MZQ CONSULTING, LLC PROTOTYPE HEALTH & WELFARE

Wrap Plan Document and Summary Plan Description (Including a Separate Cafeteria Plan)

MZQ CONSULTING, LLC PROTOTYPE HEALTH & WELFARE WRAP PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

PART I—GENERAL PLAN INFORMATION

This MZQ Consulting, LLC Prototype Health & Welfare Wrap Plan and Summary Plan Description, together with (1) the MZQ Consulting, LLC Prototype Health & Welfare Wrap Plan and Summary Plan Description Adoption Agreement, and (2) the related summaries, certificates, contracts, agreements, and insurance policies, constitute the official Plan Document and Summary Plan Description governing the Plan named in the Adoption Agreement as required by ERISA. These documents are available for review during normal work hours. You may also request copies of these documents. If a summary differs from the underlying contract, agreement, or insurance policy, the underlying document will control. In addition, the Plan Administrator or other personnel cannot modify the terms of the Plan through written or oral statements.

Nothing contained in this Plan Document/SPD creates any contractual employment agreement between you and the Plan Sponsor.

PART II—BENEFITS

The benefits available under the Plan are listed in Part II of the Adoption Agreement.

You will have the opportunity to enroll in most of the component welfare programs when you first become eligible and at least once per year after your initial eligibility date during open enrollment. You may also be automatically enrolled in certain benefits.

Generally, you may only change your benefit elections during the Plan Sponsor's annual open enrollment. However, you may be permitted to change your benefit elections, including the amount of your pre-tax contributions, if you experience certain qualifying changes, such as:

- Change in legal marital status, including marriage, death of spouse, divorce, legal separation or annulment;
- Change in number of dependents, including birth, death, adoption or placement for adoption;
- Change in employment status of you, your spouse or dependents, including termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave, change in worksite, or switching to an eligible or ineligible job category;
- Change in dependent eligibility; or
- Change in place of residence of you, your spouse or dependents.

These changes are often referred to as a "change in status" or a "life event." If a change in status occurs, you must complete a new enrollment form within 30 days. Your election change must be consistent with the change in status. You may also change your election if you experience certain significant cost or coverage changes, such as a significant curtailment of health or other coverage.

Certain other election changes may also be permitted. More details regarding permitted election changes are included below in the HIPAA Rights Section and in the Plan Sponsor's Cafeteria Plan.

PART III—ELIGIBILITY

If you are an employee or former employee of the Plan Sponsor, or a participating employer listed in Section I.K. of the Adoption Agreement, you may be eligible to participate in the Plan.

The waiting period(s) and eligibility criteria for each component benefit program under the Plan are listed in Section III of the Adoption Agreement. Additionally, any employee who is not otherwise eligible to participate under the Plan, but who meets the definition of full-time employee under Section 4980H of the Internal Revenue Code as determined based on the administrative policies of the Plan Sponsor, will be offered coverage under the component welfare programs subject to Patient Protection and Affordable Care Act (PPACA).

Your spouse, children, or other dependents may also be eligible for coverage, depending on the terms of the component welfare program.

Your participation in the Plan ends when you are no longer eligible for any of the component welfare programs, the Plan is terminated, or in the event of fraud or material misrepresentation of fact relating to coverage, subject to any protections in the PPACA or other applicable law.

The cost to participate in the Plan varies according to the component welfare programs in which you participate. Some of the component welfare programs may be provided by the Plan Sponsor at no cost to you. If you participate in the Plan Sponsor's Cafeteria Plan (also called a "Flexible Benefits Plan "or "Section 125 Plan"), you may be able to make pre-tax contributions to help pay the premiums for a benefit. Other benefits may require contributions on an after-tax basis.

Please see the summary booklets for the component welfare programs and the enrollment materials for details on the exact cost of these benefits to you.

PART IV—CLAIMS PROCEDURES

ERISA contains guidelines and time limits for responses to claims for benefits. The rules are different for Group Health Plan claims, disability claims, and other non-health claims. The following is a general summary of the claims procedures for these types of benefits. State law may require additional claims procedures for certain Plan benefits.

A. DISABILITY CLAIMS

1. Initial Claim. Generally, the people who handle your disability claim must process it within 45 days after they receive it. However, if they need more time, they will notify you that an additional 30-day processing period is required. Under certain circumstances, a second 30-day extension may be needed. The notice of extension will explain the Plan's standards for entitlement to disability benefits, the unresolved issues that are preventing a decision, and the additional information needed to resolve those issues. You will have 45 days to provide the necessary information.

2. Claim Denials. If your claim for disability benefits is wholly or partially denied, or your disability benefits are cancelled or discontinued retroactively (for reason other than your failure to pay for such benefits), you will receive notice of an adverse benefit determination. Any notice of adverse benefit determination under the Plan will:

    - State the specific reasons for the determination;
    - Refer to specific Plan provisions on which the determination is based;
    - Describe additional material or information necessary to complete the claim and why such information is necessary;

- Describe Plan procedures and time limits for appealing the determination, your right to obtain information about those procedures and the right to sue in federal court;

- If applicable, describe the basis for disagreeing with or not following:

    - Any documentation you present to the Plan, from any health care professional that has treated you or vocational expert that has evaluated you;
    - The views of any medical or vocational expert whose advice was obtained by the Plan in connection with the claim, regardless of whether the advice was relied on in making the adverse benefit determination; and

    - Any disability determination you present to the Plan made by the Social Security Administration.

- Disclose any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or provide notice that such rules, guidelines, protocols, standards or similar criterion do not exist);
- If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, the Plan will explain the scientific or clinical judgment for the determination, applying Plan terms to your medical condition (or the notice will state that such information will be provided free of charge upon request); and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claims for benefits.

3. Request for Review. If you believe your claim was denied in error, you have 180 days after receiving a denial to appeal the decision. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review and will not be influenced by the initial claim decision.

   A different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the Plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the Plan obtained the advice of a medical or vocational expert in connection with the denial of your claim, we will provide you with the names of each such expert, regardless of whether the advice was relied upon.

   Before denying your appeal, the Plan will provide you (free of charge) with:

   - Any new or additional information considered, relied upon, or generated by the Plan, the Plan Administrator, or any individual working at their direction in connection with the claim; and

   - Any new or additional rationale on which it intends to base its determination.

4. Decision on Review. Within 45 days after your request for review, the Plan Administrator will notify you of the final decision. (In special circumstances, an additional 45 days for processing will be allowed.)

   If your appeal is denied, the denial notice will:

   - State the specific reasons for the determination on appeal;

- Refer to specific Plan provisions on which the determination was based;
- State that you are entitled to receive upon request, and without charge, reasonable access to and copies of all documents, records and other information relevant to the determination;
- Describe any voluntary appeal procedures offered by the Plan and your right to obtain information about these procedures;
- Describe your right to bring a civil lawsuit under federal law and any contractual limitations under the Plan, on the time period available to you in which to bring such a lawsuit;
- If applicable, describe the basis for disagreeing with or not following:
    - Any documentation you present to the Plan, from any health care professional that has treated you or vocational expert that has evaluated you;
    - The views of any medical or vocational expert whose advice was obtained by the Plan in connection with the claim, regardless of whether the advice was relied on in making the adverse benefit determination; and
    - Any disability determination you present to the Plan made by the Social Security Administration.
- Disclose any internal rule, guideline, protocol, standard or similar criterion relied on in making the adverse determination (or provide notice that such rules, guidelines, protocols, standards or similar criterion do not exist); and
- If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgment for the determination, applying Plan terms to your medical condition (or the notice will state that such information will be provided free of charge upon request).

5. Impartiality. To ensure independence and impartiality, the Plan Administrator will not make decisions regarding the hiring, compensation, termination, promotion, or other similar matters related to any individual involved in adjudicating claims under this Plan (e.g., a claims adjudicator or medical or vocational expert), based on the likelihood that the individual will support a denial of benefits.

6. Language Assistance. If you live in a county in the United States where more than ten percent of the population is literate only in the same non-English language (as determined by the Department of Labor), you may request copies of any notices provided to you under Sections A.2 or 3 above in that non- English language. The Plan will also provide oral language services (such as a telephone customer assistance hotline) to you in that language.

B. OTHER NON-HEALTH CLAIMS

1. Initial Claim. Generally, the people who handle your claim must process it within 90 days after they receive it. However, if they need more time, they will notify you that an additional 90-day processing period is required. The notice of extension will indicate the special circumstances requiring an extension and the date by which a determination may be expected.
2. Claim Denials. You will be notified of any adverse benefit determination, including the specific reason(s) for the adverse determination and the provisions in the Plan Documents on which the determination was based. The notification will point out what additional information is needed, if any, that could change the adverse determination. The notice will also tell you how you can have your claim reviewed.

3. Request for Review. You will have 60 days to file a written request for review of an adverse benefit determination with the Plan Administrator. You may look at the documents relevant to your claim and submit issues and comments to the Plan Administrator in writing. You may also have a representative act on your behalf.

