CONVEX

FLEXIBLE BENEFITS PLAN

PLAN DOCUMENT

EFFECTIVE DATE: JUL 01, 2022

ADOPTION AGREEMENT

SPONSOR INFORMATION	
Sponsor Name	CONVEX
Sponsor Address	444 De Haro Street, Suite 218, San Francisco, CA 94107
Sponsor Phone Number	6502235948
Sponsor EIN	86-3197984
Sponsor's State of Headquarters	CA

PLAN INFORMATION	
Effective Date	Jul 01, 2022
Plan Year	Jul 01, 2022 — Jun 30, 2023
Available Benefits:	
• Health Flexible Spending Account	Yes
• Dependent Care Flexible Spending Account	Yes
• Health Savings Account	No

HEALTH FLEXIBLE SPENDING ACCOUNT	
Plan Name	CONVEXHealth Flexible Spending Account Plan
Plan Number	501
Type of Plan	Medical Expense Reimbursement Plan
Named Fiduciary	CONVEX
Plan Administrator	CONVEX
Type of Administration	Third-Party
Agent for Service of Legal Process	Service of process may be made upon the Plan Administrator.
Funding Medium	Employer general assets only.
For the eligible classes of Employees, what are the eligibility rules?	An Employee is eligible if he or she is a US-based Employee and is regularly scheduled to work at least 30 hours per week for the Employer (as determined by the Employer)
What is the maximum employee contribution? (NOTE: Cannot exceed the amount permitted by law, less any employer contributions.)	$2,850
Is there a Carryover?	No
What is maximum Carryover? (NOTE: Cannot exceed the amount permitted by law.)	$570
Is there a 2.5-month Grace Period?	Yes
Claims Administrator Name	Alegeus
Claims Administrator Address	1601 Trapelo Rd, Waltham, MA 02451, USA
Claims Administrator Telephone	888-852-6334
Will the Employer make contributions?	No
Which Participants are eligible for the Employer Contributions?	N/A
What is the amount of the contribution for a Participant enrolled as of the first day of the Plan Year?	N/A
Is the employer contribution pro-rated for an individual who begins participating mid-year?	N/A

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT INFORMATION	
For the eligible classes of Employees, what are the eligibility rules?	An Employee is eligible if he or she is a US-based Employee and is regularly scheduled to work at least 30 hours per week for the Employer (as determined by the Employer)
Is there a 2.5-month Grace Period?	Yes
Claims Administrator Name	Alegeus
Claims Administrator Address	1601 Trapelo Rd, Waltham, MA 02451, USA
Claims Administrator Telephone	888-852-6334
Will the Employer make contributions?	No
Which Participants are eligible for the Employer contributions?	N/A
What is the timing of the Employer contributions?	N/A
What is the amount of the Employer contribution?	N/A

HEALTH SAVINGS ACCOUNT INFORMATION	
Will the Employer make contributions?	N/A
Which Participants are eligible for the Employer contributions?	N/A
What is the timing of the Employer contributions?	N/A
What is the amount of the Employer contribution for a Participant enrolled as of the first day of the Plan Year?	N/A
Is the Employer contribution pro-rated for an individual who begins participating mid-year?	N/A

AUTHORIZED SIGNATURE

I, the undersigned, am authorized by the Sponsor (identified above) to sign this Adoption Agreement and Plan Document on the Sponsor's behalf.

1. I acknowledge that I have consulted with appropriate advisors concerning the completion of this Adoption Agreement and the legal and tax implications of adopting this Plan.
2. I understand that I should review the Plan Document (including the Adoption Agreement) carefully, because I have final responsibility for ensuring that the legal and operational requirements for the Plan are met.
3. I understand that my failure to properly complete this Adoption Agreement may result in the Plan being ineffective or disqualified.
4. On behalf of the Sponsor, the Plan (including the Adoption Agreement) is hereby adopted, effective as of the effective date set forth above.

CONVEX

Signature: 

Print Name: Myoung Kang

Print Title: Interim CFO

Date: 05/18/2022

CONVEX

FLEXIBLE BENEFITS PLAN

INTRODUCTION

CONVEX (the “Sponsor”) has adopted the CONVEX Flexible Benefits Plan (the “Plan”) in order to permit Participants to choose between receiving taxable wages or making nontaxable contributions toward certain Benefits made available by an Employer.

This Plan is hereby amended and restated as provided herein, effective as of the effective date specified in the Adoption Agreement. The Plan is maintained for the exclusive benefit of Eligible Employees. Each Employer intends that the Plan terms be legally enforceable.

This Plan is intended to be a “cafeteria plan” within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted accordingly. If the Adoption Agreement indicates that the Health Flexible Spending Account is an available benefit, then this document shall serve as the plan document and summary plan description for the Health Flexible Spending Account.

ARTICLE I
DEFINITIONS

Administrator means the Sponsor, unless another person or entity has been designated by the Sponsor in the Adoption Agreement to administer the Plan on its behalf. If the Sponsor is the Administrator, the Sponsor may appoint any person, including but not limited to Employees, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with Sponsor. Upon the resignation or removal of any individual performing the duties of the Administrator, the Sponsor may designate a successor.

Adoption Agreement means the Adoption Agreement signed by the Sponsor in conjunction with this Plan.

Affiliate means an entity that: (i) with respect to the Sponsor, is in the same “controlled group” (as defined by Code Section 414(b)), is under “common control” (as defined by Code Section 414(c)), or is in the same "affiliated service group" (as defined by Code Section 414(b)); (ii) Plan Sponsor allows to participate in the Plan; and (iii) chooses to participate in the Plan.

Benefit means a benefit under this Plan, as specified in the Adoption Agreement and the corresponding Article(s).

Carryover means any amounts remaining in a Health Flexible Spending Account at the end of the Plan Year, but not exceeding $570.

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

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

Compensation means the amounts received by the Participant from the Employer during a Plan Year.

Coverage Period means the Plan Year and any corresponding Grace Period. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

Dependent means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). In addition, for purposes of the Health Flexible Spending Account Benefit, Dependent includes: (i) a Participant's child (as defined by Code Section 152), if the child is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609; and (ii) a Participant's child (as defined by Code Section 152) shall be considered a Dependent if the child has not reached the limiting age of 27 as of the last day of the calendar year, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person.

Eligible Employee means any Employee who meets the eligibility requirements set forth in Section 2.1.

Employee means any person reported on the payroll records of the Employer as a common law employee of the Employer. It is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not Employees and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors. Notwithstanding the foregoing, Employee shall not include (i) any employee of the Employer who is a member of a collective bargaining unit covered under a collective bargaining agreement unless the collective bargaining agreement provides for the Employee's participation in the Plan; (ii) any leased employee as defined under Code Section 414(n); (iii) any person who is not classified by the Employer as a common law employee, notwithstanding the later reclassification by a court or any administrative agency of the person as a common law employee of the Employer; (iv) any person classified by the Employer as a temporary employee; or (v) any nonresident alien with no U.S. source income. Notwithstanding the foregoing, for purposes of Article VIII, Employee means any person who is both reported on the payroll records of the Employer as a common law employee of the Employer and enrolled in a High Deductible Health Plan sponsored by the Employer.

Employer means the Sponsor and each Affiliate, individually.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

FMLA means the Family Medical Leave Act of 1993, as amended

Grace Period means the period of two and one-half (2.5) months following the end of a Plan Year, if the Grace Period is elected in the Adoption Agreement.

High Deductible Health Plan means an arrangement that qualifies as a high deductible health plan under Code Section 223.

