University of New England

FLEXIBLE BENEFITS PLAN

MASTER PLAN DOCUMENT

Effective 1/1/2025

Version January 1, 2021

Table of Contents

Article 1. Introduction

The University of New England Flexible Benefit Plan (the "Plan") was adopted effective 1/1/2025 by University of New England. The Plan was previously amended and restated on 1/1/2024 This amended and restated plan is adopted effective 1/1/2025, which supersedes the prior version of the Plan and all amendments made to prior versions of the Plan. The Plan has been amended and restated to utilize a separate Adoption Agreement which, when executed by an Employer, forms the elective provisions of this Plan as it is to be governed with respect to the adopting Employer.

The purpose of the Plan is to enable Employees who become covered under the Plan to elect payment of required premiums or contributions for various coverages in lieu of cash compensation. With respect to benefit coverages, this Plan only governs the payment of premium or contribution expenses and/or flexible spending account benefits on a pre-tax basis. This Plan has no effect on the benefits or claim payments made under each benefit plan or area of benefit coverage.

The Plan is intended to qualify as a "cafeteria plan" within the meaning of Code Section 125, as amended. Additionally, the Plan is designed to offer eligible Employees the ability to receive certain reimbursement of medical expenses not reimbursed through other sources and to receive reimbursement of certain Dependent Care Expenses as provided under Code Section 129. To the extent the Company establishes a medical reimbursement plan pursuant to this Plan document, it is intended to comply with Code Section 105(b), as amended, and is to be interpreted in a manner consistent with all relevant provisions of the Code and ERISA, as amended.

Article 2. Definitions.

Wherever used in this Plan, the singular includes the plural and the following terms have the following meanings, unless a different meaning is clearly required by the context:

2.1 "**Adoption Agreement**" means the separate agreement, as amended from time to time, which is executed by the Company and sets forth the elective provisions of this Plan as specified by the Company.

2.2. "**Administrator**" means the Company or such other person or committee as may be appointed from time to time by the Company to supervise the administration of the Plan.

2.3. "**Benefit Eligible Employee**" means a full-time Employee or part-time Employee who meets the eligibility criteria identified in Section 9 of the Adoption Agreement.

2.4. **"Claims Filing Deadline"** means the deadline for filing a claim for reimbursement as established in Section 11 of the Adoption Agreement. The Company may extend the Claims Filing Deadline for expenses incurred during the Grace Period, if applicable.

2.5. "**Code**" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions which amend, supplement or replace such section or subsection.

2.6. "**Company**" means the entity described in Section 1 of the Adoption Agreement and any successor to all or a major portion of its assets or business that assumes the obligations of the Company under the Plan.

2.7. "**Coverage Amount**" means the amount of medical reimbursement coverage elected by the Participant for the Plan Year in accordance with Section 4.2.

2.8. "**Dependent**" means any person who is a Dependent of the Participant within the meaning of Code Section 152. For this purpose, any child to whom Code Section 152(e) applies shall be treated as a Dependent of both parents. With respect to Dependent care assistance plans adopted pursuant to this Plan, "Dependent" means any individual who is (a) a Dependent of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to an exemption under Code Section 151(c), or (b) a Dependent of the Participant (within the meaning of Code Section 152), or the spouse of the Participant, who is physically or mentally incapable of caring for himself or herself. In determining whether an individual is a Dependent of the Participant, the special rules of Code section 21(e)(5) shall be taken into account, where applicable.

2.9. "**Dependent Care Expenses**" means expenses incurred by a Participant which (a) are incurred for the care of a Dependent of the Participant or for related household services, (b) are paid or payable to a Dependent Care Service Provider, and (c) are incurred to enable the Participant and spouse, if married, to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant. If spouse is not employed, the services provided permit the spouse to actively seek employment or to attend school full time. "Dependent Care Expenses" shall not include expenses incurred (i) for services outside the Participant's household for the care of a Dependent, unless such Dependent is described in Section 2.8(a) or regularly spends at least eight hours each day in the Participant's household, (ii) for services at a camp where the Dependent stays overnight, or (iii) before the Participant became a Participant. Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

2.10. "**Dependent Care Service Provider**" means a person who provides care or other services described in Section 2.9(a) above, but shall not include (a) a Dependent care center (as defined in Code Section 21(b)(2)(D)), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or (b) a related individual described in Code Section 129(c).

2.11. "**Dependent Care Flexible Spending Account**" or "**DCFSA**" means the account described in Article 5.

2.12. "**Earned Income**" shall have the meaning set forth in Code Section 32(c)(2).

2.13. "**Effective Date**" means the date identified in Section 4 of the Adoption Agreement, and if the Plan is being restated the date identified in Section 5 of the Adoption Agreement.

2.14. "**Employee**" means any individual who is employed by an Employer.

2.15. "**Employer**" ;. A subsidiary or affiliated employer will become an Employer as of the date agreed upon pursuant to such adoption and consent.

2.16. "**ERISA**" means the Employee Retirement Income Security Act of 1974, as from time to time amended. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions which amend, supplement or replace such section or subsection.

2.17. "**Grace Period**" means the 2.5 month period immediately following each Plan Year. If elected in Section 15 of the Adoption Agreement, Qualifying Health Care Expenses and/or Dependent Care Expenses incurred during the Grace Period may be reimbursed from any balance remaining under the Participant's HCFSA and/or DCFSA (as applicable) at the end of such immediately preceding Plan Year if the Participant applies for reimbursement of such expenses in accordance with the applicable Claims Filing Deadline. Unused benefits or contributions relating to a HCFSA and/or DCFSA may only be used to pay or reimburse Qualifying Health Care Expenses or Dependent Care Expenses, as applicable, and may not be used for any other benefit under the Plan. The reimbursement of Qualifying Health Care Expenses incurred during the Grace Period shall be made in accordance with IRS Notices 2005-42, 2020-29, 2020-32, and any subsequent guidance issued by the IRS with respect to such reimbursements.

2.18. "**Health Care Flexible Spending Account**" or "**HCFSA**" means the account described in Article 6.

2.19. "**Key Employee**" means any person who is a key employee, as defined in Code Section 416(i)(1) with respect to an Employer.