4. Decision on Review. Within 60 days after your request for review, the Plan Administrator will notify you of the final decision. (In special circumstances, an additional 60 days for processing will be allowed.) If an adverse benefit determination is made upon review, you will be told the specific reason(s) for the determination, and you will be given a reference to the Plan provisions on which the determination is based. You may look at the documents relevant to your claim.

C. HEALTH CLAIMS

1. Health Claims Generally. Claims procedures vary depending on whether the claim is an urgent care, pre-service, or post-service claim. For example, urgent care claims generally must be decided within 72 hours, pre-service claims generally must be decided within 15 days, and post-service claims generally must be decided within 30 days. The claims procedure for each type of claim is described separately below.

    a. Urgent Care Claims. Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain.

    The reasonable layperson standard is used for these claims, except that if a physician determines the condition is urgent, the Plan must accept the physician's determination.

    If your claim is complete:

    - The Plan has 72 hours after receiving your initial claim to approve or deny the claim.
    - If denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
    - The Plan has 72 hours after receiving your appeal to notify you of its appeal decision.

    If your claim is incomplete or improperly filed:

    - The Plan has 24 hours after receiving your initial claim to notify you that your claim is incomplete or that you failed to follow the Plan's procedures for filing claims.
    - You have 48 hours after receiving notice from the Plan to provide sufficient information to complete your claim.
    - The Plan has 48 hours to notify you if your claim is approved or denied. The Plan must do so within the earlier of 48 hours of:
        - Receiving your completed claim, or
        - Your deadline to complete the claim.
    - If denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
    - The Plan has 72 hours after receiving your appeal to notify you of its appeal decision.

    b. Pre-Service Claims. Group health claims where treatment must be pre-certified before it is performed.

If your claim is complete:

- The Plan has 15 days after receiving your initial claim to notify you if your claim is approved or denied.
- You have 180 days after receiving the claim denial to appeal the Plan's decision.
- The Plan has 15 days after receiving your appeal to notify you of its decision.
- If the Plan allows two levels of appeal, you have 180 days to appeal the decision. The Plan has 15 days after receiving your appeal to notify you of its decision.

If your claim is incomplete or improperly filed:

- The Plan has 5 days after receiving your initial claim to notify you that you failed to follow the Plan's procedures for filing claims.
- The Plan has 15 days after receiving your claim to notify you of its decision to approve or deny the claim. If the Plan needs more information and provides an extension notice during the initial 15-day period, the Plan has 30 days after receiving the claim to notify you of its decision. (The time the Plan waits for claimant information is not counted in totals.)
- You have 45 days after receiving the extension notice to provide any additional information to complete your claim.
- If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
- The Plan has 15 days after receiving your appeal to notify you of its decision.
- If the Plan allows two levels of appeal, you have 180 days to appeal the decision. The Plan has 15 days after receiving your appeal to notify you of its decision.

c. Post-Service Claims. Group health claims where you request reimbursement after treatment has been performed.

If your claim is complete:

- The Plan has 30 days after receiving your initial claim to notify you if your claim is denied.
- If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
- The Plan has 30 days after receiving your appeal to notify you of the appeal decision.
- If the Plan allows two levels of appeal, you have 180 days to appeal the decision. The Plan has 30 days after receiving your appeal to notify you of the appeal decision.

If the Plan needs further information or an extension:

- The Plan has 30 days after receiving the initial claim to notify you if your claim is denied. If the Plan needs more information and provides an extension notice during the initial 30-day period, the Plan has 45 days after receiving the claim to notify you

if your claim is denied. (The time the Plan waits for claimant information is not counted in totals.)

- You have 45 days after receiving the extension notice to provide any additional information to complete your claim.
- If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
- The Plan has 30 days after receiving your appeal to notify you of the appeal decision.
- If the Plan allows two levels of appeal, you have 180 days to appeal the decision. The Plan has 30 days after receiving your appeal to notify you of the appeal decision.

2. Claim Denials. If your claim for health benefits is wholly or partially denied, any notice of adverse benefit determination under the Plan will:

   - State the specific reasons for the determination;
   - Refer to specific Plan provisions on which the determination is based;
   - Describe additional material or information necessary to complete the claim and why such information is necessary;
   - Describe Plan procedures and time limits for appealing the determination, your right to obtain information about those procedures and the right to sue in federal court;
   - Disclose any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or the notice will state that such information will be provided free of charge upon request).
   - If the denial is based on medical necessity or experimental treatment, the Plan will explain the scientific or clinical judgment for the determination, applying Plan terms to your medical condition (or the notice will state that such information will be provided free of charge upon request); and
   - For urgent care claims, the denial notice will include a description of the expedited review process for those claims. This denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification.

3. Request for Review. If you believe your claim was denied in error, you have 180 days after receiving a denial to appeal the decision. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review and will not be influenced by the initial claim decision.

   A different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the Plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the Plan obtained the advice of a medical or vocational expert in connection with the denial of your claim, we will provide you with the names of each such expert, regardless of whether the advice was relied upon.

If your appeal is denied, the denial notice will:

- State the specific reasons for the determination on appeal;
- Refer to specific Plan provisions on which the determination was based;
- State that you are entitled to receive upon request, and without charge, reasonable access to and copies of all documents, records, and other information relevant to the determination;
- Describe any voluntary appeal procedures offered by the Plan and your right to obtain information about these procedures;
- Describe your right to bring a civil lawsuit under federal law;
- Disclose any internal rule, guideline, protocol or similar criterion relied in making the adverse determination (or the notice will state that such information will be provided free of charge upon request); and
- If the denial is based on medical necessity or experimental treatment, explain the scientific or clinical judgment for the determination, applying Plan terms to your medical condition (or the notice will state that such information will be provided free of charge upon request).

D. ADDITIONAL INTERNAL CLAIMS AND APPEALS PROCEDURES FOR HEALTH CLAIMS

Any adverse claims determination will include:

- Information necessary to identify the claim, including the date of service, the health care provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis and treatment codes, along with the corresponding meaning of these codes;
- The reason for the adverse claims determination, including a description of the standard, if any, used in denying the claim;
- A description of available internal appeals and external review procedures, including information about how to initiate an appeal; and
- A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform to assist individuals with the internal claims and appeals and external review procedures.

Any such determination will be provided in a "culturally and linguistically appropriate manner" as defined by the PPACA.

E. ADDITIONAL EXTERNAL CLAIMS AND APPEALS PROCEDURES FOR HEALTH CLAIMS

For fully insured plans, these procedures will be prescribed by state law and/or described in the underlying contract, agreement, or insurance policy.

The procedures below apply to self-insured programs.

1. Right to External Review. An adverse benefit determination will be eligible for external review if:

    - It involves medical judgment, whether the Plan is complying with the surprise billing and cost-sharing protections in the No Surprises Act, or relates to a retroactive termination of coverage (for a reason other than the failure to pay premiums); and

- The claims administrator does not follow all the claims and appeals requirements under federal law, or the standard levels of appeal have been exhausted.

2. Notice of External Review Rights and Assignment to IRO (Independent External Review Organization). If your final internal appeal is denied, you will be notified in writing that your claim is eligible for external review, and you will be informed of the steps necessary to request an external review. You will have 4 months from the date of the denial to file your request for external review.

   If you decide to seek external review, an IRO will be assigned to your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise to review your claim. The ultimate decision of the IRO is binding on all parties.

3. Preliminary Review. Within 5 business days of receipt, your request for an external review will be evaluated to confirm:

   - You were covered under the program at the time the service was requested or provided;
   - The determination relates to medical judgment or a rescission of coverage;
   - You have exhausted the internal appeals process (or the claims administrator failed to follow the appropriate claims and appeals procedures); and
   - You have provided all of the paperwork necessary to complete the external review.

   Within one business day of completing its initial assessment, the claims administrator will provide you with written notice of its determination. If your request is complete, but not eligible for external review, the claims administrator will provide you with:

   - The reason(s) your request is ineligible for external review, and
   - Contact information for the Employee Benefits Security Administration: toll-free number 866-444-EBSA (3272).

   If your request is not complete, the notice will describe the missing information or materials. You will have until the later of the last day of the original 4-month filing period or 48 hours from the receipt of the notice to provide that information to the claims administrator.

4. Referral to the IRO. If your request is eligible for external review, the claims administrator will assign it to an accredited IRO and provide the IRO with the internal file and other materials considered during the internal appeals process. The IRO will notify you in a timely manner relied, in writing, that it is reviewing your claim and provide you with the opportunity to submit additional information you believe should be considered by the IRO. You will have 10 business days from your receipt of this notice to provide the IRO with additional information. The IRO will forward any information you provide to the claims administrator so that it may consider whether to approve your claim based on the new information.