Key Employee means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

Participant means an Eligible Employee, who has elected to participate in the Plan (or is deemed to have so elected) as provided under Article II, and whose participation has not ceased as provided therein.

Plan means this CONVEX Flexible Benefits Plan, including the Adoption Agreement and all authorized amendments.

Plan Year means the twelve (12) month period specified in the Adoption Agreement.

Salary Reduction Amount means the amount withheld from the Participant's Compensation, on a pretax

basis, pursuant to the Participant's Election.

Sponsor means CONVEX

Spouse means an individual who is legally married to a Participant and who is treated as a spouse under the Code.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

PARTICIPATION

2.1 **Eligibility**

(a) ***Generally.*** An Employee is eligible for a given Benefit if the Employee meets the eligibility criteria set forth on the Adoption Agreement for that Benefit, subject to any additional eligibility requirements set forth herein. Any Eligible Employee shall be eligible to participate hereunder as of his date of employment (or the Effective Date of the Plan, if later). However, any Eligible Employee who was a Participant in the Plan on the effective date of this restatement shall continue to be eligible to participate in the Plan.

(b) ***Additional Rules for Health Flexible Spending Accounts.*** An Employee who is enrolled in the Health Savings Account benefit shall not be eligible for the General Purpose Health Flexible Spending Account benefit. A Participant cannot participate in both the General Purpose Health Flexible Spending Account benefit and the Limited Purpose Health Flexible Spending Account benefit for the same period of time. Individuals shall also be eligible for the Health Flexible Spending Account to the extent required by COBRA.

(c) ***Additional Rule for Dependent Care Flexible Spending Account.*** If a Participant in the Dependent Care Flexible Spending Account takes a leave of absence, the Participant' shall cease to be eligible for the Dependent Care Flexible Spending Account after 14 consecutive days of leave.

(d) ***Additional Rule for Health Savings Account.*** An Employee shall not be eligible for the Health Savings Account benefit unless the Employee is enrolled in a High Deductible Health Plan sponsored by the Employer.

2.2 **Commencement of Participation.** An Eligible Employee shall not become a Participant until he (i) timely completes an Election with respect to a Health Flexible Spending Account or Dependent Care Flexible Spending Account, (ii) timely completes an Election with respect to a Health Savings Account, or (iii) if the Employer has elected to make Employer Contributions to Health Savings Accounts and the Employee is eligible for such contributions, begins coverage in a High Deductible Health Plan sponsored by the Employer. The Administrator shall determine the effective date of participation.

2.3 **Termination of Participation.**Each Participant shall remain a Participant until the earlier of: (a) the date the Participant is no longer eligible for any Benefit, except where continued participation is required by COBRA, (b) the date on which the Participant ceases to be employed by an Employer, except where continued participation is required by COBRA, (c) the date on which the Employer stops participating in this Plan, as described in Section 2.4, or (d) the date on which this Plan is terminated.

2.4 **Effect of Employer Ceasing Participation.** An Employer that is an Affiliate shall have the right to stop participating in the Plan. When an Employer stops participating in this Plan, all Employees of such

Employer shall immediately stop being Participants.

ARTICLE III
CONTRIBUTIONS AND ALLOCATIONS

3.1 **Generally.** Benefits under the Plan shall be financed by Salary Reduction Amounts, by Employer Contributions, or by both, as specified in the Adoption Agreement. As soon as reasonably practical after each payroll period, the Employer shall allocate the appropriate Salary Reduction Amounts and Employer Contributions to the appropriate account(s) on behalf of the Participant.

3.2 **Periodic Contributions.** Notwithstanding the requirement that Salary Reduction Amounts be contributed to the Plan by the Employer on behalf of an Employee on a reasonably level basis for each payroll period, the Administrator may implement a procedure in which Salary Reduction Amounts are contributed throughout the Plan Year on a periodic basis that is not level. However, with regard to the Health Flexible Spending Account, the contribution schedule may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV
BENEFITS

4.1 **Benefit Options.** The Adoption Agreement specifies which of the following Benefits are available under this Plan. Unless specified in the Adoption Agreement, the Benefit is not available and all references to that benefit in this Plan are ineffective. All Benefits are subject to the eligibility, enrollment, and participation requirements and other terms and conditions described herein.

(a) ***Health Flexible Spending Account.*** An Eligible Employee may elect to participate in the Health Flexible Spending Account Benefit described herein.

(b) ***Dependent Care Flexible Spending Account.*** An Eligible Employee may elect to participate in the Dependent Care Flexible Spending Account Benefits described herein.

(c) ***Health Savings Account.*** An Eligible Employee who is enrolled in a High Deductible Health Plan sponsored by the Employer shall automatically be treated as a Participant in the Health Savings Account Benefit as described herein.

4.2 **Nondiscrimination Requirements**

(a) ***Intent to be nondiscriminatory.*** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) ***25% concentration test.*** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) ***Adjustment to avoid test failure.*** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce

contributions or nontaxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 **Generally**

(a) ***Definition of Election.*** An Eligible Employee may elect a Salary Reduction Amount with respect to each of the Benefits for which the Employee is eligible. The election of such Salary Reduction Amount, when reducing compensation on a pretax basis, is considered "Elections" for purposes of this Plan.

(b) ***Election Requirement.*** An Eligible Employee who wishes to contribute Salary Reduction Amounts on a pretax basis to one or more Benefits shall, during the applicable Election Period, complete an Election in a manner set forth by the Administrator. In the event that the Election sets forth an annual Salary Reduction Amount, the Administrator shall ensure that salary reductions are made on a reasonably level basis each payroll period. The maximum Salary Reduction Amount for each benefit shall be the amount established under applicable law; there shall be no minimum Salary Reduction Amount.

(c) ***Elections Irrevocable.*** A Participant's Election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change the Election pursuant to Sections 5.5 through 5.7, as applicable.

5.2 **Initial Elections.** An individual shall have the opportunity to make an initial Election when he or she first becomes an Eligible Employee. These initial Elections shall be made on an election form or through an election process provided by the Administrator, within the time period specified by the Administrator. The Administrator shall establish the effective date for initial Elections. Notwithstanding the foregoing, an Eligible Employee's initial Election shall be effective retroactively to the Employee's start date so long as the initial Election is made within 30 days from the Employee's start date; otherwise, the initial Election will be effective prospectively only.

5.3 **Annual Elections.** Before the beginning of each Plan Year, Eligible Employees and Participants shall have the opportunity to change their Elections, such change to be effective on the first day of the next Plan Year. Such changes shall be made on an election form or through an election process provided by the Administrator, within the time period specified by the Administrator.

5.4 **Election Upon Reemployment.** If an Eligible Employee or Participant is terminated and reemployed, and if the period between termination and reemployment is less than 31 days, then the individual will not be permitted, upon reinstatement, to make a new Election. If the period between termination and reemployment is 31 days or more, then the individual will be permitted to make a new Election.

5.5 **Failure to Elect.**

(a) ***Flexible Spending Accounts.*** An Eligible Employee or Participant who fails to complete an Election by the end of the applicable Election Period shall be deemed to have elected not to participate in the Health Flexible Spending Account or Dependent Care Flexible Spending Account for the remainder of the Plan Year or for the upcoming Plan Year, as applicable. The deemed election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change the Election pursuant to Section 5.5 and 5.6, as applicable.

(b) ***Health Savings Account.*** If an Eligible Employee or Participant who is enrolled in a High Deductible Health Plan sponsored by the Employer fails to complete an Election by the end of the applicable Election Period, the Eligible Employee or Participant shall be deemed to have elected not to contribute Salary Reduction Amounts to the Health Savings Account for the remainder of the Plan Year or for the upcoming Plan Year, as applicable. The deemed election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change the election pursuant to Section 5.7.