2.20. "**Optional Benefit Coverages**" means the coverages available to a Participant under the plans of the Company set forth in Section 10 of the Adoption Agreement.

2.21. "**Participant**" means any individual who participates in the Plan in accordance with Article 3.

2.22. "**Plan**" means the University of New England Flexible Benefits Plan as set forth herein, together with the Adoption Agreement and any and all Schedules, amendments and supplements hereto.

2.23. "**Plan Year**" means the Plan's accounting year as identified in Section 6 of the Adoption Agreement. Unless there is a short Plan Year, the Plan Year will be a twelve-consecutive month period.

2.24. "**Qualifying Health Care Expense**" means an expense incurred by a Participant, or by the spouse or Dependent of such Participant, for medical care as defined in Code Section 213(d) (including, without limitation, amounts paid for hospital bills, doctor and dental bills, and prescribed drugs (in accordance with IRS Notice 2010-59)), but only to the extent that the Participant or other person incurring the expense is not reimbursed or entitled to reimbursement for the expense through insurance or otherwise (other than under the Plan).

"Qualifying Health Care Expense" does not include any premium paid for health coverage under any plan maintained by an Employer or any other employer. Qualifying Health Care Expenses shall be deemed to be incurred at the time the services to which the expenses related are rendered. Notwithstanding the foregoing, the definition of "Qualifying Health Care Expenses" may be further limited as provided in the Adoption Agreement, to the extent the Company has adopted a limited purpose Health Care Flexible Spending Account.

2.25. "**Required Premium**" means the Participant's Coverage Amount for the Plan Year divided by 12 (or, if greater than 12, the number of regular compensation payments, if any, expected to be received by the Participant during the Plan Year). In the case of an Employee who first becomes a Participant in the middle of the Plan Year, the Required Premium shall be the Participant's Coverage Amount divided by the number of regular compensation payments remaining in the Plan Year. If the Participant changes his or her election under the Flexible Benefits Plan to increase or decrease his or her Coverage Amount during the Plan Year, the Required Premium shall likewise be increased or decreased by the amount of such change divided by the number of regular compensation payments remaining in the Plan Year.

Article 3. Participation.

3.1. Commencement of Participation. Each Benefit Eligible Employee will become a Participant on the date he or she becomes a Benefit Eligible Employee, subject to the limitations of Section 9 of the Adoption Agreement.

3.2. Cessation of Participation. A Participant will cease to be a Participant as of the earlier of

(a) the date on which the Plan terminates or

(b) the date on which he or she ceases to be a Benefit Eligible Employee.

3.3. Reinstatement of Former Participant. A former Participant will become a Participant again if and when he or she again becomes a Benefit Eligible Employee, subject to the limitations contained in Section 9 of the Adoption Agreement.

Article 4. Optional Benefit Coverages.

4.1. Coverage Options. Each Participant may choose under this Plan to receive his or her full compensation in cash or to have all or a portion of it applied by his or her Employer toward the cost of the Optional Benefit Coverages available to the Participant. Notwithstanding anything herein to the contrary, Optional Benefit Coverages shall be limited to those coverages and benefits that are available to the Participant under the plans identified in Section 10 of the Adoption Agreement.

4.2. Description of Optional Benefit Coverages. While the election of one or more of the Optional Benefit Coverages may be made under this Plan, the coverages and benefits thereunder will be provided not by this Plan but by the plans identified in Section 10 of the Adoption Agreement. The types and amounts of benefits available under each plan described in Section 10 of the Adoption Agreement, the requirements for participating in such plan, and the other terms and conditions of coverage and benefits under such plan are as set forth from

time to time in the plans identified in Section 10 of the Adoption Agreement, and in any group insurance contracts and prepaid health plan contracts that constitute (or are incorporated by reference in) certain of those plans. The benefit descriptions in such plans, as in effect from time to time, are hereby incorporated by reference into this Plan.

4.3. Election of Optional Benefit Coverages in Lieu of Cash. A Participant may elect under this Plan, in accordance with the procedures described in Sections 4.4, 4.5 and 4.6, to receive one or more Optional Benefit Coverages to the extent available to the Participant under the applicable plans identified on Section 10 of the Adoption Agreement.

(a) If a Participant elects coverage for a Plan Year under a plan under which the Participant is required to pay a share of the cost of such coverage, such share shall be paid by the Participant's Employer by means of a reduction in the Participant's regular compensation for the Plan Year. The balance of the cost of each such coverage, if any, shall be paid by the Employers under this Plan with nonelective Employer contributions.

(b) If a Participant elects coverage for a Plan Year under an account program, the Participant's regular cash compensation for the Plan Year will be reduced by such amount as the Participant elects (but in no event greater than the maximum permitted by Code Section 125(i)) and an amount equal to the reduction in compensation will be credited to the appropriate reimbursement account in accordance with the applicable plan or program identified on Section 10 of the Adoption Agreement.

4.4. Election Procedure. Prior to the commencement of each Plan Year, the Administrator shall provide (or make available) a means of election for each Participant and for each other individual who is expected to become a Participant at the beginning of the applicable Plan Year. The election shall be effective as of the first day of the Plan Year. Each Participant who desires to elect an Optional Benefit Coverage shall so specify in his or her election. The Participant shall agree to a reduction in his or her compensation equal to the cost of the Optional Benefit Coverages elected by the Participant. Each election must be completed and returned to the Administrator on or before such date as the Administrator shall specify.

4.5. New Participants. Before, or as soon as practicable after, an individual becomes a Participant under Section 3.1 or 3.3, the Administrator shall provide the means of election described in Section 4.4 to the individual. If the individual desires one or more Optional Benefit Coverages for the balance of the Plan Year (and the associated Grace Period, if applicable), the individual shall so specify in his or her election. The Participant shall agree to a reduction in his or her compensation equal to the cost of the Optional Benefit Coverages elected by the Participant. Each election must be completed and returned to the Administrator on or before such date as the Administrator shall specify.

4.6. Failure to Make Election.

(a) A new Participant's failure to make an election under Section 4.4 or 4.5 on or before the due date specified by the Administrator for the Plan Year in which he

or she becomes a Participant shall constitute an election by the Participant to receive his or her full compensation in cash.