5. Review by the IRO. The IRO will review any information or documents you provide within the 10-day window. In reaching its decision, the IRO is not bound by any decisions or conclusions reached by the claims administrator. Where appropriate, the IRO will also review:

   - Your medical records;
   - The attending health care professional's recommendation;
   - Reports from appropriate health care professionals and other documents submitted by the Plan,

you or your treating provider;

- The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan (unless the terms are inconsistent with applicable law);

- Appropriate practice guidelines, including applicable evidence-based standards, and any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

- Any applicable clinical review criteria developed and used by the claims administrator unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

- The opinion of the IRO's clinical reviewer.

The IRO will provide written notice of the final external review decision to you, the claims administrator, and the Plan within 45 days of the date it receives the claim.

If the IRO overturns the claims administrator's denial of your claim, the Plan will immediately provide coverage or payment for your claim.

6. Expedited External Review. You may immediately request an expedited external review at the time you receive:

   - An initial internal claim denial involving a medical condition that would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines;

   - A final internal claim denial involving a medical condition that would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines; or

   - A final internal appeal denial involving an admission, availability of case, continued stay, or a health care item or service for which you received emergency services, but have not been discharged from a facility.

   Immediately upon receipt of your request, the claims administrator will determine whether the request is eligible for expedited external review. The claims administrator will immediately send you a notice of its eligibility determination.

7. Referral of Expedited Review to IRO. Upon a determination that a request is eligible for expedited external review following a preliminary review, the claims administrator will assign an IRO. The IRO will render a decision as quickly as your medical request or the circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, the assigned IRO will provide you, the claims administrator, and the Plan with a written notification of its decision within 48 hours.

8. Maintenance of Appeals Records. The IRO will maintain records of all claims and notices associated with the external review process for 6 years. The records will be available for examination by you, the Plan, or any state or federal oversight agency upon request, except where disclosure would violate state or federal privacy laws.

F. GENERAL

You and the 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.

You must complete the Plan's procedures for filing and appealing claims before you can file any litigation with respect to an adverse benefit determination.

You must commence any legal action to recover benefits under the Plan within two years after the Plan Administrator issues its final determination on appeal.

Please see the summary that applies to your benefits for more details on the claims procedure. If a summary for a particular benefit contains procedures that are different than those described above, those procedures will control over the procedures described above. Some insurers may require that you submit your claims to a specific person or may require certain documentation.

PART V—PLAN FUNDING

Each component welfare program governs the amount and timing of participant contributions and any contributions that the Plan Sponsor is required to make. All Plan assets must be used for the exclusive benefit of Plan participants and their beneficiaries.

Plan benefits will be paid in the form, in the amount, and pursuant to the terms of each component welfare program. A participant's or beneficiary's benefits, rights and interests under the Plan cannot be transferred, assigned or otherwise alienated unless lawfully permitted under the terms of a component welfare program or required by law.

Plan benefits are provided through insurance contracts and from the general assets of the Plan Sponsor. No assets or funds are paid to, held in, or invested in any separate trust. No participant or beneficiary has any right to, or interest in, the assets of the Plan Sponsor. Any premiums or rebates issued under an insurance contract held by the Plan Sponsor will be attributable to the Plan Sponsor's contributions (up to the total the Plan Sponsor contribution), and therefore will not be Plan assets.

Most of the component welfare programs available under the Plan are fully insured. Under these programs, the insurer guarantees payment of all benefits due under the insurance contract. The insurer determines if, and at what rate, claims are reimbursable under the policy and pays claims. The Plan Sponsor and its employees make contributions for this coverage. The insurers for each fully insured program are listed in Section II of the Adoption Agreement.

Any other benefits under the Plan are self-funded by the Plan Sponsor. No insurance company guarantees these benefits.

PART VI—SITUATIONS THAT MAY IMPACT BENEFITS

A. PLAN AMENDMENT OR TERMINATION

The Plan Sponsor expects to continue the Plan indefinitely. However, the Plan Sponsor reserves the right to amend or terminate the Plan or contribution rates at any time. Plan amendments will be in writing. Amendments may, but are not required to, be made by inserting a dated replacement page into this Plan document.

In addition, the Plan Sponsor can change or replace the group insurance, administrative services, or other contracts and agreements through which benefit claims are paid under the Plan. If the Plan Sponsor amends the Plan to eliminate Plan benefits for some or all participants, or terminates the Plan, the rights of a participant covered under the Plan are limited to the payment of eligible expenses incurred prior to the Plan's amendment or termination.

B. RIGHT OF RECOVERY

At times, you may be asked to provide information or proof of your right to a benefit under the Plan. If you fail to submit the requested information or proof, make a false statement, or furnish fraudulent or incorrect information, your benefits under the Plan may be denied, suspended or discontinued by the Plan Administrator at its sole and absolute discretion.

If a component welfare program makes payment for benefits that are more than expenses actually incurred or amounts allowed under the Plan, due to error, fraud, or any other reason, the Plan reserves the right to recover the overpayment plus interest and costs, by whatever means necessary. For example, the Plan may require you to return the overpayment, offset your future benefit payments, or take legal action.

C. REPAYMENT OF HEALTH BENEFITS (SUBROGATION AND REIMBURSEMENT)

The Plan will not pay benefits for covered expenses related to an illness or injury that is the result of an act or omission of another if you pursue, or have the right to pursue, a recovery for that act or omission. For example, if you are injured in an auto accident and either your insurance company or the other driver's insurance company settles with you, you must reimburse the Plan for the benefits the Plan provided to you for your medical expenses resulting from the accident, but only up to the amount of your settlement.

By accepting benefits related to such an illness or injury, you agree:

- That the Plan has established a lien in the amount of any benefits paid on your behalf from the Plan on any recovery received by you or your legal representative or agent;
- That you will notify any third party responsible for your illness or injury of the Plan's right to reimbursement;
- That you will notify the Plan within 30 days of the date when any notice is given to any party, including an attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to any injury, illness or condition for which the Plan has paid benefits;
- That you will promptly reimburse the Plan from any reimbursement or recovery, even if you are not fully compensated or made whole for your loss (or the recovery is not specifically identified as a reimbursement of medical expenses);
- That the Plan's claim is not subject to reduction for attorneys' fees or costs under the "common fund" doctrine or otherwise;
- That if you do not pursue your claim(s) against the third party, the Plan will be equitably subrogated to your right of recovery and may pursue your claims;
- That you will assign, upon the Plan's request, any right or cause of action to the Plan;
- That you will complete all forms and provide all information requested by the Plan in a timely manner, including completing and submitting any applications or other forms or statements the Plan may reasonably request;
- That you will not take or fail to take any action to prejudice the Plan's ability to recover the benefits paid;

- That the source and timing of any recovery do not matter. The Plan has the right to be reimbursed whether the recovery is made to you or on your behalf, in a single payment or over a period of time, or collected by an action at law, judgment, settlement or otherwise;

- That the Plan's lien may be enforced by any claims administrator or any entity acting as the Plan's delegate or as the provider of administrative services to the Plan;

- That the Plan's rights under these provisions will take precedence over the rights of any other third parties relative to any other third parties; and

- That you will cooperate in doing what is reasonably necessary to assist the Plan in obtaining reimbursement.

No benefit will be payable for charges and expenses that are excluded from coverage under other provisions of the Plan. The Plan may enforce its right to reimbursement by whatever means necessary. For example, the Plan may recoup the amount owed from your future benefits (regardless of whether you have assigned your benefits to the doctor, hospital or other provider), take legal action, and/or pursue equitable remedies such as the imposition of a constructive trust or equitable lien upon particular funds or property.

The Plan Administrator may, at its sole and absolute discretion, permit you to turn over less than the full amount of benefits reimbursed or recovered.

PART VII—YOUR RIGHTS UNDER THE PLAN

A. ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

   Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

2. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

3. Continue Group Health Plan Coverage. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

4. Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining

a welfare benefit or exercising your rights under ERISA.

5. Enforce Your Rights. If your claim for a welfare 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 Plan 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, as adjusted for inflation, 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'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 the Plan's 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.

6. 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.

B. USERRA RIGHTS

If you are returning from uniformed service, you have certain rights with respect to the Plan pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In addition, special health care continuation coverage rules may apply while you are performing military service. Contact the Plan Administrator for more information.

C. FMLA RIGHTS

If you take a leave of absence for your own serious health condition or to care for a family member with a serious health condition or to care for a newborn or adopted child, or if you take certain kinds of military family leave, you may be able to continue your health coverage under the Family and Medical Leave Act (FMLA). If you drop your health coverage during the leave, you can also have your health coverage reinstated on the date you return to work, assuming you pay any contributions required for the coverage. Contact the Plan Administrator for more information.

D. MATERNITY RIGHTS

Under federal law, Group Health Plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse-midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

E. RECONSTRUCTIVE SURGERY RIGHTS

Federal law requires that Group Health Plans and health insurance issuers offering group health insurance coverage and providing medical and surgical benefits for mastectomies must also cover:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

The coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Please see the summary for your health care coverage for any deductibles and co-insurance limitations applicable to this coverage.

F. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If a qualified medical child support court order (QMCSO) issued in a domestic relations proceeding (*e.g.*, a divorce or legal separation proceeding) requires you to cover a child who is not in your custody under a Group Health Plan, you may do so. To be qualified, a medical child support order must include:

- Name and last known address of the parent who is covered under the Group Health Plan;
- Name and last known address of each child to be covered under the Group Health Plan;
- Type of coverage to be provided to each child; and
- Period of time the coverage is to be provided.

An appropriately completed National Medical Support Order is also treated as a QMCSO. QMCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Group Health Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Group Health Plan. Your child will be treated as a beneficiary covered under the Group Health Plan and will be entitled to information that the Group Health Plan provides to participants under ERISA's reporting and disclosure rules. You may request a free copy of the QMCSO procedures from the Plan Administrator at any time.

G. COBRA RIGHTS

If you leave your employment with the Plan Sponsor, your participation in the Group Health Plan generally ends. However, you and your dependents may be eligible to continue participation in the Group Health Plan under COBRA. You may also be able to elect an alternative to COBRA, as described below.

The Plan's COBRA Administrator is identified in Section I.L. of the Adoption Agreement.

1. COBRA Eligibility.

   a. Generally. You are eligible for COBRA under the Plan:

      - If you are an employee and you lose medical coverage because your employment with the Plan Sponsor ends (other than for gross misconduct) or your hours are reduced, you may continue your medical coverage for up to 18 months from the date your employment ends or your hours are reduced. You may also choose continuation coverage for any children born to you or placed with you for adoption while you are receiving continuation coverage.

      - If you are the employee's dependent child, spouse, or former spouse, you may continue your medical coverage for:

         - Up to 18 months if you lose medical coverage because the employee's employment with the Plan Sponsor ends (other than for gross misconduct) or the employee's hours are reduced;

         - Up to 36 months, if you lose medical coverage because of the employee's death, divorce, legal separation, or entitlement to Medicare;

         - Up to 36 months, if you are the employee's dependent child and you lose medical coverage because you are no longer considered a dependent.

      - In most cases, your COBRA premium will be the full cost of the health coverage you elect (including any portion usually paid by the Plan Sponsor), plus a 2% administrative fee.

   b. Limited COBRA for Health Care Spending Account. You may continue your participation in the Health Care Spending Account only until the end of the current Plan Year. In addition, you are only eligible for COBRA if, on the date of your qualifying event, you have elected to contribute more money to your Health Care Spending Account for the Plan Year than you have taken out in your claims.

   c. Special Rules for Second Qualifying Events. If you are receiving 18 months of COBRA coverage because of an employee's termination or reduction in hours, and you lose medical coverage again because of the employee's death, divorce, legal separation or Medicare entitlement, or your loss of dependent child status, your maximum COBRA period may increase from 18 to 36 months, measured from the employee's termination or reduction in hours. (This extension is not available if the second qualifying event by itself would not have caused you to lose medical coverage.)

   d. Disability Extension. If you (or a covered family member) are disabled for Social Security purposes before the 60th day of COBRA coverage due to employment termination or reduction in hours, you may be entitled to 29 months of COBRA coverage instead of 18 months. Non-disabled family members are also entitled to this extension. The COBRA premium is 150% of the full cost of the medical coverage, including any portion usually paid by the Plan Sponsor, for the additional months.

      To obtain the 11-month extension, your disability must last until the end of the original 18-month COBRA period. In addition, you must notify the Plan Administrator before the end of the original 18-month COBRA period, and within 60 days of the latest of the following events: (1) the date of the Social Security disability determination, (2) the date of employment termination or reduction in hours, or (3) the date on which medical coverage would end because of the employment termination or reduction in hours. You must provide this notice to the COBRA Administrator at the address listed in Section I.L. of the Adoption Agreement, along with a copy of the Social Security disability

determination.

If you no longer qualify for Social Security disability benefits, you must notify the Plan Administrator within 30 days after the date of the Social Security Administration's final determination. You must provide this notice to the COBRA Administrator at the address listed in Section I.L. of the Adoption Agreement, along with a copy of the final Social Security disability determination. COBRA coverage will end, effective with the month that begins more than 30 days after the date on which Social Security determines that you are no longer disabled.

e. Extension Because of Employee's Prior Entitlement to Medicare. If you are an employee who enrolled in Medicare Part A or Part B less than 18 months before your employment termination or reduction in hours, the maximum COBRA period for your covered spouse or children is extended to 36 months from the date you enrolled in Medicare. (The employee's maximum COBRA period is still 18 months.) COBRA periods are measured from the date of the event which causes you to lose medical coverage (termination of employment, divorce, death, etc.)

f. Early Termination of COBRA Rights. COBRA coverage can end early for several reasons, including:

- You do not pay the required COBRA premium on time;
- You become covered under another Group Health Plan that does not contain any exclusion or limitation which applies to any pre-existing condition you may have;
- After you have elected COBRA, you become entitled to Medicare;
- The Plan Sponsor no longer provides group health coverage to any of its employees;
- If you are receiving extended coverage because you (or a family member) are disabled, the Social Security Administration determines that you (or your family member) are no longer disabled; or
- If your Group Health Plan is cancelled due to fraud.

2. Notice Requirements.

a. Notice of Qualifying Event. You or a family member must inform the Plan Administrator within 60 days of a divorce, legal separation, or child losing dependent status (or within 60 days of the date on which medical coverage would end, if later). You must provide this notice to the Plan Sponsor in writing, along with supporting documentation (such as a divorce decree). The Plan Sponsor must inform the Plan Administrator within 30 days of a death, termination of employment, reduction in hours, or Medicare entitlement. The Plan Administrator must then inform you within 14 days of your rights to COBRA continuation coverage.

b. Notice of Second Qualifying Event. If your covered spouse or children have a second qualifying event while on COBRA coverage due to your employment termination or reduction in hours, you (or your spouse or child) must inform the Plan Administrator within 60 days after the second qualifying event. You must provide this notice to the Plan Sponsor in writing, along with supporting documentation (such as a divorce decree).

c. Notice of New Dependents. If you wish to choose COBRA coverage for any children born to you or placed with you for adoption while you are receiving COBRA coverage, you must notify the Plan Administrator within 30 days of the birth or placement for adoption. You must provide this notice to the Plan Sponsor in writing, along with supporting documentation.

3. Electing and Paying for COBRA Continuation Coverage. You must elect COBRA coverage within 60 days after the date you are notified of your COBRA rights (or, if later, the date your medical coverage

would otherwise end). A covered employee or spouse who experiences a COBRA qualifying event can make a COBRA election on behalf of all family members with respect to that qualifying event. A minor child's parent or guardian can make a COBRA election for the child. You must submit your election form to the address shown on the COBRA notice.

You must submit your first monthly payment within 45 days after you elect COBRA coverage. Your first payment must cover the months from the date your medical coverage would otherwise end to the time of your first payment. Subsequent monthly payments are due by the first day of each month. COBRA premiums must be sent to the COBRA Administrator. If the COBRA Administrator receives your COBRA premium more than 30 days late, your COBRA coverage will end. In most cases, your COBRA premium will be the full cost of the medical coverage (including any portion usually paid by the Plan Sponsor), plus a 2% administrative fee.

4. Special COBRA Rights Under the Trade Act of 2002. The Trade Act of 2002 created a tax credit for certain retired employees receiving pension payments from the Pension Benefit Guarantee Corporation (PBGC) and for certain individuals who become eligible for trade adjustment assistance (TAA) pursuant to the Trade Act of 1974. (Workers whose employment is adversely affected by international trade [increased imports or a shift in production to another country] may become entitled to receive TAA.) Under these provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage.

   The Trade Act of 2002 also provides a second 60-day COBRA election period for TAA-eligible individuals (but not for PBGC-eligible individuals). If you are a TAA-eligible individual, and you did not elect COBRA coverage during the 60-day election period that directly resulted from your TAA-related loss of health coverage, you are entitled to a second 60-day COBRA election period. You may elect COBRA coverage for you and your family during the 60-day period that begins on the first day of the month in which you are determined to be a TAA-eligible individual, as long as you make your election within 6 months after your TAA-related loss of health coverage. COBRA coverage will begin with the first day of your second COBRA election period. It will not be retroactive to the date you originally lost health coverage.

5. Alternatives to COBRA. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

   Additionally, you may qualify for a 30-day special enrollment period for another Group Health Plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You can learn more about many of these options at www.healthcare.gov. Your COBRA election form will also contain information to help you decide whether to elect COBRA, to enroll in Marketplace coverage, or to enroll in another Group Health Plan.