5.6 **Change of Elections for Health Flexible Spending Accounts and Dependent Care Flexible Spending Accounts.** An Election change shall be effective prospectively only, except to the extent permitted by the Code. Subject to the previous sentence and applicable law, the Administrator shall establish the effective date of the Election change.

(a) ***Cost Changes.*** If the Participant's cost for Dependent Care increases or decreases during the Plan Year, and if the cost change is imposed by a Dependent Care provider who is not a relative of the Participant or Eligible Employee, then the Participant or Eligible Employee may make a corresponding change in his Election. No election change shall be permitted under this paragraph unless the Participant or Eligible Employee provides written notice to the Administrator of within 30 days of the significant cost increase or decrease.

(b) ***Change in Coverage under Another Employer Plan.*** A Participant may make a prospective change in his Election, if the change is on account of and corresponds with a change made under another employer's plan or another Employer plan, and if:

(i) The other plan permits participants to make an election change that would be permitted under Treas. Reg. Sections 1.125-4(b)-(g) (disregarding Section 1.125-4(f)(4)); or

(ii) This Plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the other plan.

No election change shall be permitted under this paragraph unless the Participant or Eligible Employee provides notice to the Administrator within 30 days of the change under the other plan.

(c) ***Change in Status.*** If a change in status occurs, and if a Participant or Eligible Employee changes his Benefit Plan enrollment due to that change in status, then the Participant may make a corresponding change in his Election. No election change shall be permitted under this paragraph unless the Participant or Eligible Employee provides notice to the Administrator within 30 days of the change in status. For purposes of this subsection, "change in status" means:

(i) Events that change the Participant's legal marital status, including the following: marriage; death of the Participant's Spouse; divorce; legal separation; and annulment;

(ii) Events that change the Participant's number of Dependents, including the following: birth; death; adoption; and placement for adoption;

(iii) Events that change the employment status of the Participant or of his Spouse or of his Dependents, including the following: the reduction or increase in hours of employment (including a switch between part-time and full-time); the termination or commencement of employment; a strike or lockout; a commencement of, or return from an unpaid leave of absence; a change in worksite; or a switch between salaried and hourly-paid;

(iv) An event that causes the Participant's Dependent to satisfy or cease to satisfy eligibility requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(v) A change in the place of residence or work of the Participant or his Spouse or Dependent.

(d) ***Special Enrollment Rights.***

(i) If a Participant or Eligible Employee changes his enrollment in an employer-sponsored group health plan due to the exercise of a special enrollment right provided in Section 9801(f) of the Code, then the Participant or Eligible Employee may make a corresponding change in his Election. No election change shall be permitted under this paragraph unless the Participant or Eligible Employee provides notice to the Administrator within 30 days of the event giving rise to the special enrollment right.

(ii) If a Participant or Eligible Employee changes his enrollment in an employer-sponsored group health plan due to an Eligible Employee, Spouse or Dependent, becoming eligible for premium assistance under Medicaid or the Children's Health Insurance Program ("CHIP") or losing eligibility for coverage under Medicaid or CHIP, then the Participant or Eligible Employee may make a corresponding change in his Election. No election change shall be permitted under this paragraph unless the Participant or Eligible Employee provides notice to the Administrator within 60 days of gaining or losing such eligibility.

(e) ***Qualified Medical Child Support Orders and Other Orders*** If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (which may or may not constitute a qualified medical child support order that meets the requirements of Section 609(a)(2)(A) of ERISA) requires health coverage for a Participant's or Eligible Employee's child, then the Participant or Eligible Employee may make a corresponding change in his Election. If a judgment, decree or order (which may or may not constitute a qualified medical child support order that meets the requirements of Section 609(a)(2)(A) of ERISA) requires the Participant's former Spouse to provide health coverage for the Participant's child, and if such coverage is in fact provided by the former Spouse, then the Participant may make a corresponding change in his Election.

(f) ***Entitlement to Medicare or Medicaid.*** If a Participant or Eligible Employee changes his enrollment in an employer-sponsored group health plan due to the Participant or Eligible Employee, Spouse, or Dependent gaining or losing entitlement to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare), or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), then the Participant or Eligible Employee may make a corresponding change in his Election. No election change shall be permitted under this paragraph unless the Participant or Eligible Employee provides notice to the Administrator within 31 days of gaining or losing such entitlement to coverage.

(g) ***Change in Election Due to COBRA.*** If a Participant, Spouse, or Dependent enrolls in COBRA continuation coverage under the Health Flexible Spending Account, then the Participant may make a corresponding change in his Election. No election change shall be permitted under this paragraph unless the Participant or Eligible Employee provides notice to the Administrator within 30 days of the COBRA enrollment.

5.7 **FMLA**

(a) The provisions of this Section apply only if the Employer is subject to the FMLA.

(b) Any Participant who takes an unpaid leave of absence pursuant to FMLA ("FMLA Leave"), may

revoke his Elections relating to a Health Flexible Spending Account.

(c) If the Participant revokes his Election pursuant to subsection (b) above, and if the Participant returns from the unpaid FMLA Leave without an intervening termination of employment, the Participant shall have the right to reinstate his prior Election.

(d) A Participant who elects to continue coverage in the Health Flexible Spending Account during an unpaid FMLA Leave shall pay the Salary Reduction Amounts for such coverage by one of the following payment methods, which (if offered by the Administrator) must be offered on a nondiscriminatory basis:

(i) Remitting payment to the Employer on a regular basis during the leave period; or

(ii) Repaying the amounts that will become due during the leave period; or

(iii) Having the Employer advance the amounts on behalf of the Participant. However, when the Participant returns from FMLA Leave, he must re-pay the Employer. If this method of payment is offered and elected, it must be agreed upon in advance of the leave of absence by the Participant and the Employer.

Payments made under subparagraph (1) shall be made on an aftertax basis. Payments made under subparagraphs (2) and (3) may be made on either a pretax basis or on an aftertax basis, pursuant to procedures established by the Administrator.

(e) Notwithstanding the foregoing, to the extent an Employer is subject to state or local family and medical leave requirements that are not preempted by Federal law, such requirements shall govern where applicable.

5.8 **Change of Elections for Health Savings Accounts.** A Participant in the Health Savings Account Benefit may make a new Election with respect to Salary Reduction Amounts each pay period, using such procedures as may be established by the Administrator from time to time. An Election change shall be effective prospectively only, except to the extent permitted by the Code. Subject to the previous sentence and applicable law, the Administrator shall establish the effective date of the Election change.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 **Establishment.** This Article is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and with the Treasury regulations thereunder. The Administrator shall establish a Health Flexible Spending Account for each Participant who designates a Salary Reduction Amount in relation to such an account. Such Participants may submit claims for the reimbursement of applicable Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account.

6.2 **Coordination with Plan.** The provisions of this Article shall be coordinated with the Plan to the greatest extent possible. The Plan provisions regarding enrollment, participation, contributions, allocations, elections and the like shall apply to the Health Flexible Spending Account.

6.3 **Definitions.** The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account. In addition, for the purposes of this Article and the Plan, the terms below have the following meaning:

Eligible Medical Expenses means a Medical Expense that is incurred during a Plan Year (or during a corresponding Grace Period).