(b) Subject to the Employer's election on Section 12 of the Adoption Agreement, an existing Participant's failure to make an election relating to an Optional Benefit Coverage on or before the due date specified by the Administrator for any subsequent Plan Year may either constitute (1) a re-election of the same coverage or coverages, if any, under such plan as were in effect just prior to the end of the preceding Plan Year, except for elections related to HCFSA or DCFSA (to the extent such coverage remains available as an Optional Benefit Coverage under the Plan), and an agreement to a reduction in the Participant's compensation for the subsequent Plan Year equal to the cost of such coverage or coverages, or (2) a waiver of the Participant's right to participate in the Plan for the following Plan Year.

(c) An existing Participant's failure to make an election relating to coverage under a flexible spending arrangement plan or under a Health Savings Account on or before the due date specified by the Administrator for any Plan Year shall constitute an election by the Participant of cash compensation in lieu of such coverage, regardless of any election in effect during the preceding Plan Year.

4.7. Revocation or Change of Election by the Participant during the Plan Year.

(a) Any election made under the Plan (including an election made through inaction under Section 4.6) shall be irrevocable by the Participant during the Plan Year except as otherwise provided in (b) through (h) below.

(b) With respect to any Optional Benefit Coverage, a Participant may revoke an election in writing for the balance of the Plan Year (and the associated Grace Period, if applicable) and, if desired, file a new election in writing if, under the facts and circumstances, (1) a change in status occurs, and (2) the requested revocation and new election satisfy the consistency requirements in Section 4.9 below. For this purpose, a change in status includes the following events:

(1) Legal marital status. An event that changes a Participant's legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.

(2) Number of Dependents. An event that changes a Participant's number of Dependents, including birth, death, adoption or placement for adoption.

(3) Employment status. An event that changes the employment status of the Participant or the Participant's spouse or Dependent, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, and a change in worksite, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of his or her employer.

(4) Requirements for unmarried Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(5) Residence. A change in the place of residence of the Participant, his or her spouse or Dependent, having a reasonable effect on benefit eligibility.

(6) Other. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Plan Year under regulations and rulings of the Internal Revenue Service.

(c) In the case of coverage under a medical plan identified in Section 10 of the Adoption Agreement, a Participant may revoke an election in writing for the balance of the Plan Year and file a new election in writing that corresponds with the special enrollment rights provided in Code Section 9801(f), whether or not the change in election is permitted under Section 4.7(b) above.

(d) In the case of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of the Participant, a Participant may change his or her election (1) in order to provide coverage for the child under a health coverage identified on Section 10 of the Adoption Agreement if the order so requires, or (2) in order to cancel a health coverage identified on Section 10 of the Adoption Agreement for the Participant's child if such order requires the Participant's spouse or former spouse or another individual to provide coverage for the child and that coverage is, in fact, provided.

(e) In the case of qualifying medical coverage identified on Section 10 of the Adoption Agreement, a Participant may revoke an election for the balance of the Plan Year and file a new election in order to cancel or reduce such medical coverage for the Participant or any covered Dependent of the Participant to the extent that the Participant or Dependent becomes entitled 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). In addition, if the Participant or any eligible Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election for the balance of the Plan Year to commence or increase a medical coverage identified on Section 10 of the Adoption Agreement.

(f) In the case of an Optional Benefit Coverage or a Dependent Care Flexible Spending Account Plan (but not a Health Care Flexible Spending Account Plan), if the Participants' share of the cost of such coverage significantly increases or significantly decreases during the Plan Year, the Participants may make a corresponding change in election under the Plan for the balance of the

Plan Year (and the associated Grace Period, if applicable), which will include (but not be limited to) the following:

(1) for a significant cost increase, Participants electing such coverage may revoke their election and either elect a similar coverage on Section 10 of the Adoption Agreement for the balance of the Plan Year (and the associated Grace Period, if applicable), or drop such coverage if there is no similar coverage identified therein; or

(2) for a significant cost decrease, Participants may elect to commence participation in the Optional Benefit Coverage with the significant cost decrease and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year (and the associated Grace Period, if applicable).

This Section 4.7(f) shall apply to a Dependent Care Flexible Spending Account Plan identified on Section 10 of the Adoption Agreement only if the significant cost change is imposed by a Dependent care provider that is not a relative of the Participant. No election change may be made as to the Health Care Flexible Spending Account Plan identified in Section 10 of the Adoption Agreement on account of a significant cost change.

(g) If elected by the Company under Section 17 of the Adoption Agreement, Employees may revoke their election for coverage under a group health plan during the Coverage Period in order to enroll in alternative coverage, so long as the requirements of either subsection (1) or (2) are met:

(1) Change in Hours of Service. Both (A) and (B) are met:

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

(B) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Employee, and any Spouse or Dependent who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked; or

(2) Enrollment in a qualified health plan through the Health Insurance Marketplace. Both (A) and (B) are met:

(A) The Employee is eligible for a Special Enrollment Period to enroll in a qualified health plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period; and

(B) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Employee, and any Spouse or Dependent who cease coverage due to the revocation in a qualified health plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Plan shall rely on, and the Employee shall be required to provide, a representation that the Employee and related individuals have enrolled or intend to enroll in another plan meeting the requirements above and within the required timeframe.

(h) In the case of an Optional Benefit Coverage, if the Participant or his or her spouse or Dependent experience a significant curtailment in coverage during the Plan Year, the Participant may make a corresponding change in election under the Plan for the balance of the Plan Year as follows:

(1) for a significant curtailment that is not a loss of coverage, the Participant electing such coverage may revoke his or her election and elect a similar coverage identified on Section 10 of the Adoption Agreement for the balance of the Plan Year; or

(2) for a significant curtailment that is (or is deemed by the Administrator to be) a loss of coverage, the Participant electing such coverage may revoke his or her election and either elect a similar coverage identified on Section 10 of the Adoption Agreement for the balance of the Plan Year, or drop such coverage if there is no similar coverage identified on Section 10 of the Adoption Agreement.

(i) If during the Plan Year a new Optional Benefit Coverage becomes available, or an existing Optional Benefit Coverage is significantly improved, Participants may elect the new or significantly improved coverage, and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year, provided that no such election change may be made as to the Health Care Flexible Spending Account Plan. For purposes of this Section 4.7(i), a Participant's change in Dependent care provider shall be treated as a change in available coverage.