   You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

   When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

H. HIPAA SPECIAL ENROLLMENT RIGHTS

1. After Declining Coverage. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or Group Health Plan coverage, you may be able to enroll

yourself and your dependents in the Group Health Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

2. New Dependents. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

3. Coordination with Medicaid and CHIP. If you or your dependents are covered under a state Medicaid Plan or CHIP, you may be able to enroll yourself and your dependents if you or your dependents lose eligibility for coverage under Medicaid or CHIP. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends. You may also request enrollment within 60 days of becoming eligible for state premium assistance under Medicaid or CHIP.

4. Special Enrollment Procedures. To request special enrollment or obtain more information, contact the Plan Sponsor.

I. HIPAA PRIVACY AND SECURITY RIGHTS

A Group Health Plan generally cannot use or disclose your individually identifiable health information (i.e., Protected Health Information or "PHI") or that of your dependents, except as authorized by you or by the regulations issued by the Department of Health and Human Services (HHS). However, de-identified health information (e.g., health information from which the name, Social Security Number, and similar identifying information have been removed) is not protected. In addition, the health privacy regulations broadly authorize claims administrators and other health plan vendors to routinely use and disclose protected health information for treatment, payment, or health care operations. In contrast, employers can use PHI only under very strict conditions.

A complete description of your privacy rights under HIPAA can be found in the Notice of Privacy Practices distributed to Group Health Plan participants.

J. GINA RIGHTS

Group Health Plans must comply with the requirements of the Genetic Information Non-discrimination Act of 2008 (GINA). The Plan will not request or require you to undergo genetic tests and will not collect genetic information prior to or in connection with enrollment, or for underwriting purposes.

K. PATIENT PROTECTION AND AFFORDABLE CARE ACT RIGHTS

The PPACA applies to the component welfare programs under the Plan that are "Group Health Plans" under HIPAA and not otherwise subject to an exception under PPACA.

PPACA does not apply to limited scope dental and vision benefits provided through the Plan.
Each of the component welfare programs subject to PPACA will comply with its applicable rules. In the event of a conflict between a component benefit program and this Section, the terms of the component benefit program will control so long as its terms comply with PPACA.

1. Prohibition on Pre-Existing Condition Exclusions. No limitations or exclusions from benefits (including a denial of coverage) will be based on the fact that a condition was present before the effective date of coverage (or if coverage is denied, the date of the denial).

2. Limitation on Waiting Periods. The period of time that must pass before coverage begins for an otherwise eligible employee or dependent will not exceed 90 days.

3. Cost-Sharing Limit. The total "cost-sharing" obligation on participants, including deductibles, co-insurance, co-payments and other similar charges, for essential health benefits will not exceed the annual limit on cost-sharing established under Section 1302(c)(1) of PPACA. For 2022, this limit is $8,700 for self-only coverage and $17,400 for family coverage. It will be indexed for inflation in future years.

4. Clinical Trials. The component welfare program will not:

    - Deny any qualified individual the right to participate in a clinical trial;
    - Deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in a clinical trial; or
    - Discriminate against any qualified individual who participates in a clinical trial.

    For this purpose, a "clinical trial" is a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is (1) federally approved or funded (by an agency listed under PPACA), (2) conducted under an investigational new drug application reviewed by the FDA, or (3) a drug trial that is exempt from filing an investigational new drug application.

5. First Dollar Coverage for Preventive Care. No cost-sharing requirements will apply to preventive care services (as defined by PPACA).

6. Designation of Primary Care Provider/Pediatrician. If a component benefit program requires/allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the Health Plan's network and who is available to accept you or your family members. For any dependent who is a child, you may designate a primary care provider who is a pediatrician.

7. Access to OB/GYN. No preauthorization or referral requirement will apply to obstetrical or gynecological care.

8. Coverage for Emergency Services. Coverage for emergency services will:
    - Not require pre-authorization, including for services provided out-of-network;
    - Be available whether the provider is in- or out-of-network;
    - Not be subject to any administrative requirement or coverage limitation that is more restrictive than those that apply to in-network emergency services;
    - Not apply higher co-payments or co-insurance rates for out-of-network emergency services than apply to in-network emergency services.
    - Comply with the provisions of the No Surprises Act and its related regulations regarding the coverage of emergency services and all related prohibitions on balanced billing for out-of-network services.

9. Coverage of Adult Children Through Age 26. Where dependent coverage is available, the adult children of eligible employees will be eligible for that coverage until they turn age 26.

10. No Annual or Lifetime Limits. No annual or lifetime limits will be applied to essential health benefits.

11. No Rescission. Your coverage under the Plan will only be retroactively cancelled in the event of a failure to pay premiums or in the case of fraud or a misrepresentation of a material fact. You will be provided with prior written notice at least 30 days before coverage is cancelled as a result of fraud or a

misrepresentation of material fact.

For purposes of this rule, enrolling an ineligible individual or otherwise failing to comply with the Plan's eligibility requirements constitutes fraud or an intentional misrepresentation of a material fact. If your coverage is rescinded, you will be liable for any benefits paid by the Plan on your behalf prior to the date of rescission.

L. COVID-19 DIAGNOSTIC TESTING RIGHTS

No cost-sharing will apply to diagnostic testing for COVID-19 to the extent required by the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security Act, and any successor statutes thereto.

M. NO SURPRISES ACT RIGHTS

The No Surprises Act ("NSA") applies for plan years beginning on or after January 1, 2022. Under the NSA, you will be entitled to pay any applicable cost-sharing as if you received services from an in-network provider for any "protected services" you receive from a non-network provider. For this purpose, "protected services" include: (1) emergency services, as defined by applicable regulations under the NSA, (2) non-emergency services provided by a non-network provider at an in-network facility (unless you have expressly waived this right), and (3) covered non-network air ambulance services.

N. MENTAL HEALTH PARITY RIGHTS

To the extent that the Plan provides mental health and substance use disorder benefits, such benefits will be provided in a manner that complies with the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008.

PART VIII—HIPAA PRIVACY AND SECURITY RULES

The Plan may include programs that are considered "Group Health Plans" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Each of these Group Health Plans will comply with HIPAA's privacy and security standards and the requirements of the Health Information Technology for Economic and Clinical Health Act (HITECH).

(Note: These rules do not apply if the program has fewer than 50 participants and is administered entirely in-house.)

A. SHARING PHI WITH THE PLAN SPONSOR

HIPAA safeguards "protected health information," or "PHI." PHI is information that relates to an individual's past, present, or future physical or mental health or condition, or to providing health care to the individual. PHI also can relate to the past, present, or future payment for providing health care. To be PHI, there must be a reasonable basis to believe that the information can be used to identify the individual. In addition, the information must be created or received by a health care provider, health plan, employer, or health care clearinghouse.

The Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses the information only for "plan administration functions" that the Plan Sponsor performs on the Plan's behalf. Plan administration functions include payment and health care operations, such as quality assurance, claims processing, auditing and monitoring.

B. SAFEGUARDING PHI SHARED WITH THE PLAN SPONSOR

If the Plan (or a health insurance issuer or HMO on behalf of the Plan) shares PHI with the Plan Sponsor, the Plan Sponsor must comply with certain safeguards. Specifically, the Plan Sponsor must:

- Not use or further disclose PHI other than as the Plan documents permit or require, or as required by law;
- Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other Plan Sponsor benefit or the Plan Sponsor employee benefit plan unless authorized by an individual;
- Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with the HIPAA regulations;
- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA regulations:
    - Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;
    - If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
    - Ensure that adequate separation between the Plan and the Plan Sponsor is established.

C. ENSURING ADEQUATE SEPARATIONS BETWEEN THE PLAN AND THE PLAN SPONSOR

Employees only have access to, use, and disclose PHI to the extent necessary to carry out the plan administration functions that the Plan Sponsor performs for the Plan. If the Plan Sponsor becomes aware that any of these persons has not complied with the HIPAA safeguards, the Plan Sponsor will inform the Plan. The Plan will investigate the violation and determine, in accordance with the privacy policies and procedures for the Plan, what sanctions, if any, will be imposed.

D. CERTIFICATION FROM THE PLAN SPONSOR

The Plan will not disclose PHI to the Plan Sponsor until the Plan receives a certification from the Plan Sponsor that the Plan documents include the above safeguards, and that the Plan Sponsor has agreed to these safeguards.

E. OTHER PERMITTED DISCLOSURES TO THE PLAN SPONSOR

In addition to disclosing PHI as described above, the Plan (or a health insurance issuer or HMO on the Plan's behalf) may share information with the Plan Sponsor as otherwise permitted by HIPAA, including the following:

- The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled or has disenrolled from a health insurance issuer or HMO offered by the Plan.

- The Plan may disclose "summary health information," as defined in the HIPAA regulations, to the Plan Sponsor if the Plan Sponsor requests the information to obtain premium bids or to modify, amend, or terminate the Plan. Summary health information summarizes the claims history, claims expenses, or types of claims experienced by Plan participants. Names and certain other identifying information must be removed.

- The Plan may disclose PHI to the Plan Sponsor consistent with a valid authorization from the individual.