Health Flexible Spending Account means the account established for Participants pursuant to this Plan to which Salary Reduction Amount may be allocated and from which all allowable Medical Expenses may be reimbursed. Subject to the provisions of this Plan, there are two types of Health Flexible Spending Accounts under this Plan: (i) a "General Purpose Health Flexible Spending Account" may reimburse all "Medical Expenses" as defined below; and (ii) a "Limited Purpose Health Flexible Spending Account" may reimburse only those "Medical Expenses" that constitute vision care or dental care.

Highly Compensated Participant means, for the purposes of this Article and determining discrimination under Code Section 105(h), a Participant who is: (i) one of the 5 highest paid officers; (ii) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or (iii) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

Incurred means the date when the Participant is provided with the medical care that gives rise to the Medical Expense, and not when the Participant is formally billed or charged for, or pays for, the medical care.

Medical Expenses means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. **Medical Expenses** an be incurred by the Participant, his Spouse, or his Dependent. Notwithstanding the foregoing, **Medical Expenses** do not include (and a Participant cannot be reimbursed for): (i) the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin; (ii) the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by a Participant, Spouse, or Dependent; (iii) "qualified long-term care services" as defined in Code Section 7702B(c), or (iv) amounts payable or reimbursable by any other health plan.

6.4 **Eligibility and Participation.**

(a) An Eligible Employee may elect to participate in the Limited Purpose Health Flexible Spending Account benefit or the General Purpose Health Flexible Spending Account Benefit, subject to subsections (b) and (c). Certain Eligible Employees, as described in Section 6.5(e), shall be automatically treated as Participants in the Limited Purpose Heath Flexible Spending Account.

(b) An Eligible Employee shall not be permitted to participate in both the Limited Purpose Health Flexible Spending Account and the General Purpose Health Flexible Spending Account at the same time.

(c) A Participant enrolled in a High Deductible Health Plan sponsored by the Employer shall not be eligible for the General Purpose Health Flexible Spending Account benefit.

6.5 **Contributions and Allocations.**

(a) ***Maximum.*** The maximum Salary Reduction Amount that may be contributed to a Participant's Health Flexible Spending Account for any Plan Year contributed to a Participant's Health Flexible Spending Account for any Plan Year shall be as set forth on the Adoption Agreement. Notwithstanding the foregoing, such amount shall not exceed the difference between the Employer Contributions described in

the next subsection and the maximum contribution permitted by law. For Plan Years beginning in 2021, the maximum contribution permitted by law is $2,750; for Plan Years beginning in 2022 and beyond, this figure shall be adjusted for changes in the cost of living in accordance with Code Section 125(i)(2). The maximum shall be calculated without regard to Carryover amounts, and without regard to any Grace Period.

(b) ***Employer Contributions.*** The Employer shall make the contributions to the Health Flexible Spending Accounts of Participants as specified in the Adoption Agreement.

(c) ***Participant Contributions.*** Participant contributions to Health Flexible Spending Accounts shall be made consistent with the applicable Elections.

(d) ***Participation in Other Plans*** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the maximum amount described in subsection (a). If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Salary Reduction Amount under all of such cafeteria plans shall not exceed the maximum amount described in subsection (a).

(i) An Eligible Employee is entitled to a Carryover into a given Plan Year only if the Eligible Employee was a Participant in the Health Flexible Spending Account on the last day of the preceding Plan Year.

(ii) If an Employee is eligible for the Health Flexible Spending Account for a Plan Year and does not make a Health Flexible Spending Account Election for that Plan Year, but has a Carryover, the Eligible Employee will automatically be treated as a Participant in the Limited Purpose Health Flexible Spending Account for the Plan Year, and any available Carryover will be automatically allocated to that Limited Purpose Health Flexible Spending Account.

(e) ***Carryovers.*** Notwithstanding any other provision of the Plan to the contrary, and only to the extent that the Adoption Agreement provides for a Carryover, unused amounts remaining in a Participant's Health Flexible Spending Account at the end of a Plan Year shall be carried over and used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year, unless the Participant waives the Carryover as described in paragraph 6.5(e)(iv). The amount carried over from the first Plan Year to the second Plan Year shall not exceed 20% of the maximum amount that may be contributed to a health flexible spending account for the first Plan Year under Code Section 125(i). Unused amounts in excess of the Carryover amount specified in the Adoption Agreement shall be forfeited. Carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit under subsection (a) above.

(i) An Eligible Employee is entitled to a Carryover into a given Plan Year only if the Eligible Employee was a Participant in the Health Flexible Spending Account on the last day of the preceding Plan Year.

(ii) If an Employee is eligible for the Health Flexible Spending Account for a Plan Year and does not make a Health Flexible Spending Account Election for that Plan Year, but has a Carryover, the Eligible Employee will automatically be treated as a Participant in the Limited Purpose Health Flexible Spending Account for the Plan Year, and any available Carryover will be automatically allocated to that Limited Purpose Health Flexible Spending Account.

(iii) If a Participant enrolls in a High Deductible Health Plan sponsored by the Employer as of the beginning of a Plan Year, and if the Participant has a Carryover, the Participant will be treated as

automatically enrolled in the Limited Purpose Health Flexible Spending Account for that Plan Year, and any available Carryover will be automatically allocated to that Limited Purpose Health Flexible Spending Account.

(iv) A Participant may elect prior to the beginning of a Plan Year to waive the Carryover from the preceding Plan Year in accordance with procedures established by the Plan Administrator.

6.6 **Nondiscrimination Requirement.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder. If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

6.7 **Expenses and Reimbursements**

(a) ***Reimbursement available throughout Coverage Period.*** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to the total Salary Reduction Amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the Coverage Period, without regard to the Salary Reduction Amounts that have been allocated to the Account at any given point in time.

(b) ***Payee.*** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider.

6.8 **Debit and Credit Cards.** To the extent permitted by the Administrator, and subject a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, Participants may use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) ***Card only for medical expenses.*** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) ***Card issuance.*** Such card shall be issued upon the Participant's Effective Date of Participation and may be reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) ***Maximum dollar amount available.*** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.5(a).

(d) ***Only available for use with certain service providers.*** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) ***Card use.*** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following: (i) co-payments for doctor and other medical care; (ii) purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations; or (iii) purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) ***Substantiation.*** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) ***Correction methods.*** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card: (1) repayment of the improper amount by the Participant; (2) withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law; (3) claims substitution or offset of future claims until the amount is repaid; and (4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

6.9 **Forfeitures.** The amount in the Health Flexible Spending Account as of the end of any Plan Year (or as of the end of any corresponding Grace Period), and after the processing of all claims for such Plan Year (and any corresponding Grace Period) shall be forfeited. In such event, the Participant shall have no further claim to such amount for any reason. The Administrator, in its sole discretion, may use forfeitures: (i) to defray plan administration expenses; (ii) to reduce salary reduction amounts for the following year; (3) to provide a cash refund to employees.

6.10 **Claim and Appeal Procedures.**

(a) ***Filing Initial Claim.*** In order to receive reimbursement from his or her Health Flexible Spending Account, a Participant must submit a written Claim to the Claims Administrator. The Claim must be in the form designated by the Administrator and must include sufficient substantiation. The Claim must be filed no later than 90 days after the end of the Plan Year (or after the end of the corresponding Grace Period).

(b) ***Approval of Initial Claim.*** If a Claim is approved, the Administrator will provide the Participant with written or electronic notice of such approval. The notice will include the amount of benefits to which the Participant is entitled and other pertinent information concerning the benefit.