(j) In the event that a Participant's spouse or Dependent makes an election change under a plan maintained by his or her employer, the Administrator may permit

the Participant to revoke an election under this Plan and make a new election for the balance of the Plan Year (and the associated Grace Period, if applicable) that is on account of and corresponds with the election change made by the Participant's spouse or Dependent, if:

(1) the election change made by the Participant's spouse or Dependent under his or her employer's plan satisfies the regulations and rulings under Code Section 125; or

(2) the period of coverage under the plan maintained by the employer of the Participant's spouse or Dependent does not correspond with the Plan Year of this Plan.

(k) In the event that a Participant or his or her spouse or Dependent loses group health coverage sponsored by a governmental or educational institution, the Participant may elect health coverages identified on Section 10 of the Adoption Agreement for the balance of the Plan Year (and the associated Grace Period, if applicable) for the Participant, his or her spouse or Dependent.

(l) Notwithstanding anything in this Article 4 to the contrary, with respect to contributions to a Health Savings Account, Participants may prospectively elect, revoke or change salary reduction elections for HSA contributions at any time during the Coverage Period with respect to salary that has not become currently available at the time of the election. Any such changes shall be subject to such administrative requirements as the Administrator may from time to time establish.

(m) Any application for a revocation and new election under this Section 4.7 must be made within the time specified by the Administrator following the date of the actual event and shall be effective at such time as the Administrator shall prescribe, unless otherwise required by law.

4.8. Grace Period for Account Plans or Programs. With respect to benefits offered under an account plan or arrangement and only to the extent elected by the Employer under Section 15 of the Adoption Agreement, expenses incurred during the Grace Period may be reimbursed from unused contributions made with respect to that benefit as of the end of the immediately preceding Plan Year if the Participant applies for reimbursement of such expenses in accordance with the reasonable procedures prescribed by the Administrator by the Claims Filing Deadline. Unused benefits or contributions relating to a particular benefit only may be used to pay or reimburse expenses incurred with respect to the same benefit. The reimbursement of expenses incurred during the Grace Period shall be made in accordance with IRS Notice 2005-42, 2005-43 I.R.B. 1204, Prop. Regs. §1.125-1(e), and any subsequent guidance by the IRS with respect to such reimbursements. Notwithstanding the foregoing, if the Employer elects a Grace Period, then a Participant in the Health Care Flexible Spending Account (if any) during the immediately preceding Plan Year is not eligible to contribute to an HSA until the first day of the first month following the end of the Grace Period.

4.9. Consistency Rules.

(a) A Participant's requested revocation and new election under Section 4.7(b) will be consistent with a change in status (1) if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a plan of the Employer or under a plan maintained by the employer of the Participant's spouse or Dependent, and (2) with respect to Dependent care assistance, if the election change is on account of and corresponds with a change in status that affects expenses described in Code Section 129 (including employment-related expenses as defined in Code Section 21(b)(2)). A change in status that affects the eligibility under an employer's plan shall include a change in status that results in an increase or decrease in the number of a Participant's family members or Dependents who may benefit from coverage under the plan.

(b) Notwithstanding anything to the contrary in Section 4.9(a), a Participant's election to either increase or decrease the amount of the Participant's group-term life insurance and/or group disability coverage (if any) identified in Section 10 of the Adoption Agreement in response to a change in status described in Section 4.7(b) shall be deemed to meet the requirements of Section 4.9(a).

4.10. Changes by Administrator. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such year any nondiscrimination or other requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

4.11. Adjustment of Compensation Reductions. If the cost of an Optional Benefit Coverage provided to a Participant increases or decreases during a Plan Year, including any increase or decrease due to a change in the Participant's salary, a corresponding change shall be made in the compensation reductions of the Participant in an amount reflecting such increase or decrease, as determined by the Administrator. If the cost of Dependent care assistance provided to a Participant increases or decreases during a Plan Year because of cost changes imposed by a Dependent care provider who is not a relative of the Participant, a corresponding change may be made in the compensation reduction of the Participant in an amount to be determined by the Administrator.

4.12. Automatic Termination of Election. Any election made under this Plan (including an election made through inaction under Section 4.6) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under a plan identified on Section 10 of the Adoption Agreement may continue if and to the extent provided by such plan. In the event such a former Participant again becomes a Participant before the end of the same Plan Year, the elections previously in effect for the

Participant under the plans identified on Section 10 of the Adoption Agreement shall be reinstated subject to the Administrator's policy on reinstatement.

4.13. Maximum Elective Contributions to Flexible Spending Arrangements. The maximum amount of elective contributions to flexible spending arrangements under the Plan for any Participant shall not exceed the maximum dollar amount identified in Section 10 of the Adoption Agreement, as adjusted for inflation if elected to the extent available under Code Section 125(i) and Section 18 of the Adoption Agreement.

4.14. Cessation of Required Contributions. Nothing in this Plan shall prevent the cessation of coverage or benefits under any plan identified on Section 10 of the Adoption Agreement, in accordance with the terms of such plan, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through compensation reduction or otherwise.

4.15. Elections Via Other Media. The Administrator may, in its discretion, use any electronic or other alternative media form that it deems necessary or appropriate for the election of benefits under the Plan, and such elections will be deemed elections in writing.

4.16. Participation during Leaves of Absence. The Family and Medical Leave Act ("FMLA") generally requires a covered Employer to offer coverage under any group health plan for the duration of a leave that is required to be extended by the FMLA, whether the leave is paid or unpaid. The group health plan coverage is to be offered under the same conditions as coverage would have been provided if the Employee had been continuously working during the entire leave period. The Employee has the right to keep this coverage by continuing to pay his or her cost of the premium. The requirements for Employees on paid FMLA leave are generally addressed by the FMLA and its regulations, which allow premium payments to be continued on the same basis as existed prior to the leave. The provisions below address benefit election choices under this Plan when the Employee is on an unpaid FMLA leave. Nothing herein shall be construed to alter the terms of any underlying benefit plan documentation and should not be construed to grant coverage under a benefit when the documentation for that benefit would not allow coverage to continue during a leave of absence.