F. SECURITY STANDARDS FOR ELECTRONIC PHI

These security standards apply to PHI that is transmitted by electronic media or maintained in electronic media ("electronic PHI"). If the Plan (or a health insurance issuer or HMO on behalf of the Plan) shares electronic PHI with the Plan Sponsor, the Plan Sponsor must comply with certain safeguards. Specifically, the Plan Sponsor must:

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

- Ensure that the adequate separation required by the HIPAA privacy provisions is supported by reasonable and appropriate security measures;

- Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides electronic PHI, agree to implement reasonable and appropriate security measures to protect such electronic PHI; and

- Report to the Plan any security incident of which it becomes aware.

G. BREACH REPORTING

The Plan Sponsor will promptly report to the Plan any breach of unsecured PHI of which it becomes aware, in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, pursuant to HHS regulations or other applicable guidance.

PART IX—PLAN ADMINISTRATOR

A. ERISA

The Plan is subject to a federal law, the Employee Retirement Income Security Act of 1974 (ERISA). Although the Plan provides for a variety of benefits, the Plan is a single welfare benefit plan for ERISA purposes. The Plan is intended to meet all applicable requirements of ERISA and the Internal Revenue Code, as well as rulings and regulations issued under ERISA and the Code. However, not all the component welfare programs under the Plan are subject to ERISA.

B. NAMED FIDUCIARY

Every ERISA plan has a "Named Fiduciary" who controls and manages the Plan's operation and administration. The Plan's "Named Fiduciary" is the Plan Sponsor listed in Section I.B. of the Adoption Agreement.

The Plan Sponsor may delegate responsibilities for the Plan's operation and administration, may employ persons to assist in fulfilling its responsibilities under the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

C. PLAN ADMINISTRATOR

Every ERISA plan has a "Plan Administrator." The Plan Administrator is the Plan Sponsor listed in Section I.B. of the Adoption Agreement, or any person or committee that the Plan Sponsor appoints to administer the Plan. The Plan Administrator determines eligibility, interprets the Plan, and determines whether a claim should be paid or denied.

The Plan Administrator may delegate its responsibilities under the Plan. Unless the Plan Administrator determines otherwise, a party designated as responsible for benefits administration under a component welfare program is delegated the responsibility for the operation and administration of that component welfare program.

The Plan Administrator (and its delegates) have full discretion to construe and interpret the Plan, and to decide all matters arising under the Plan, including whether you are eligible for Plan participation and/or entitled to Plan benefits. The Plan Administrator (and its delegates) may use their discretion to resolve conflicts between the provisions of the various documents that make up the Plan. The determinations of the Plan Administrator (and its delegates) are final and binding on you and all other parties, except as otherwise provided by law. Because the Plan Administrator has full discretion to construe and interpret the Plan, decisions made by the Plan Administrator will be given deference if reviewed by a court.

D. FIDUCIARY DUTIES AND RESPONSIBILITIES

Both the Named Fiduciary and the Plan Administrator are Plan fiduciaries under ERISA. The Plan may have other fiduciaries as well. Each Plan fiduciary must discharge his or her duties with respect to the Plan solely in the interest of Plan participants and their beneficiaries, for the exclusive purpose of providing benefits to those individuals and defraying reasonable expenses of Plan administration, and in accordance with the terms of the Plan. Each fiduciary must act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising that authority.

A fiduciary may serve in more than one fiduciary capacity. A named fiduciary may allocate any of the named fiduciary's responsibilities for the Plan's operation and administration to other fiduciaries. Either the named fiduciary or other fiduciary appointed by the named fiduciary may employ one or more persons to render advice regarding any responsibilities the fiduciary has under the Plan.

E. PLAN CONSTRUCTION

The Plan will be construed and enforced according to the law of the State listed in the Plan Sponsor's address in Section I.C. of the Adoption Agreement, to the extent not preempted by federal law which will otherwise control. If any Plan provision is held invalid or unenforceable, the Plan will be construed and enforced as if the invalid or unenforceable provision had not been included in the Plan.

CAFETERIA PLAN

CAFETERIA PLAN

This Cafeteria Plan only applies if elected in Section IV of the Adoption Agreement. It permits eligible employees of the Plan Sponsor listed in Section I.B. of the Adoption Agreement to pay for certain benefits on a pre-tax basis. The Cafeteria Plan is intended to comply with the rules for cafeteria plans in Internal Revenue Code Section 125 and will be administered and construed so as to comply with those rules. The Plan Sponsor will take any steps it deems necessary to maintain the tax-favored status of benefits under the Cafeteria Plan, including making changes in available benefits, eligibility to participate, or limits on benefits. The Plan Year for the Cafeteria Plan is the same as the Plan Year listed in Section I.H. of the Adoption Agreement.

This Cafeteria Plan, in combination with the other relevant portions of the Plan, will be considered a separate written plan as required under the Internal Revenue Code.

A. ELIGIBILITY

Any employee eligible to participate in the Plan is eligible to participate in the Cafeteria Plan as of the first day they become eligible under the Plan. However, some component benefit programs may have specific eligibility requirements or waiting periods. Coverage for a particular benefit begins when the employee is eligible for that benefit. Participation in the Cafeteria Plan ends when the employee is no longer eligible for any Plan benefits.

B. CONTRIBUTIONS

Each Plan Year, an eligible employee may enter into a salary reduction agreement with the Plan Sponsor. The Plan Sponsor will reduce the employee's salary during the Plan Year and credit the amount of the reduction towards the Plan benefits elected by the employee for that Plan Year. If the plan sponsor contributes more towards benefits under the plan than the total cost of the benefits elected by the employee, the plan sponsor may, but need not, permit the employee to take any such excess contribution in the form of taxable compensation. In certain circumstances, an employee who is receiving insufficient or no salary may make after-tax contributions towards his or her Plan benefits; for example, if the employee is on unpaid FMLA leave. The maximum amount of salary reduction contributions available to any one employee in any one Plan Year is limited to that employee's compensation for that Plan Year, less any withholdings required by law. If an employee does not elect any Plan benefits, the employee will receive the full amount of his or her compensation for the Plan Year as taxable pay.

The Plan Sponsor may reduce any employee's elected salary reduction to prevent the Cafeteria Plan, or any benefit program associated with the Cafeteria Plan, from being discriminatory, as defined in the Code. In addition, if the cost of an employee's elected Plan benefits increases (or decreases) during the Plan Year, the Plan Sponsor may automatically make a corresponding increase (or decrease) in the employee's elected salary reduction for the remainder of the Plan Year.

C. OPEN ENROLLMENT

An employee must make his or her benefit and salary reduction elections for the Plan Year during the Cafeteria Plan's annual open enrollment period, except in the special circumstances described below. The Plan Sponsor will hold open enrollment annually during a designated period before the start of the new Plan Year. Except as provided below, the Plan benefits elected by the employee, and the salary reduction contributions for those benefits, may not be changed during the Plan Year. Unless otherwise specified by the Plan Sponsor for a specific plan year, if an employee does not submit new elections during open enrollment, the employee's current benefit elections, other than for the Health Care and Dependent Care Flexible

Spending Accounts, if applicable, will continue during the new Plan Year, at the cost established by the Plan Sponsor for the new Plan Year.

D. NEWLY HIRED AND REHIRED EMPLOYEES

A new employee's initial Plan benefit and salary reduction elections are effective from the first day he or she participates in the Plan until the end of that Plan Year. In order for coverage to begin on the first day of the new month, the employee must have made his or her elections by that date.

A rehired employee's prior election will remain in place if he or she was rehired within 30 days of his or her termination. In all other cases, rehired employees must make new Plan benefit and salary reduction elections. The rehired employee's elections are effective from the first day of the new month after the employee's date of rehire until the end of that Plan Year.

E. ELECTION CHANGES DURING THE PLAN YEAR

1. Notice Requirements. Except as otherwise required by law, the election changes described below will only be permitted if the participant notifies the Plan Administrator of his or her request within 30 days (or 31 days if permitted under the applicable component welfare program) of the event triggering the right to make the election change.

2. Effective Date of Changes. The election changes described below will be implemented prospectively in all cases other than the addition of a child as a result of a birth, adoption or placement for adoption, in which case the change will be effective as of the date of the birth, adoption or placement for adoption.

3. Cost Changes. If the cost for a benefit changes during the Plan Year:

    - Your salary reduction election will be adjusted automatically unless that change is "significant."
    - In the case of a significant decrease in cost, you may choose to begin participating in the benefit.
    - In the case of a significant increase in cost, you may choose to switch to another option providing similar coverage, or if no other option is available, drop coverage.

    These cost change rules do not apply to any Health Care Flexible Spending Account.