(c) ***Notice of Denial of Initial Claim.*** If a Claim is denied (in whole or in part), the Administrator will provide the Participant with written or electronic notification of such denial. The notice of denial of the Claim will include: the specific reason that the Claim was denied; a reference to the specific provisions of the Plan on which the denial was based; a description of any additional material or information necessary to perfect the Claim and an explanation of why this material or information is necessary; a description of the appeal procedures and the time limits that apply to such procedures, including a statement of the Participant’s right to bring a civil action under ERISA § 502(a) if the Claim is denied on appeal; if an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the Claim, either (i) the specific rule, guideline, protocol, or other similar criterion, or (ii) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and

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

(d) ***Timing of Claims Decision.*** The notice required by this Section will be provided within 30 days after receipt of the Claim, unless special circumstances require an extension of time for processing the Claim.

(e) ***Filing an Appeal.*** If a Claim is denied (in whole or in part), the Participant may appeal the denial by providing a written notice of appeal to the Administrator within 180 days after the Participant receives the notice of denial of the Claim. At the same time the Participant submits a notice of appeal, the Participant may also submit written comments, documents, records, and other information relating to the Claim. The Participant is entitled to review and receive, free of charge, copies of all documents, records, and other information relevant to the initial Claim (whether a document is relevant will be determined pursuant to 29 C.F.R. § 2560.503-1(m)(8)).

(f) ***General Appeal Procedure.*** The Administrator may hold a hearing or otherwise ascertain such facts as it deems necessary and will render a decision which shall be binding upon both parties. In deciding the appeal: no deference will be given to the decision denying the initial Claim; the appeal will be decided by an individual who did not decide the initial Claim and who is not a subordinate of anyone who decided the initial Claim; the individual deciding the appeal will review and consider all information submitted by the Participant, without regard to whether the information was submitted or considered in conjunction with the initial Claim; if the appeal is based, in whole or in part, on a medical judgment, the individual deciding the appeal will consult with a health care professional who has appropriate training and experience in the relevant field; the health care professional will not be an individual who participated in the denial of the initial Claim and will not be the subordinate of any such individual; and if the Administrator obtained advice from any medical or vocational experts in conjunction with the initial Claim, such experts will be identified to the Participant (this identification must occur even if the Administrator did not rely on the advice obtained).

(g) ***Notice of Decision on Appeal.*** The appeal decision will be provided in written or electronic form to the Participant. If the appeal decision is adverse to the Participant, the written decision will include the following: the specific reason or reasons for the appeal decision; reference to the specific provisions of the Plan on which the appeal decision is based; a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim (whether a document, record, or other information is relevant to a Claim will be determined by reference to 29 C.F.R. § 2560.5031(m)(8)); a statement describing any voluntary appeal procedures and the Participant's right to obtain the information about such procedures; a statement of the Participant's right to bring an action under ERISA § 502(a); if an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the Claim, either (A) the specific rule, guideline, protocol, or other similar criterion, or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request; if the denial of the Claim is based on a medical necessity or experimental treatment or similar exclusion or limit, either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request; and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory

agency."

(h) ***Timing of Notice of Decision on Appeal.*** The Administrator will render a decision on appeal within 60 days after receipt of the appeal.

(i) ***Extensions of Time.*** If the Administrator requires an extension of time to review a Claim or an appeal, the Administrator will provide the Participant with written or electronic notice of the extension before the first day of the extension. The notice of the extension will include: an explanation of the circumstances requiring the extension, which circumstances must be matters beyond the control of the Administrator; the date by which the Administrator expects to render a decision; the standard on which the Participant's entitlement to a benefit is based; the unresolved issues, if any, that prevent a decision on the Claim or on appeal; and the information needed to resolve those issues. In the event such information is needed, the Participant will have at least 45 days in which to provide the specified information. In addition, the time for determining an initial Claim will be tolled from the date on which the notice of extension is sent to the Participant until the date on which the Participant responds to the request for additional information. For an initial Claim, the Administrator may obtain no more than one extension of 15 days. For an appeal, the Administrator may not obtain an extension.

(j) ***Legal Action.*** A Claimant must exhaust his or her administrative remedies under these procedures prior to bringing any legal action with respect to a Claim. In no event may a Claimant bring such legal action more than one year after the final decision on appeal.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 **Establishment.** This Article is intended to qualify as a dependent care assistance program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section and with the Treasury regulations thereunder. The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who designates a Salary Reduction Amount in relation to such an account. Such Participants may submit claims for the reimbursement of Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 **Coordination with Plan.** The provisions of this Article shall be coordinated with the Plan to the greatest extent possible. The Plan provisions regarding enrollment, participation, contributions, allocations, elections and the like shall apply to the Dependent Care Flexible Spending Account.

7.3 **Definitions.** The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account. In addition, for the purposes of this Article and the Plan, the terms below have the following meaning

Dependent Care Expenses means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment-related expenses under Code Section 21(b)(2), but only if the expense is incurred while the Participant is enrolled in a Dependent Care Flexible Spending Account. Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant, Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of

whether an amount qualifies as a Dependent Care Expense shall be made subject to the following rules:

(a) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Dependent Care Expenses only if incurred for a Qualifying Dependent who regularly spends at least 8 hours per day in the Participant's household;

(b) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(c) Dependent Care Expenses of a Participant shall not include amounts paid or payable to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

Dependent Care Flexible Spending Account means the account established for a Participant pursuant to this Article to which Salary Reduction Amounts may be allocated and from which Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

Earned Income means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

Qualifying Dependent means, for Dependent Care Flexible Spending Account purposes: (i) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13; (ii) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or (iii) a child that is deemed to be a Qualifying Dependent described in clause (i) or (ii) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

7.4 **Contributions and Allocations.**

(a) ***Maximum.*** The maximum allocations to a Participant's the Dependent Care Flexible Spending Account for any Plan Year shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500.00 if a separate tax return is filed by a Participant who is married as determined under Code Section 21(e)(3) and (4)). The maximum shall be calculated without regard to any Grace Period.

(b) ***Employer Contributions.*** The Employer shall make contributions to the Dependent Care Flexible Spending Accounts of Participants as specified in the Adoption Agreement.

(c) ***Participant Contributions.*** Participant contributions to Dependent Care Flexible Spending Accounts shall be made consistent with the applicable Elections.

7.5 **Expenses and Reimbursements.** In each Plan Year (and in each corresponding Grace Period), a Participant shall be reimbursed for, and the Participant's Dependent Care Flexible Spending Account balance shall be reduced by, the amount of any Dependent Care Expense incurred by the Participant during the Plan Year (or corresponding Grace Period). However, a Participant shall not be entitled to reimbursements in excess of the balance of the Participant's account.

7.6 **Nondiscrimination Requirement.** Contributions or benefits under this Article shall not be discriminatory

under Code Section 129(d). Not more than 25 percent of the amounts paid under this Article during a given Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer. If the Administrator deems it necessary to avoid discrimination, it may (but shall not be required to) reject or reduce any Elections or reduce nontaxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

7.7 **Annual Statement.** On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant in the Dependent Care Flexible Spending Account Benefit during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 **Forfeitures.** The amount in the Dependent Care Flexible Spending Account as of the end of any Plan Year (or as of the end of any corresponding Grace Period, and after the processing of all claims for such Plan Year (and any corresponding Grace Period), shall be forfeited. In such event, the Participant shall have no further claim to such amount for any reason. The Administrator, in its sole discretion, may retain these forfeitures, or may use the forfeitures: (i) to defray plan administration expenses; (ii) to reduce salary reduction amounts for the following year on a reasonable and uniform basis; (3) to provide a cash refund to employees on a reasonable and uniform basis.