(a) Health Benefits. Notwithstanding anything herein to the contrary and to the extent required by the FMLA, an eligible Employee may be permitted to terminate one or more health-related benefit elections (such as for group health coverage or for a Health Care Flexible Spending Account) if the Employee takes an unpaid FMLA leave of absence. If such Employee terminates the receipt of a health benefit, or if the Employee continues the coverage yet coverage terminates because the Employee fails to pay the required premium, then there will be no coverage under the health benefit following such termination, and expenses incurred after termination are not eligible for payment. On timely return from an FMLA leave, the Employee shall be entitled to resume Plan participation under the same terms and conditions that existed prior to the leave. However, any terms and conditions that may have changed for active Employees also apply to the Employee returning from an FMLA leave.

Upon return from an FMLA leave during which coverage terminated, the Employer may require reinstatement into a health benefit that is a Health Care Flexible Spending Account, provided that Employees on a non-FMLA leave are also required to be reinstated into the spending account. Upon reinstatement, whether or not required, the Employee may not retroactively elect spending account coverage for claims incurred during the period when the coverage was terminated. The Employee may resume coverage at the level in effect prior to the beginning of the leave, thus increasing premium payments upon return from the leave or, alternatively, the Employee may elect to resume coverage at a reduced level, continuing premium payments in the same amount as in effect before the leave. Example: If an Employee has elected $1,200 of annual coverage under a Health Care Flexible Spending Account ($100 pre-tax funding monthly) and is on an FMLA leave during April, May, and June, during which coverage ceases, Employee on return from the leave in July may resume coverage at $1,200 by paying $150 per month from July through December. Alternatively, the Employee may resume coverage at the reduced level of $900 annually by paying $100 per month from July through December.

In lieu of allowing an employee to elect to terminate the receipt of health-related benefits, the Employer may provide that health-related coverage automatically continues and allow the Employee to discontinue payment of his or her required premium during the period of the FMLA leave. Should this happen, the Employer has the right to recover the Employee's share of the premiums when the Employee returns to work, or as may otherwise be allowed by the FMLA.

If an Employee goes on an unpaid FMLA leave and chooses to continue one or more health-related benefits, the Employee may pay his or her share of the premium by one of the following methods. The optional methods provided below are to be offered in accordance with regulations under Code Section 125 relating to cafeteria plans and FMLA leaves, and in accordance with the Employer's practices and procedures:

(1) Pre-Pay. An Employee may pre-pay the premium for the expected duration of the leave either with after-tax dollars or with pre-tax dollars. Pre-tax dollars may not be used to pre-pay coverage during the subsequent Plan Year, and pre-payment may not be the sole method made available.

(2) Pay-As-You-Go. An Employee may make premium payments during the course of the leave by sending such payments as directed by the Employer, on a payroll period basis, or on any other basis as authorized. Contributions under this option are generally made on an after-tax basis. Coverage may cease if payments are not timely made, in accordance with the FMLA and its requirements. Alternatively, the Employer may choose to continue the health coverage of the Employee who fails to pay premiums. In such case, the Employer may recoup the premiums paid on the Employee's behalf, as authorized by regulations.

(3) Catch-Up. An Employee may make an advance agreement with the Employer that coverage will continue during the leave and that the Employee will not pay premiums until returning from the leave, after which time the Employee will catch-up those premium payments.

(4) Other. If any other option is made available to Employees on non-FMLA leave, then such option is also available to Employees on FMLA leave.

An Employee on FMLA leave has the right to revoke or change elections under the same terms and conditions as are available to active employees.

(b) Non-Health Benefits. If an Employee goes on an FMLA leave, then entitlement to non-health benefits shall be determined by the Employer's policies and procedures for providing such benefits when an Employee is on a leave not covered by the FMLA, and also by the terms of the underlying benefit plan documentation. It is possible that an Employer may continue the Employee's non-health benefits while on FMLA leave in order to ensure that the Employee is eligible to be reinstated in the benefit upon return from leave as may be required by the FMLA. In such a case, the Employer is entitled to recoup the costs incurred for paying the Employee's share of the premium. Such costs may be recovered on any basis allowed by law.

If an Employee goes on a leave of absence that is not covered by the FMLA, such absence may constitute a change in status as addressed in this Article. The ability of such Employee to continue any underlying benefit shall be determined by the terms and conditions of the underlying benefit plan documentation and by the Employer's policies and procedures. If the benefit can be continued, then this Plan accommodates the ability to pay for the benefit on a pre-tax basis where Compensation is available during the leave.

Article 5. Dependent Care Flexible Spending Account Plan

(This Article only applies if both (1) the Company elects to offer a Dependent Care Flexible Spending Account Plan to its employees under Section 10 of the Adoption Agreement and (2) the Company does not have another Dependent care assistance plan document).

5.1. Election Procedure. A Participant may elect to receive Dependent care assistance under the Plan for any Plan Year by filing an election and salary reduction agreement in accordance with the procedures established in Article 4 above. An election to receive Dependent care assistance shall not be revoked by the Participant during the Plan Year, except as provided in Article 4. However, such an election may automatically terminate, or may be terminated or modified by action of the Plan Administrator, in accordance with Article 4. Each year, the Participant must make another election to receive benefits through that Participant's Dependent Care Flexible Spending Account.

5.2. Establishment of Accounts. The Company will cause to be established and maintained a Dependent Care Flexible Spending Account for each Plan Year with respect to each Participant who has elected to receive Dependent care assistance for the Plan Year.

5.3. Crediting of Accounts. There shall be credited to a Participant's Dependent Care Flexible Spending Account for each Plan Year, as of each pay period for the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in the Participant's compensation for such pay period in accordance with the Participant's Dependent care election and salary reduction agreement under this Plan. All amounts credited to each such Dependent Care Flexible Spending Account shall be the property of the Company until paid out pursuant to this Article.

5.4. Debiting of Accounts. A Participant's Dependent Care Flexible Spending Account for each Plan Year shall be debited from time to time in the amount of any payment under this Article to or for the benefit of the Participant for Dependent Care Expenses incurred during such year and associated Grace Period.