4. Coverage Changes. In the event:

    - Of a significant curtailment of coverage, that is not a loss of coverage, you may revoke your election and elect to receive coverage under a similar plan on a prospective basis.
    - If a loss of coverage under a benefit program occurs, you may revoke your election and elect to either receive similar coverage on a prospective basis or to drop coverage if no similar coverage is available.
    - A new benefit option is added during the Plan Year, or coverage under an existing option is significantly improved during the Plan Year, you may elect to revoke your coverage and to receive the new or improved benefit on a prospective basis.

    These coverage change provisions do not apply to any Health Care Flexible Spending Account.

5. Change in Coverage under Another Employer Plan. You may make a prospective change during a Plan Year on account of a change under another employer plan if:

    - The other cafeteria plan permits participants to make an election that would be permitted under applicable regulations; and

    - The other cafeteria plan has a different plan year than this Cafeteria Plan, and a change would otherwise be permitted under that plan.

    These changes in coverage under another employer plan provisions do not apply to any Health Care Flexible Spending Account.

6. Loss of Coverage under Other Group Health Coverage. You may add coverage under this Cafeteria Plan if you (or your spouse or eligible dependent(s)) lose coverage under a plan of a governmental or educational institution, including the following:

    - A State's children's health insurance program ("CHIP") under Title XXI of the Social Security Act;

    - A medical care program of an Indian Tribal Government (as defined in Section 7701(a)(40) of the Internal Revenue Code);

    - A State health benefits risk pool; or

    - A foreign government group health plan.

7. Change in Status. If you experience a status change, you may make an election change consistent with that status change. Status changes include:

    - Changes to marital status, including marriage, divorce, death of a spouse, legal separation or annulment;

    - Changes in the number of dependents, including birth, death, adoption, or placement for adoption;

    - Changes in employment status, including: the reduction or increase in employment (including a switch between part-time and full-time), the termination or commencement of employment, a strike or lock-out, a commencement of, or return from, an unpaid leave of absence, a change in worksite, or a switch between salaried and hourly-paid;

    - An event that causes a dependent to satisfy or cease to satisfy eligibility requirements for coverage due to reaching a certain age or a similar circumstance; and

    - A change in the place of work or residence.

8. Special Enrollment Rights. You may enroll in a health benefit during any special enrollment periods provided under the Health Insurance Portability and Accountability Act ("HIPAA"), as required by HIPAA. A special enrollment period may occur if an individual with other health insurance coverage loses that coverage, or if a person becomes a dependent through marriage, birth, adoption, or placement for adoption, or in the event of termination of Medicaid or CHIP coverage or eligibility for employment assistance under Medicaid or CHIP. You have 60 days to request an election change if the right to that change is triggered by eligibility for or termination of coverage under CHIP.

9. Entitlement to Medicare or Medicaid. You may revoke your election upon becoming entitled to Medicare or Medicaid.

10. Qualified Medical Child Support Orders and Other Orders. You may enroll or cancel coverage for your child at any time pursuant to a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order under ERISA Section 609) that requires accident or health coverage for an employee's child or for a foster child who is the employee's dependent.

11. Election Changes Under FMLA. The Plan Sponsor will permit election changes as needed to comply with the Family and Medical Leave Act ("FMLA") and any regulations or other guidance issued under FMLA.

12. Employees in Uniformed Service. If you are absent from the Plan Sponsor on account of being in uniformed service, as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may continue to participate in the Cafeteria Plan, to the extent required by USERRA. The Plan Sponsor will permit election changes as needed to comply with USERRA and any regulations or other guidance issued thereunder.

13. Enrollment in Other Minimum Essential Coverage Due to a Drop in Hours. You may prospectively drop health coverage during a plan year if:

    - You move from an employment status that is reasonably expected to average at least 30 hours per week to a status that is expected to work less than 30 hours per week (regardless of whether this reduction triggers a loss of eligibility under the Group Health Plan); and

    - You, and any related dependents whose coverage is also being dropped, intend to enroll in another group health plan that provides minimum essential coverage, and which is effective by no later than the first day of the second month following the month in which coverage is dropped.

    These enrollments in other minimum essential coverage rules do not apply to any Health Care Flexible Spending Account.

14. Enrollment in a Qualified Health Plan. You may prospectively drop health coverage during a Plan Year if:

    - You are eligible to enroll in a Qualified Health Plan through a health insurance Marketplace established under the ACA; and

    - You, and any related dependents whose coverage is also being dropped, intend to enroll in a Qualified Health Plan through a Marketplace for new coverage that is effective immediately following the date that coverage under this Plan is dropped.

    These enrollments in a qualified health plan rules do not apply to any Health Care Flexible Spending Account.

15. Other. The Plan Administrator may also elect, at its discretion, to permit any other election changes permitted during the Plan Year under applicable IRS rulings and regulations.

F. AVAILABLE BENEFITS

You may elect from among the component welfare programs marked with an "*" under Section II of the Adoption Agreement. The Plan Sponsor will determine the salary reduction contributions required for each benefit and will communicate the amounts each enrollment period.

G. HEALTH SAVINGS ACCOUNT

If you are eligible, you may be able to maintain a health savings account ("HSA"), as defined under Internal Revenue Code Section 223. An HSA is primarily for the reimbursement of medical expenses.

1. Eligibility. You may be eligible to participate in an HSA if you have elected medical coverage benefits through a high deductible health plan offered by the Plan Sponsor and you do not participate in a disqualifying non-high deductible health plan. For more information on whether you are eligible to participate in an HSA, contact your personal tax advisor.

2. Employee Contributions. If you maintain an HSA, you will also be able to make salary reduction contributions to your account. You may increase, decrease or revoke your salary reduction contributions to your HSA at any time.

3. Employer Contributions. If you maintain an HSA, the Plan Sponsor may make contributions to it. The amount of the Plan Sponsor contributions, if any, will be determined by the Plan Sponsor, at its discretion and may be changed by the Plan Sponsor at any time.

4. Not Subject to ERISA. Any HSA to which contributions are made is not an employer-sponsored employee benefit plan subject to ERISA. HSAs are individual trusts or custodial accounts separately maintained by a trustee or custodian outside of the Plan.

5. Trusts or Custodial Agreements. The terms and conditions governing your HSA are described in the HSA trust or custodial agreement provided to you by the trustee or custodian and are not part of the Plan. The Plan Sponsor has no authority or control over the funds deposited into an HSA.

H. FUNDING

Contributions to the Cafeteria Plan will be recorded as bookkeeping entries only. No assets or funds will be paid to, held in or invested in any separate trust or account.

The Plan Sponsor, and any insurance contracts purchased or held by the Plan Sponsor, are the sole source of benefits under the Cafeteria Plan. No employee or other person has any right to, or interest in, any assets of the Plan Sponsor upon termination of employment or otherwise, except as provided from time to time under the Cafeteria Plan, and then only to the extent of the benefits payable under the Cafeteria Plan to the employee or other person.

If the Plan Sponsor enters into a contract with an insurance company to provide a Plan benefit, the benefit will be limited to the benefit provided under the contract. The employee may look only to that insurance company for payment of the benefit.

Any dividends, retroactive rates or other refunds of any type that may become payable under any insurance contract will be the property of, and will be retained by, the Plan Sponsor.

I. ADMINISTRATION

The Plan Sponsor administers the Cafeteria Plan. The Plan Sponsor has the right to interpret the Cafeteria Plan and to decide all matters arising under the Cafeteria Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions. Among its powers, the Plan Sponsor may make and enforce rules governing the Cafeteria Plan and decide questions concerning the Cafeteria Plan, Cafeteria Plan administration, and any employee's eligibility to participate in the Cafeteria Plan. In carrying out its duties, the Plan Sponsor has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Cafeteria Plan, in all matters entrusted to it. The Plan Sponsor's determinations will be given deference and will be final and binding on all interested parties.

The Plan Sponsor may employ the services of such firms or persons as the Plan Sponsor deems necessary or desirable in connection with the Cafeteria Plan. In addition, the Plan Sponsor may delegate any of its powers or duties under the Cafeteria Plan to another person or persons.

J. AMENDMENT OR TERMINATION

The Plan Sponsor reserves the right to amend or terminate the Cafeteria Plan, including available benefits and contribution rates, at any time. Plan amendments will be in writing. Any amendment or termination will be effective on such date as the Plan Sponsor may determine.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This section on the Health Care Flexible Spending Account only applies if elected in Section IV of the Adoption Agreement. In combination with the other relevant portions of the Plan, this Section will be considered a separate written plan as required under the Internal Revenue Code.

A. AMOUNT OF CONTRIBUTIONS

The amount of salary reduction contributions that may be credited to your Health Care Flexible Spending Account will be no greater than the statutory limit defined in Code Section 125(i), as adjusted for inflation.

B. ELIGIBLE EXPENSES

Payments from this Account will be made to you in cash as reimbursement for health expenses incurred by you or your spouse, eligible children, or dependents, as defined in Code Section 105(b), during the Plan Year and while you are covered by the Plan, which:

- Are not covered, paid or reimbursed under any other health plan coverage;
- Meet the criteria for expenses incurred for medical care, as defined in Code section 213(d), and for reimbursable medical expenses under Code Sections 125 and 106(f) (provided that if an expense is for a medicine or a drug, it will only be considered a medical expense if it is prescribed or insulin);
- Are not taken as a deduction from income on your federal income tax return in any tax year.