7.9 **Claims and Appeals Procedures.** Claims for the reimbursement of Dependent Care Expenses must be submitted to the Claims Administrator, together with appropriate documentation substantiating the Claim. Dependent Care Expenses incurred in any Plan Year shall be paid as soon after a Claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year (or after the end of the corresponding Grace Period), those Dependent Care Expense claims shall not be considered for reimbursement by the Administrator. The Administrator may establish such other Claims and Appeals procedures as it deems necessary or appropriate.

ARTICLE VIII
HEALTH SAVINGS ACCOUNT

8.1 **Establishment.** When an Eligible Employee enrolls in a High Deductible Health Plan sponsored by the Employer, the Employer shall establish a Health Savings Account, in the name of the Eligible Employee, with a qualified trustee/custodian of the Employer’s choice. The Health Savings Account shall be established and maintained outside of this Plan. The Employer contributions and Participant contributions (described below) shall be forwarded to the trustee/custodian. 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 Health Savings Account and not in this Plan. The Employer has no authority or control over the funds deposited in a Health Savings Account. Even though this Plan may allow contributions to a Health Savings Account, the Health Savings Account is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

8.2 **Coordination with Plan.** The provisions of this Article shall be coordinated with the Plan to the greatest extent possible. The Plan provisions regarding enrollment, participation, contributions, allocations, elections and the like shall apply to the Health Savings Account.

8.3 **Eligibility and Participation.** No Participant shall be permitted to elect concurrent participation, under the Plan, in this Health Savings Account Benefit and the General Health Flexible Spending Account Benefit. In order to be eligible for this Health Savings Account Benefit, the Eligible Employee must be enrolled in a High Deductible Health Plan sponsored by the Employer.

8.4 **Contributions.**

(a) ***Maximum.*** The maximum amount that may be contributed to a Health Savings Account through this Plan by or on behalf of a Participant with respect to any Plan Year is the statutory amount for contributions as set forth in Code Section 223, subject to any cost-of-living adjustments permitted by law, and subject to increased amounts permitted by law for Participants who are age 55 or above.

(b) ***Employer Contributions.*** The Employer shall make the contributions to the Health Savings Accounts of Participants as specified in the Adoption Agreement.

(c) ***Participant Contributions.*** Participant contributions to Health Savings Accounts shall be made consistent with the applicable Elections.

(d) ***Exception.*** Notwithstanding the foregoing, if a Participant's effective enrollment date in the High Deductible Health Plan sponsored by the Employer is in December of a given Plan Year, the Participant shall not be entitled to an Employer contribution for that Plan Year, and the Participant shall not be permitted to make any Participant contributions for that Plan Year.

(e) ***Coordination with Grace Period.*** If the Participant has a General Purpose Health Flexible Spending Account with a positive balance on the last day of a Plan Year, and if such Account has a grace period feature, the Participant shall not be eligible to make contributions to a Health Savings Account, or receive Employer Contributions for a Health Savings Account, until the first day of the first month beginning after the end of the applicable grace period. The foregoing sentence does not apply to a Participant whose balance in the Health Flexible Spending Account on the last day of a Plan Year is zero.

8.5 **Claims Procedure.** The procedure for filing Health Savings Account claims is determined by the Health Savings Account custodian/trustee, not by this Plan. Participants shall submit Health Savings Account claims to the custodian/trustee, not to this Plan.

ARTICLE IX
PLAN ADMINISTRATION

9.1 **Powers and Duties of the Administrator.** The Plan shall be administered by the Administrator. The Administrator may delegate any of its duties or powers at any time, including, but not limited to, a delegation of its discretionary authority under this Article, to a person or persons who are employees of the Plan Sponsor or any other Employer, or to a third-party administrator selected by the Administrator. The Administrator shall have the right to change its delegates from time to time, or to take over functions previously delegated, all without cause. The Administrator may allow the entities to which it delegates its duties or powers to further delegate such duties or powers. The Administrator shall have the following administrative responsibilities and authority with respect to the Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To establish and maintain records appropriate to permit the Plan to be administered according to its terms and requirements of applicable law;

(g) To prepare and file or otherwise disseminate all reports, filings and documents required in order to comply with the reporting and disclosure obligations imposed by applicable laws or regulations;

(h) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them (this authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan);

(i) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609;

(j) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan; and

(k) Take all other steps deemed necessary to properly administer the Plan in accordance with its terms and the requirements of applicable law.

The Administrator's determinations on all such matters shall be applied in a uniform manner to all Employees and Participants similarly situated. To the maximum extent possible, the Administrator's determinations on all such matters shall be final and binding upon all persons involved. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on review unless it is shown that the interpretation or determination was arbitrary and capricious.

9.2 **Consultations and Reliance.** The Administrator shall be entitled to rely upon all tables, valuations, certificates, opinions and reports furnished by counsel, accountants or consultants retained by or on behalf of the Plan; and the Administrator shall be protected to the extent permitted by applicable law in respect of any action taken or permitted by the Administrator in good faith in reliance upon any such tables, valuations, certificates, opinions and reports and all actions so taken or permitted shall be conclusive upon the Administrator and upon all persons having or claiming to have any interest in or under the Plan to the extent permitted by law.

9.3 **Expenses of the Administrator.** Any Employees serving the Administrator shall serve without compensation for their services as such, but all expenses of the Administrator shall be paid or reimbursed by the Employers. Any Employees serving the Administrator shall be indemnified by the Employers against expenses reasonably incurred by them in connection with any action to which they may be party by reason of their service as Administrator except in relation to matters as to which they shall be adjudged in such action to be liable for gross negligence or willful misconduct in the performance of their duty. The foregoing right to indemnification shall be in addition to such other rights as such Employees may enjoy as a matter of law or by reason of insurance coverage of any kind. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which such Employees may be eligible pursuant to the articles of incorporation or by-laws of the Sponsor or any Employer.

9.4 **Paperless Communications.** Notwithstanding anything contained herein to the contrary, the Administrator may from time to time establish uniform procedures whereby with respect to any or all instances herein where a writing is required, including but not limited to any required written notice, election, consent, authorization, instruction, direction, designation, request or claim, communication may be made by any other means designated by the Administrator, including by paperless communication, and such alternative communication shall be deemed to constitute a writing to the extent permitted by applicable law, provided that such alternative communication is carried out in accordance with such procedures in effect at such time.

9.5 **Self-Interest.** No Employee or Participant, while exercising any authority or responsibility of the Administrator, shall take part in decisions that deal specifically with his rights under the Plan, but this shall not preclude his participation in decisions affecting Participants generally.

9.6 **Sponsor as Agent of Employers.** As among the Employers, the Sponsor shall have exclusive authority over all matters relating to the administration of the Plan and shall have sole authority to enforce the terms of the Plan, as agent, on behalf of any other Employer has chosen to participate in this Plan.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 **Amendment.** The Sponsor reserves the right to amend or terminate the Plan, in whole or in part, as it shall determine, in its sole discretion, to be necessary and appropriate. Except as otherwise specifically provided, any amendment or termination shall apply with respect to all Employers, and copies of any amendment or termination shall be provided by the Sponsor or Administrator to all Employers. No amendment shall have the effect of depriving any individual of any benefit to which the individual has already become entitled at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 **Effect of Termination on Flexible Spending Accounts** x In the event the Plan is terminated, no further contributions shall be made, but claims under the Health Flexible Spending Account and Dependent Care Flexible Spending Account, if incurred prior to termination, shall be adjudicated if submitted within a reasonable time following termination, such reasonable time to be determined by the Administrator in its sole discretion.