5.5. Forfeiture of Accounts. The amount credited to a Participant's Dependent Care Flexible Spending Account for any Plan Year shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Plan Year and, if elected by the Company under Section 15 of the Adoption Agreement, associated Grace Period. The Participant must apply for reimbursement by the Claims Filing Deadline. If any balance remains in the Participant's Dependent Care Flexible Spending Account for any Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for any Dependent Care Expense incurred during a subsequent Plan Year (except to the extent such expense is incurred during the Grace Period for the immediately preceding Plan Year and reimbursed hereunder). Such balance shall not be available to the Participant in any other form or manner, but shall remain the property of the Company to the extent permitted by law, and the Participant shall forfeit all rights with respect to such balance.

5.6. Claims for Reimbursements. A Participant who has elected to receive Dependent care assistance for a Plan Year may apply to the Administrator for reimbursement of Dependent Care Expenses incurred by the Participant during such Plan Year and associated Grace Period by submitting an application in writing to the Administrator, in such form as the Administrator may prescribe, setting forth:

(a) the amount, date and nature of the expense with respect to which a reimbursement is requested;

(b) the name of the person, organization or entity to which the expense was or is to be paid;

(c) a statement that the expense (or the portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other Dependent care plan coverage; and

(d) such other information as the Administrator shall from time to time require.

Such application shall be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, or other documents showing the amounts of such expenses, together with any additional documentation which the Administrator may request. Such application may

be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

5.7. Reimbursement or Payment of Expenses. The Administrator shall pay or reimburse the Participant from the Participant's Dependent Care Flexible Spending Account, at such time and in such manner as the Administrator may prescribe, for Dependent Care Expenses incurred during the Plan Year and associated Grace Period (if applicable) for which the Participant submits a written application and documentation in accordance with Section 5.6. No reimbursement or payment under this Section of expenses incurred during a Plan Year and associated Grace Period (if applicable) shall at any time exceed the balance of the Participant's Dependent Care Flexible Spending Account for the Plan Year and associated Grace Period at the time of the reimbursement or payment, nor shall any payment or reimbursement be made if the Participant's claim is for an amount less than the minimum claim amount established by the Administrator. The amount of any Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence shall be carried over and reimbursed or paid only if and when the Participant's claim equals or exceeds such minimum and the balance in the Participant's Dependent Care Flexible Spending Account permits such reimbursement or payment.

5.8. Report to Participants on or before January 31 of Each Year. On or before each January 31, and at such other times as the Administrator may determine, the Administrator shall furnish to each Participant (or former Participant) who has elected Dependent care assistance under this Plan for the prior calendar year a written statement showing the amount of such assistance paid or payable during such year with respect to Dependent Care Expenses incurred by the Participant (or former Participant). If the amount of such Dependent Care Expenses is not yet known to the Administrator by January 31, the written statement shall show the amount of Dependent care assistance elected by the Participant (or former Participant) for such year.

5.9. Limitation on Reimbursements or Payments with Respect to Certain Participants. Not more than 25 percent of the total amounts reimbursed or paid under the Plan during any Plan Year may be reimbursed or paid with respect to the class of individuals who own more than five percent of the stock of the Employer (or their spouses or Dependents). Notwithstanding any other provision of the Plan, the Administrator may limit the amounts contributed, reimbursed or paid with respect to any Participant who is a highly compensated employee (within the meaning of Code Section 414(q)), to the extent that the Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section 5.5.

5.10. Maximum Dependent Care Reimbursement. Unless otherwise specified in Section 10 of the Adoption Agreement, the maximum amount which the Participant may receive in any calendar year in the form of Dependent care assistance under this Plan with respect to Dependent Care Expenses incurred in any calendar year and associated Grace Period (if applicable) shall be the least of:

(a) the Participant's Earned Income for the calendar year (after all reductions in compensation including the reduction related to Dependent care assistance);

(b) the actual or deemed Earned Income of the Participant's spouse for the calendar year; or

(c) $5,000 (or, if the Participant does not certify to the Administrator's satisfaction that he or she either is unmarried or will file a joint federal income tax return for the year, $2,500).

In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income of not less than $250 per month if the Participant has one Dependent and $500 per month if the Participant has two or more Dependents. In the case of two Participants who are married to each other and who file a joint federal income tax return for the calendar year, the $5,000 limit in (c) above shall be reduced for each such Participant by the amount received for the calendar year under the Plan by the Participant's spouse. A Participant shall be treated as not married if the Participant is not considered as married under the special rules of Code Section 21(e)(3) and (4).

Article 6. Health Care Flexible Spending Account Plan

(This Article only applies if both (1) the Company elects to offer a Health Care Flexible Spending Account Plan to its employees under Section 10 of the Adoption Agreement and (2) the Company does not have another Health Care Flexible Spending Account Plan document).

6.1. Election Procedure. A Participant may elect under this Plan to receive payments or reimbursements of his or her Qualifying Health Care Expenses for any Plan Year or associated Grace Period (if elected under Section 15 of the Adoption Agreement) by executing an election and salary reduction agreement in accordance with the procedures established under this Plan. An election to receive payments or reimbursements of Qualifying Health Care Expenses shall be irrevocable by the Participant during the Plan Year, except as provided in this Plan. However, such an election may automatically terminate, or may be terminated or modified by action of the Administrator of the Plan, in accordance with the terms of the Plan.

6.2. Participation of Spouses or Dependents. If and to the extent required by law, coverage under this Article shall be made available to the spouse or a Dependent of a Participant or former Participant in lieu of (or in addition to) the Participant, such spouse or Dependent shall be treated as a Participant under this Plan, but only to such extent and for such period as the law requires. No salary reduction agreement shall be required for such a spouse or Dependent. Required Premiums must be paid to the Employer by or on behalf of such spouse or Dependent on a monthly basis (or within such other time limit as may be provided for by law), and coverage under the Plan shall cease upon nonpayment of any such Required Premium.

6.3. Coverage Amount. A Participant may elect to receive payments or reimbursements of Qualifying Health Care Expenses incurred in a Plan Year or associated Grace Period (if applicable) up to any dollar amount duly elected under the Plan by the Participant, provided that such amount is not more than $2,500 (as adjusted for inflation if elected) for any Plan Year.

