require an election for the subsequent Plan Year. Notwithstanding the foregoing, the Participant shall forfeit all rights with respect to any such balance above $550.00.

(b) Use *of Forfeitures.*

All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for Health FSA

(a) *Timing.*

Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.*

A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 3 month(s) following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who

ceases to be eligible to participate, this must be done no later than 3 month(s) after the date that eligibility ceases, as described in Section 7.8) setting forth:

• the person(s) on whose behalf Medical Care Expenses have been incurred;

• the nature and date of the Expenses so incurred;

• the amount of the requested reimbursement;

• a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and

• other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XIII.

(d) *Claims Ordering; No Reprocessing.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the

Participant ceases to be eligible (provided that the Participant (or the Participant's estate) files a claim within 3 month(s) after the date that the Participant ceases to be a Participant. Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA.

Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5(a) and Section 7.5(b) without regard to Section 7.5(c), they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

7.9 RESERVED

7.10 Coordination of Benefits With HSA, HRA, etc.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, the Participant may choose to seek reimbursement from either the Health FSA or the HSA, but not both.

A general-purpose health FSA constitutes family coverage because it is available to pay or reimburse the qualified medical expenses of the employee and the employee's spouse and dependents. Consequently, if either spouse participates in a general-purpose health FSA, neither spouse will be eligible to contribute to an HSA either through the spouse's employer or individually through a bank. Likewise, the fact that an adult child's qualified medical expenses could be reimbursed by a parent's general-purpose health FSA (i.e., because the child is under age 27 as of the end of the taxable year) will prevent the adult child from being HSA-eligible.

If the Employer ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the Participant will need to refer to the HRA Summary Plan Description for ordering rules.

7.11 Coordination of Benefits With HSA, HRA, etc.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, the Participant may choose to seek reimbursement from either the health FSA or the HSA, but not both.
A general-purpose health FSA constitutes family coverage because it is available to pay or reimburse the qualified medical expenses of the employee and the employee's spouse and dependents. Consequently, if either spouse participates in a general-purpose health FSA, neither spouse will be eligible to contribute to an HSA either through the spouse's employer or individually through a bank, unless the HSA contribution is limited to self-only coverage .
Likewise, the fact that an adult child's qualified medical expenses could be reimbursed by a parent's general-purpose health FSA (i.e., because the child is under age 27 as of the end of the taxable year) will prevent the adult child from being HSA-eligible.

If the Employer ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the Participant will need to refer to the HRA Summary Plan Description for ordering rules.

ARTICLE VIII. DCAP Component

8.1 DCAP Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article IV), such election of DCAP Benefits is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 8.4(b). (For example, if the maximum $5,000.00 annual benefit amount is elected, then the annual Contribution amount is also $5,000.00.)

8.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force. In addition, certain individuals may receive reimbursement for Dependent Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in their DCAP Accounts for that Plan Year in accordance with Section 8.4(f).

(a) *Incurred.*

A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) Dependent Care Expenses.

"Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services—provided, however, that this term shall not include any expenses for

which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

(c) *Qualifying Individual.*

"Qualifying Individual" means:

• a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1);

• a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

• a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

(d) *Qualifying Dependent Care Services.*

"Qualifying Dependent Care Services" means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed—

• in the Participant's home; or

• outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household.

In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(e) *Exclusion.*

Dependent Care Expenses do not include amounts paid to:

• an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;

• a Participant's Spouse;

• a Participant's child (as defined in Code § 152(f)(1)) who is under l9 years of age at the end of the year in which the expenses were incurred; or

• a parent of a Participant's under age 13 qualifying child (as defined in Code § 152(a)(1)).

8.4 Maximum and Minimum Benefits for DCAP

(a) *Maximum Reimbursement Available.*

The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 8.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements).) Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) Maximum and Minimum Dollar Limits.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $0.00. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000.00 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

• the Participant's Earned Income for the calendar year;

• the Earned Income of the Participant's Spouse for the calendar year (note: a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense; and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or

• either $5,000.00 or $2,500 for the calendar year, as applicable:

(1) $5,000.00 for the calendar year if one of the following applies:

- the Participant is married and files a joint federal income tax return;

- the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or

- the Participant is single or is the head of the household for federal income tax purposes; or

(2) $2,500 for the calendar year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $0.00.

Changes; No Proration.

For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(c) Effect on Maximum Benefits If Election Change Permitted.

Any change in an election under Article IV affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 8.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

(f) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 8.4(b), an individual may be reimbursed for Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her DCAP Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year DCAP Amounts") if he or she is a Participant with DCAP coverage that is in effect on the last day of that Plan Year.

• Prior Plan Year DCAP Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year DCAP Amounts may not be used to reimburse Medical Care Expenses.

• Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 8.7 will be reimbursed first from any available Prior Plan Year Health DCAP Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the DCAP is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Dependent Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year DCAP Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year DCAP Amounts will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such Prior Plan Year DCAP Amounts.

• Claims for reimbursement of Dependent Care Expenses incurred during a Grace Period must be submitted no later than 3 month(s) following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year DCAP Amounts.