ARTICLE XI
ERISA AND OTHER FEDERAL REQUIREMENTS

11.1 **ERISA Compliance.** The Health Flexible Spending Account constitutes an ERISA plan (unless it is a governmental plan or church plan). The Health Flexible Spending Account shall be operated in compliance with ERISA. An ERISA notice is attached hereto as Appendix A. Additional ERISA information for the Health Flexible Spending Account benefit is set forth in the Adoption Agreement.

11.2 **COBRA Compliance.** This section shall only apply if the Employer is subject to COBRA. The Health Flexible Spending Account shall be operated in compliance with COBRA. A COBRA notice is attached hereto as Appendix B. A current Employee may elect to pay COBRA contributions for the Employee, Spouse, or Dependent on a pretax basis from current compensation; all others shall pay the COBRA contributions on an aftertax basis.

11.3 **USERRA Compliance.** This Section shall only apply if the Employer is subject to USERRA. The Health Flexible Spending Account is a health plan subject to the continuation coverage of USERRA. The Plan shall operate in accordance with such requirement. Procedures similar to those described in Section 5.6 above shall apply to a Participant in the Health Flexible Spending Account who takes an unpaid leave of absence on account of being in "uniformed service" under USERRA, unless the Participant elects COBRA continuation coverage with respect to the Health Flexible Spending Account with respect to such leave of absence.

11.4 **HIPAA Privacy and Security.** This Section applies if the Health Flexible Spending Account has more than 50 Participants or is administered by a party other than an Employer.

(a) ***Applicability.*** The Plan is a "hybrid entity" within the meaning of HIPAA. The Plan elects to provide the privacy and security protections required by HIPAA only to Health Flexible Spending Account.

(b) ***Uses and Disclosures of PHI by Sponsor.*** The Sponsor may use or disclose PHI pursuant to this Section.

(c) ***Permitted Uses and Disclosures.*** The Sponsor may use and disclose any PHI obtained pursuant to this Section only for the purposes of administrative functions that the Sponsor performs for or on behalf of the Health Flexible Spending Account.

(d) ***Required Uses and Disclosures.*** The Sponsor is required to use and/or disclose PHI: (i) to an individual, when requested under and required by 45 C.F.R. § 164.524 in order to provide an individual with access to his or her own PHI; (ii) to an individual, when requested under and required by 45 C.F.R. § 164.528 in order to provide an individual with an accounting of disclosures of that individual's PHI; and (iii) when required by the Secretary of the Department of Health and Human Services or those acting under the authority or at the direction of the Secretary to investigate or determine the Plan's compliance with HIPAA.

(e) ***Restrictions on Sponsor's Use and Disclosure of PHI***

(i) The Sponsor will not use or disclose Participants' PHI, except (i) as required by law, or (ii) as permitted or required by this plan document.

(ii) The Sponsor will ensure that any agent, including any subcontractor, to whom it provides Participants' PHI, agrees to the restrictions and conditions of this Section with respect to Participants' PHI.

(iii) The Sponsor will not use or disclose Participants' PHI: (i) for the purpose of employmentrelated actions or decisions; (ii) in connection with an employee benefit plan or arrangement of the Sponsor other than a group health plan.

(iv) Promptly upon learning of any use or disclosure of Participants' PHI that is inconsistent with the uses and disclosures allowed under this Section, the Sponsor will report such inconsistent use or disclosure to the Health Flexible Spending Account.

(v) The Sponsor will make PHI available to the Participant who is the subject of the information, in accordance with 45 C.F.R. § 164.524.

(vi) The Sponsor will make Participants' PHI available for amendment, and will amend Participants' PHI, in accordance with 45 C.F.R. § 164.526.

(vii) The Sponsor will make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(viii) The Sponsor will make its internal practices, books and records (as they relate to its use and disclosure of Participants' PHI) available to the U.S. Department of Health and Human Services for the purpose of determining compliance with 45 C.F.R. Parts 16064.

(ix) If feasible, the Sponsor will return or destroy all Participants' PHI that the Sponsor 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, Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(f) ***Adequate Separation Between Sponsor and the Plan.*** The following members of the Sponsor's workforce may be given access to Participants' PHI: Sponsor's Human Resources and Benefits Department. These individuals will have access to Participants' PHI only to perform the administrative functions that the Sponsor conducts for the Health Flexible Spending Account. These individuals will be subject to disciplinary action and sanctions, including termination of employment, for any use or disclosure of Participants' PHI in violation of the provisions of this Section, of HIPAA, or of the Sponsor's HIPAA policies and procedures. The Sponsor will promptly report any such violation to the Health Flexible Spending Account, and will cooperate in order to correct the violation; impose appropriate disciplinary action or sanctions on each person causing the violation, and mitigate any negative effect of the violation on any Participant, the privacy of whose PHI may have been compromised by the violation.

(g) ***Disclosure to Sponsor.*** For the purpose of conducting administrative functions on behalf of the Health Flexible Spending Account, the Sponsor shall be entitled to receive PHI from business associates (and their subcontractors or agents), and any other person or entity that maintains, or has the authority to direct the disclosure of, PHI related to any Participant. Notwithstanding the foregoing, PHI shall not be disclosed to the Sponsor: (i) for the purpose of employmentrelated actions or decisions; (ii) in connection with any employee benefit plan or arrangement of the Sponsor other than a group health plan.

(h) ***Minimum Necessary.*** The Sponsor will make reasonable efforts to limit its use or disclosure of PHI to the minimum information necessary to accomplish the intended purpose of the use or disclosure. When requesting PHI from another party, the Sponsor will make reasonable efforts to limit its request to the minimum information necessary to satisfy the purpose of the request.

(i) ***Sponsor's Certification of Compliance.*** Neither the Health Flexible Spending Account nor any of its business associates will disclose Participants' PHI to the Sponsor unless the Sponsor certifies that the Plan includes the terms of this Section and that the Sponsor agrees to abide by this Section.

(j) ***Security Provisions.*** The Employer will:

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

(ii) Ensure that the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(iii) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(iv) Report to the Health Flexible Spending Account any security incident of which it becomes aware.

11.5 **Qualified Medical Child Support Order ("QMCSO").** To the extent required by law, if an Employee's Dependent is an "alternate recipient" described in a medical child support order, and if the Administrator determines the order to be a QMCSO under ERISA § 609, the Health Flexible Spending Account Benefit will be available to the Dependent. The following procedures shall be used by the Administrator in determining whether an order is a QMCSO.

(a) ***Alternate Recipients.*** The term "alternate recipient" means a child (including a child adopted by, or placed for adoption with) of a Participant who has elected to participate in the Health Flexible Spending Account Benefit.

(b) ***Medical Child Support Order.*** The term "medical child support order" means any judgment, decree or order (including approval of a settlement agreement) which (i) provides for health coverage with respect to a child of a Participant under the Health Flexible Spending Account Benefit, is made pursuant to State domestic relations law (including a community property law), and relates to benefits under the Health Flexible Spending Account Benefit; or (ii) is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act with respect to the Plan and a Component Plan that is a group health plan.

(c) ***Information.*** The medical child support order must specify (i) the name and address of the Participant and each alternate recipient covered by the order; (ii) a reasonable description of the type of coverage to be provided to each alternate recipient or the manner in which such type of coverage is to be determined; and (iii) the period to which the order applies.

(d) ***Restrictions.*** The medical child support order cannot require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law.

(e) ***Notifications*** The Administrator or its delegate shall promptly notify the Participant and each alternate recipient of the receipt of such order and the procedures for determining whether the medical child support order is a QMCSO. Within a reasonable period after receipt of such order, the Administrator or its delegate shall determine whether such order is a QMCSO and notify the Participant and each alternate recipient of such determination.