6.4. Establishment of Accounts. The Company will cause to be established and maintained a Health Care Flexible Spending Account for each Plan Year with respect to each Participant who has elected to receive reimbursements of Qualifying Health Care Expenses incurred during the Plan Year or associated Grace Period, if applicable.

6.5. Crediting of Accounts. There shall be credited to a Participant's Health Care Flexible Spending Account for each Plan Year, as of the beginning of such Plan Year, an amount equal to the Participant's Coverage Amount for such Plan Year. Except as otherwise required by law, the amount credited for each Plan Year to each such Health Care Flexible Spending Account shall be the property of the Company until paid out pursuant to Article 6.

6.6. Debiting of Accounts. A Participant's Health Care Flexible Spending Account for each Plan Year shall be debited from time to time in the amount of any payment under Article 6 to or for the benefit of the Participant for Qualifying Health Care Expenses incurred during such Plan Year or associated Grace Period.

6.7. Forfeiture of Accounts. The amount credited to a Participant's Health Care Flexible Spending Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Health Care Expenses incurred during such Plan Year or associated Grace Period (if elected by the Company) while the Employee was a Participant, and only if the Participant applies for reimbursement by the Claims Filing Deadline. If any balance remains in the Participant's Health Care Flexible Spending Account for a Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse any Participant for Qualifying Health Care Expense incurred during a subsequent Plan Year (except to the extent such expense is incurred during the Grace Period for the immediately preceding Plan Year and reimbursed hereunder), and shall not be available to the Participant in any other form or manner. Such balance shall remain the property of the Company to the extent permitted by law, and the Participant shall forfeit all rights with respect to such balance.

Any balance in the Participant's account as of the last day of the Coverage Period which is not used to provide reimbursement for Qualifying Health Care Expenses incurred during the Coverage Period shall be forfeited by the Participant and used by the Company to offset any losses of the Company under the Health Care Flexible Spending Account program, or to reduce costs of administration. Any further excess shall be used in any manner authorized by relevant law.

However, if elected by the Company in Section 16 of the Adoption Agreement, and subject to the conditions contained in the Adoption Agreement and in this paragraph, Participants may carry over to the subsequent Plan Year an amount up to 20 percent of the maximum salary reduction contribution under Code Section 125(i) for that Plan Year, as adjusted annually for inflation if elected and subject to the limitations provided in IRS Notice 2020-33. Thus, the maximum unused amount from a Plan Year starting in 2020 allowed to be carried over to the immediately following Plan Year beginning in 2021 is $550 (20 percent of $2,750, the indexed 2020 limit under Code Section 125(i)). The amount carried over may be used only to pay or reimburse Qualifying Health Care Expenses incurred during the entire Plan Year to which the amount is carried over. For purposes of this Section, the amount remaining unused shall be calculated after all Qualifying Health Care Expenses have been reimbursed as soon as administratively feasible after the end of the period for submitting eligible expenses.

Notwithstanding the foregoing, this paragraph shall not apply for a given Coverage Period, and thus no carryover will be available, if the Plan also provides for a Grace Period as of the last day of the Plan Year from which amounts would be carried over, during which benefits or contributions remaining in a Participant's Health Care Flexible Spending Account as of the end of a Plan Year are available to pay or reimburse the Participant for Qualifying Health Care Expenses incurred after that Plan Year.

With respect to the carryover allowance described above, any unused amount in excess of the carryover limitation described above that remains unused as of the end of period for submitting eligible expenses is forfeited. For ease of administration, reimbursements of all claims for expenses that are incurred in the current Coverage Period shall be treated as reimbursed first from unused amounts credited for the current Coverage Period and, only after exhausting these current Coverage Period amounts, as then reimbursed from unused amounts carried over from the preceding Coverage Period. Any unused amounts from the prior Coverage Period that are used to reimburse a current Coverage Period expense (a) reduce the amounts available to pay prior Coverage Period expenses during the period for submitting eligible expenses, (b) must be counted against the permitted carryover, and (c) cannot exceed the permitted carryover.

6.8. Claims for Reimbursement. A Participant who has elected to receive health care reimbursements for a Plan Year may apply to the Administrator for reimbursement of Qualifying Health Care Expenses incurred by the Participant while he or she was a Participant during the Plan Year or associated Grace Period by submitting a statement in writing to the Administrator, in such form as the Administrator may prescribe, setting forth:

(a) the amount, date and nature of each expense with respect to which a benefit is requested;

(b) the name of the person, organization or entity to which the expense was or is to be paid;

(c) the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant;

(d) the amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense; and

(e) a statement that the expense (or the portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

Such application shall be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, or other statements or documents that the Administrator may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

6.9. Reimbursement or Payment of Expenses. The Administrator shall reimburse the Participant from the Participant's Health Care Flexible Spending Account, at such time and in such manner as the Administrator may prescribe, for Qualifying Health Care Expenses incurred during the Plan Year or associated Grace Period for which the Participant makes written application and provides documentation in accordance with Section 6.8. No reimbursement or payment under this Section shall be made if the claim submitted by the Participant is for an amount less than the minimum reimbursable amount established by the Administrator. The amount of any Qualifying Health Care Expenses not reimbursed or paid as a result of the minimum reimbursable amount shall be carried over and reimbursed or paid only if and when the Participant's unreimbursed claims equal or exceed such minimum. Notwithstanding the preceding sentence, claims for expenses incurred during a Plan Year that are submitted for reimbursement after the last day of the Plan Year and by the Claims Filing Deadline shall be paid regardless of whether they equal or exceed the minimum reimbursable amount.

6.10. Limitation on Reimbursements or Payments with Respect to Certain Participants. Notwithstanding any other provision of this Plan, the Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a highly compensated individual (within the meaning of Code §105(h)(5) or §125(e)) to the extent that the Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section 6.7.

6.11. Named Fiduciary. With respect to this Health Care Flexible Spending Account created pursuant to this Plan only, the Administrator will be a "named fiduciary" for purposes of Section 402(a) of ERISA with the authority to control and manage the operation and administration of the Health Care Flexible Spending Account maintained under this Plan, and will be responsible for complying with all of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA.