Any Prior Plan Year DCAP Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 8.6(b).

8.5 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) *Crediting of Accounts*.

A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts*.

A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) *Available Amount Is Based on Credited Amount.*

As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

8.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year.

The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable

regulations. In addition, any DCAP Account benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

8.7 Reimbursement Claims Procedure for DCAP

(a) *Timing.*

Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.*

A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 3 month(s) following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 3 month(s) after the date that eligibility ceases, as described in Section 9.8), setting forth:

• the person(s) on whose behalf Dependent Care Expenses have been incurred;

• the nature and date of the Expenses so incurred;

• the amount of the requested reimbursement;

• the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);

• a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;

• the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 8.4(b); and

• other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

(c) *Claims Denied.*

For reimbursement claims that are denied, see the appeals procedure in Article XIII.

8.8 Reimbursements From DCAP After Termination of Participation

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in Section 8.4(f) (regarding certain individuals who may be reimbursed from Prior Plan Year DCAP Amounts for expenses incurred during a Grace Period), the Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled as provided in Section 7.4(f)), provided that the Participant (or the Participant's estate) files a claim within 3 month(s) after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible.

8.9 Report to DCAP Participants

On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement (such as Form W-2) showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the DCAP Component, as the Plan Administrator deems appropriate.

ARTICLE IX. HSA Component

9.1 HSA Benefits

An Eligible Employee can elect to participate in the HSA Component by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA Benefits offered under this Plan). As described in Article IV, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. Participants will not be HSA eligible until the first of the month following the end of the Health FSA Plan Year. In addition, a Participant who is entitled to a grace period under their Health FSA (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) with a year-end balance is ineligible for HSA contributions until the first calendar month following the grace period end date.

9.2 Contributions for Cost of Coverage for HSA; Maximum Limits

The annual Contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant. 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 option (i.e., single or family) for the calendar year in which the Contribution is made. (Note: $3,500 for single and $7,000 for family are the statutory maximum contribution limits for 2019; $3,550 for single and $7,100 for family are the statutory maximum contribution limits for 2020; $3,600 for single and $7,200 for family are the statutory maximum contribution limits for 2021.)

An additional catch-up Contribution may be made for Participants who are age 55 or older.

In addition, the maximum annual contribution shall be: (a) reduced by any matching (or other) Employer contribution made on your behalf (there are currently no such Employer contributions (other than pre-tax Salary Reductions) made under the Plan); and (b) pro-rated for the number of months in which you are an HSA-Eligible Individual.

9.3 RESERVED

9.4 Recording Contributions for HSA

As described in Section 9.6, the HSA is not an employer-sponsored employee benefit plan—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by the Participant, not by the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax Salary Reductions—such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in a HSA.

9.5 Tax Treatment of HSA Contributions and Distributions

The tax treatment of the HSA (including contributions and distributions) is governed by Code § 223.

9.6 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan

HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

ARTICLE X. HIPAA PROVISIONS FOR HEALTH FSA

10.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article X:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer shall have access to PHI from the Health FSA only as permitted under this Article X or as otherwise required or permitted by HIPAA.

10.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

10.3 Permitted Uses and Disclosure of Summary Health Information

The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

10.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 10.5 and obtaining written certification pursuant to Section 10.7, the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

10.5 Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer shall:

• not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

• ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

• not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

• report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

• make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;

• make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

• make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

• make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA's privacy requirements;

• if feasible, return or destroy all PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such information 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 the information infeasible; and

• ensure that the adequate separation between the Health FSA and the Employer (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health FSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

10.6 Adequate Separation Between Plan and Employer

The Employer shall allow the following persons access to PHI: the Vice President of Human Resources; the Benefits Manager; assistants to the Vice President of Human Resources and the Benefits Manager; Human Resources and payroll staff performing Health FSA functions; the Benefits Committee; the Plan Administrator; and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section 10.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

10.7 Certification of Plan Sponsor

The Health FSA shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.5.

ARTICLES XI and XII. RESERVED

ARTICLE XIII. Appeals Procedure

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. The Committee acts on behalf of the Plan Administrator with respect to appeals.

13.2 Claims Procedures for Medical Insurance Benefits

Claims and reimbursement for Medical Insurance Benefits shall be administered in accordance with the claims procedures for the Medical Insurance Benefits, as set forth in the plan documents and/or summary plan description for the Medical Insurance Plan.

ARTICLE XIV. Recordkeeping and Administration

14.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and 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 discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

14.4 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. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

14.5 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.

14.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

14.7 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) 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 be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

14.8 Inability to Locate Payee

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

14.9 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV. General Provisions

15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 8.6 with respect to DCAP Benefits, and then by the Employer. For HSA Benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's' HSA trustee/custodian.

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of Mississippi, to the extent not superseded by the Codeor any other federal law.

15.5 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code , the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

15.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

15.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.11 Severability

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

* * *

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Pearl River Community College Cafeteria Plan, Pearl River Community College has caused this Plan to be executed in its name and on its behalf, on this _____ day of _____, 20___.

Pearl River Community College

By: _____
Its President

Witness
Signature:_____