(f) ***Representative*** The Administrator or its delegate shall permit an alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient.

ARTICLE XII
MISCELLANEOUS

12.1 **Exclusive Benefit.** This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

12.2 **Plan Interpretation** All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner.

12.3 **Gender and Number.** Wherever any words are used herein in the masculine, feminine or neuter gender,

they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

12.4 **Rights of Employees.** The establishment of the Plan, and any distributions from the Plan shall not be construed as giving to any current or former Employee, Participant, Spouse, or Dependent any legal or equitable rights against the Sponsor, any Employer, or the Administrator, or against any employees, officers, directors or shareholders of any of them as such. Nothing in this Plan requires the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant. 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 the Plan may be made. Nothing herein contained shall be deemed to give any Employee the right to be retained in the employ of an Employer or to interfere with the right of an Employer to discharge such Employee at any time, nor shall it be deemed to give an Employer the right to require the Employee to remain in its employ, nor shall it interfere with the Employee's right to terminate his employment at any time.

12.5 **Action by the Employer.** Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

12.6 **Right of Recovery.** Whenever payments have been made with respect to allowable expenses in excess of the maximum amount permitted under the Plan or the Plan has made erroneous payments, the Administrator has the right to recover such excess or erroneous payments. If the Plan pays a Participant, Spouse or Dependent more than an amount allowed by the Plan or an erroneous payment, he or she will be asked to refund the overpayment. If not received from the individual, the Administrator shall be entitled to take such action as the Administrator shall deem necessary and equitable to correct such error including deducting the overpayment or erroneous payment from future payments.

12.7 **Indemnification of Employer by Participants.** If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

12.8 **No Oral Modifications.** This Plan cannot be modified except in writing. A Participant shall not rely on any oral statement from the Administrator or an Employer, or representatives of either, to modify or otherwise affect the Benefits provided under, or other terms of, the Plan.

12.9 **Notice of Address.** Each Participant must file with the Administrator, in writing, his post office address and each change of post office address. Any communications, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of the Plan, and there shall be no obligation on the part of the Employers or the Administrator to search for or to ascertain the location of such person. If the Administrator is unable to make payment to a former Participant because the Administrator is unable to locate such person, then such payment and all subsequent payments otherwise due to such person shall be forfeited following a reasonable time after the date any such payment first became due.

12.10 **Information.** Each Participant, Spouse, or Dependent must furnish to the Administrator such

documents, evidence, or other information, as the Administrator considers necessary or desirable for the purposes of administering the Plan or to protect the Plan. The Administrator shall be entitled to rely on representations made by Participants with respect to age, marital status and other personal facts, unless it knows said representations are false.

12.11 **Restrictions on Alienation.** No amount payable by the Plan to any person shall be subject to any manner of anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge the same shall be void. No amount payable by the Plan shall be subject to, the debts, contracts, liabilities, engagements, or torts of any person, nor shall it be subject to attachment or legal process for or against any person, and the same shall not be recognized under the Plan, except to the extent required by law.

12.12 **Headings.** The headings of the Plan are inserted for convenience and reference only and shall have no effect upon the meaning of the provisions hereof.

12.13 **Governing Law.** The Plan shall be construed, regulated and administered under the laws of the State of CA Headquarters (excluding the choice-of-law rules thereof), except that if any such laws are preempted or superseded by any applicable Federal law or statute, such Federal law or statute shall apply.

12.14 **No Guarantee of Tax Consequences.** Neither the Employer nor the Administrator makes any commitment or guarantee that any Salary Reduction Amount or payment by the Plan will be excludable from the gross income of the Participant for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether any Salary Reduction Amount or payment by the Plan is excludable from gross income for federal and state income tax purposes and to take appropriate action if there is reason to believe that any payment or amount withheld is not excludable. Neither the Employer nor the Administrator is liable for any taxes or penalties owed by any Participant, Spouse, or Dependent with respect to such amounts.

12.15 **Funding.** Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or 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 the Plan may be made.

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

12.17 **Liability Limited.** The Sponsor, any Employer, the Administrator, and/or any employees, officers, directors or shareholders of any of them, shall have no liability or responsibility with respect to this Plan, except as expressly provided in this Plan.

12.18 **Cooperation of Parties.** Any party claiming any interest under this Plan agrees to perform any acts and execute any documents that are necessary or desirable for carrying out any of this Plan's provisions.

APPENDIX A

ERISA RIGHTS NOTICE

This Notice applies only to the Health Care Flexible Spending Account Benefit.

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that participants shall be entitled to:

Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified work locations, all documents governing the Health Care Flexible Spending Account, including copies of all documents filed by the Health Care Flexible Spending Account with the U.S. Department of Labor, such as annual reports.

You may obtain, upon written request to the Plan Administrator copies of all Health Care Flexible Spending Account documents and other Health Care Flexible Spending Account information. The Plan Administrator may make a reasonable charge for the copies.

If the Health Care Flexible Spending Account is required to file annual financial reports, the Plan Administrator is required by law to furnish each participant with a copy of a summary of the financial report.

Continue Group Health Plan Coverage

You may continue your Health Care Flexible Spending Account coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this document (especially Appendix B) for more information about your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Health Care Flexible Spending Account are called "fiduciaries," and they have a duty to do so prudently and in your interest and the interest of you and other participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Health Care Flexible Spending Account benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Health Care Flexible Spending Account benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Health Care Flexible Spending Account documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the

materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse Health Care Flexible Spending Account money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX B

COBRA CONTINUATION COVERAGE NOTICE

Introduction

This Notice applies only to the Health Care Flexible Spending Account provisions of this Plan. If you have opted to contribute to a Health Care Flexible Spending Account under this Plan, then read this entire notice carefully.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of Health Care Flexible Spending Account coverage. This notice generally explains COBRA continuation 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 right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Health Care Flexible Spending Account when they would otherwise lose that coverage. For additional information about your rights and obligations under the Health Care Flexible Spending Account and under federal law, you should review the Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Health Care Flexible Spending Account coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice.

After a qualifying event, and after any required notice of that event has been properly provided, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and

your dependent children could become qualified beneficiaries if coverage under the Health Care Flexible Spending Account is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA coverage for the Health Care Flexible Spending Account will be offered only to qualified beneficiaries 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 COBRA premiums that will be charged for the remainder of the plan year for the Health Care Flexible Spending Account.

What are the Qualifying Events and Who are the Qualified Beneficiaries?

If you are an employee, you will become a qualified beneficiary if you lose your Health Care Flexible Spending Account coverage because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your Health Care Flexible Spending Account coverage because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose Health Care Flexible Spending Account coverage because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer **must notify the Plan Administrator of the qualifying event.**

You Must Give Notice of Some Qualifying Events

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), you must notify the Plan Administrator. **The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs.** You must provide this notice to the Human Resources Department.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Each qualified beneficiary will receive an Election Notice, which must be completed and returned within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. COBRA coverage under this Plan will end on the last day of the Plan Year in which the qualifying event occurs. However, if you elect COBRA and your Health Flexible Spending Account has a grace period feature, your COBRA continuation coverage will end on the last day of the grace period associated with the Plan Year in which the qualifying event occurred. Similarly, if you elect COBRA and your Health Flexible Spending Account has a carryover feature, then you may carry over unused Health Flexible Spending Account funds after the end of the Plan Year, subject to and in accordance any other applicable terms of the Plan, including the maximum carrover amount specified by the Plan.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

If you have COBRA questions, please contact the Human Resources Department.