Article 7. Cessation of Coverage

7.1. Cessation of Participation. In the event that a Participant ceases to be a Participant in this Plan for any reason during a Plan Year, the Participant's salary reduction agreement relating to this Plan shall terminate. Except as provided in Section 7.2, the Participant shall be entitled to reimbursement only for Qualifying Health Care or Qualifying Health Care Expenses incurred within the same Plan Year and associated Grace Period (if applicable) and before he or she ceased to be a Participant. The Participant shall be entitled to reimbursement or payment only for Dependent Care Expenses only if the Participant (or his or her estate) applies for such reimbursement or payment in accordance with Article 5.

7.2. Continuation of Coverage. If and to the extent required by law, in the event that a Participant ceases to be an Employee and undertakes to pay Required Premiums to the Administrator on a monthly basis (or within such other time limit as may be provided for by law), coverage under the Plan shall continue so long as such Required Premiums are paid, but not beyond the end of the period for which such coverage is required by law. In addition, the former Participant shall be treated as a Participant under the Plan to such extent as is required

by law and shall be entitled to reimbursement for Qualifying Health Care Expenses incurred during such period of continued coverage, subject to Section 7.3.

7.3. Limits on Time and Amount of Reimbursements. Reimbursements shall be made for any Plan Year under this Article 7 only if the Participant applies for such reimbursement by the Claims Filing Deadline. In the event of the Participant's death, the Participant's spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Article 7. No reimbursement under this Article 7 shall exceed the remaining balance, if any, in the Participant's Health Care Spending Account for the Plan Year in which the expenses were incurred or, in the case of expenses incurred during a Grace Period, the remaining balance in the Participant's Health Care Spending Account for the Plan Year in which the expenses were incurred and the preceding Plan Year.

Article 8. Administration of Plan.

8.1. Plan Administrator. The administration of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Administrator will have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

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

(b) To interpret the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To compute the amount of benefits which will be payable to any Participant or other person in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits will be paid;

(e) To authorize the payment of benefits;

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

(g) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be by written instrument and in accordance with Section 405 of ERISA, to the extent applicable, as well as other applicable requirements of law.

Any determination by the Administrator, or any authorized delegate, shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously. Notwithstanding the foregoing, any claim which arises under any insurance contract(s) or other employee benefit plan that is

not a Health Care Flexible Spending Account or Dependent Care Flexible Spending Account created and governed by this Plan shall not be subject to review under this Plan.

8.2. Claims for Benefits and Appeal Process for Health Care Flexible Spending Accounts and Dependent Care Flexible Spending Accounts.

Claims for Benefits

Any claim for benefits under this Plan is to be submitted to the entity that has been retained to provide claims administration, hereafter the Claims Administrator, by the Claims Filing Deadline. Within 30 days after receipt by the Claims Administrator of a claim for reimbursement, the Plan will make reimbursement for Medical Care Expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied.

The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process

In the event a claim for benefits is denied, the claimant or his or her duly authorized representative, may appeal the denial to the Committee within 180 days after receipt of written notice of the denial. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed

denial, in accordance with this paragraph. The appeal process described here must be followed, or the Participant will lose the right to appeal the denial and the right to file a civil action in court as provided by ERISA. In pursuing an appeal, the claimant or the duly authorized representative:

(a) must request in writing that the Committee review the denial;

(b) may review (on request and free of charge) all documents, records, and other information relevant to the claim; and

(c) may submit written issues and comments, documents, records, and other information regarding the claim.

The appeal will be reviewed by the Committee, and written comments, documents, records, and other information submitted by the Participant will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of the appeal. If the decision on review is adverse to the claimant, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, the claimant will be provided either the specific rule, guideline, protocol, or other similar criterion, or will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and the Participant will have the right to pursue his or her claim under ERISA, including the right to file a lawsuit.

The claim and appeal procedures explained above will be interpreted consistent with regulations issued by the U.S. Department of Labor.

8.3 Examination of Records. The Administrator will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours; *provided*, *however*, the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

8.4 Reliance on Tables, etc. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the plans identified on Section 10 of the Adoption Agreement, or by accountants, counsel or other experts employed or engaged by the Administrator.

8.5 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

8.6 Indemnification of Administrator. The Company agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator or acting for the Administrator in connection with the Plan, including any Employee or former Employee who formerly served or acted in such capacity, against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

Article 9. Amendment and Termination of Plan.

9.1. Amendment of Plan. The Company reserves the power to amend the provisions of the Plan at any time or times, to any extent that it may deem advisable. Any amendment to the Plan shall be effected by a written instrument signed by an officer of the Company, or his or her authorized delegate, and delivered to the Administrator.

9.2. Termination of Plan. The Company has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but has no obligation whatsoever to maintain the Plan for any given length of time. The Company may discontinue or terminate the Plan at any time without liability, by a written instrument signed by an officer of the Company, or his or her authorized delegate, and delivered to the Administrator.

Article 10. Miscellaneous Provisions.

10.1 Information to be Furnished. Participants shall provide their Employer, the Company and the Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan

10.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other

person any legal or equitable right against the Company or the Administrator, except as provided herein.

10.3 Employment Not Guaranteed. Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Employee any right to be retained in the employ of the Employers.

10.4 Benefits Solely from General Assets. Any benefits provided hereunder will be paid solely from the general assets of the Company. Nothing herein will be construed to require the Company 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 Company from which any payment under the Plan may be made.

10.5 Nonassignability of Rights. The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method and will not be subject to be taken by his or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.6 No Guarantee of Tax Consequences. Neither the Administrator nor the Employers make any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludible from the Participant's gross income for federal or state income tax or Social Security tax purposes, or that any other federal or state tax or Social Security tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludible from the Participant's gross income for federal and state income tax and Social Security tax purposes, and to notify his or her Employer if the Participant has reason to believe that any such payment is not so excludible.

10.7 Indemnification of the Employers by Participants. If any Participant receives one or more payments or reimbursements under the Plan that are not for Dependent Care Expenses or Qualifying Health Care Expenses, such Participant shall indemnify and reimburse his or her 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 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.

10.8 Governing Law. Except to the extent federal law applies, this Plan shall be construed, administered and enforced according to the laws of the state identified in Section 20 of the Adoption Agreement.