Further, if you are participating in a Health Savings Account, only dental, vision and preventive care expenses will be eligible for reimbursement from this account.

C. REQUESTS FOR REIMBURSEMENT

To receive a reimbursement of eligible expenses, you must submit to the claims administrator a request for reimbursement according to procedures established by the claims administrator, along with such evidence as the claims administrator deems necessary as to the amount, nature and payment of the reimbursement. All requests for reimbursement must be submitted by the date designated by the claims administrator.

To be reimbursed, expenses must be incurred while you are eligible for the Health Care Flexible Spending Account. If, during the Plan Year, you separate from service or change employment status so that you are no longer eligible to participate in the Health Care Flexible Spending Account, you may only submit requests for expenses incurred on or before the date your employment terminates or status changes (unless you elect COBRA, as described below). Any such requests for reimbursement must be submitted within 90 days following the close of the Plan Year during which the expense was incurred or by such later date as is designated by the claims administrator.

D. DEBIT CARD

The Plan Sponsor may provide you with a debit card that may be used to pay eligible expenses directly from your Health Care Flexible Spending Account.

To be eligible to use the debit card, you must agree in writing that:

- You will use the card only to pay for eligible medical expenses for you, your spouse or dependents;
- You will not use the debit card for any medical expense that has already been reimbursed;
- You will not seek reimbursement under any other health plan for any expense paid with a debit card; and
- You will obtain and keep sufficient records (including invoices and receipts) for any expense paid with the debit card.

You may be required to provide receipts to the claims administrator to substantiate the expenses paid through a debit card.

E. QUALIFIED RESERVIST DISTRIBUTION

A qualified reservist distribution is allowed if you were ordered or called to active duty for more than 179 days or for an indefinite period, and the distribution is made during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made for the Plan Year that includes the date of the order or call. You must submit a written request for a qualified reservist distribution to the Plan Administrator. The balance that can be distributed is limited to the amount of your actual payroll deductions made as of the date of the request, less any amount already disbursed for valid claims submitted.

F. FORFEITURES

Any amount in your Health Care Flexible Spending Account at the end of a Plan Year against which amount liabilities have not been accrued during the Plan Year will be forfeited and, to the extent not used to defray reasonable administrative expenses, returned to the Plan Sponsor if permitted under applicable law. In addition, the Plan Administrator may establish reasonable procedures for forfeiting reimbursement checks that are not cashed within one year of issuance.

G. CARRYOVER AMOUNT

If elected in Section IV of the Adoption Agreement, notwithstanding the forfeitures rule above, you will be allowed to carry over a balance of up to $500 (as adjusted for inflation) in your Health Care Flexible Spending Account at the end of the Plan Year. You may elect to opt-out of this provision if you enroll in a Health Savings Account for the following Plan Year.

H. GRACE PERIOD

If Section IV of the Adoption Agreement is elected and if you do not use your entire Health Care Flexible Spending Account during the Plan Year, there is a 2½ month "grace period" available. Eligible expenses incurred during the grace period may also be reimbursed. The grace period applies only if you are still participating in the Health Care Flexible Spending Account Plan as of the last day of the Plan Year.

I. COBRA CONTINUATION

If your employment terminates during a Plan Year in which you have elected to have amounts credited to your Health Care Flexible Spending Account, you will remain covered under the Health Care Flexible Spending Account until the end of the Plan Year if you elect to continue to make the required contributions

to the Health Care Flexible Spending Account pursuant to federal COBRA. Otherwise, you may only submit requests for expenses incurred on or prior to the date your employment terminated. COBRA continuation is also available if coverage under the Health Care Flexible Spending Account will end due to another qualifying event under federal COBRA, such as a reduction in hours, death, or divorce.

J. DEATH OF PARTICIPANT

Any amount payable from the participant's Health Care Flexible Spending Account after the participant's death will be paid to the participant's surviving spouse, or if there is no spouse, to the participant's estate. Payments made pursuant to this Section will completely discharge the Plan, the claims administrator, and the Plan Sponsor.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

This section on the Dependent Care Flexible Spending Account only applies if elected in Section IV of the Adoption Agreement. In combination with the other relevant portions of the Plan, this Section will be considered a separate written plan as required under the Internal Revenue Code.

A. DEFINITIONS

The following definitions apply to the Dependent Care Flexible Spending Account, unless the context clearly requires otherwise:

1. Dependent Care Center. Any facility which (a) provides care for more than six (6) individuals (other than individuals who reside at the facility), and (b) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether the facility is operated for profit).

2. Earned Income. Generally, means wages, salaries, tips and other employee compensation includible in gross income, including net earnings from self-employment, for the Plan Year (computed without regard to any community property laws), but excluding pension and annuity income and income as a non-resident alien not connected with a United States business. The earned income of a spouse who is a full-time student at an educational institution or who is a Qualifying Individual who is under a Physical or Mental Incapacity below is deemed to be not less than $250 per month if there is one Qualifying Individual or $500 per month if there are two or more Qualifying Individuals. See Code Section 32(c)(2) for the complete definition.

3. Employment-Related Expenses. Amounts paid for:

   - Expenses for Household Services; and

   - Expenses for the care of a Qualifying Individual;

   so long as the expenses are incurred to enable you or your spouse to be gainfully employed for a period for which there are one or more Qualifying Individuals with respect to you.

4. Household Services. Ordinary and usual services necessary for the maintenance of your home performed in and about the home and which are attributable in part to the care of a Qualifying Individual, as more fully defined by applicable law.

5. Physical or Mental Incapacity. A physical or mental defect which renders an individual incapable of caring for his or her hygiene or nutritional needs or which requires the full-time attention of another person for the individual's own safety or the safety of others.

6. Qualifying Individual. Means:

   - Your "qualifying child," as defined in Code Section 152(a)(1), who is under age thirteen (13);

   - Your dependent, as defined in Code Section 152 (determined without regard to sections 152(b)(1), 152(b)(2) and 152(d)(1)(B)) who is under a Physical or Mental Incapacity and who has the same principal place of abode as you for more than half the Plan Year;

   - Your spouse who is under a Physical or Mental Incapacity and who has the same principal place of abode as you for more than half the Plan Year; and

- Any other person who meets the requirements for a "Qualifying Individual" under applicable Treasury regulations or other guidance.

In the case of divorced or separated parents, a child is your Qualifying Individual for such Plan Year if you have custody of the child for a longer period during the Plan Year than the other parent if the child:

- Is under age thirteen (13) or under a Physical or Mental Incapacity,

- Receives more than half of his or her support during the Plan Year from parents who are divorced or separated under a decree of divorce or separate maintenance or a written separation agreement, or who live apart from the other parent at all times, during the last 6 months of the Plan Year, and

- Is in the custody of one or both of his or her parents for more than half of the Plan Year.

B. AMOUNT OF CONTRIBUTIONS

The amount of salary reduction contributions that may be credited to your Dependent Care Flexible Spending Account will be no greater than $5,000 per Plan Year (or, in the case of a married participant filing a separate return for the taxable year in question, $2,500 per Plan Year). The Plan Administrator may further limit this amount in the enrollment materials for the Plan Year.

C. ELIGIBLE EXPENSES

Payments from this Account will be made to you in the form of a Plan Sponsor-provided payment in accordance with the following provisions, which will be interpreted consistent with Code Section 129.

- You are eligible to receive reimbursement for employment-related expenses incurred during the applicable Plan Year after your participation date. The amount of your reimbursement may not exceed the remaining amount credited to your Dependent Care Flexible Spending Account at the time you submit the claim for reimbursement.

- The aggregate amount of reimbursements from the Dependent Care Flexible Spending Account which you may receive on a tax-free basis must not exceed your earned income, or, if you are married at the end of the Plan Year, the earned income of your spouse, if less. Any reimbursement amount received from the Dependent Care Flexible Spending Account that exceeds the lesser of your earned income or, if you are married at the end of the Plan Year, the earned income of your spouse, will be taxable to you.

- Employment-related expenses which are incurred for services outside your household will be entitled to reimbursement:

    - If incurred for the care of a Qualifying Individual who is your "qualifying child," as defined in Code section 152(a)(1), or (ii) another Qualifying Individual who regularly spends at least eight (8) hours each day in your household;

    - Incurred for services performed outside your household by a Dependent Care Center, the Center complies with the applicable laws and regulations of a State or unit of local government.

- Employment-related expenses will not be entitled to reimbursement if they are rendered by an individual:

- For whom you or your spouse is entitled to a deduction under Code Section 151(c); or

- Who is your son, daughter, stepson, stepdaughter or eligible foster child and who is under age nineteen (19) at the end of the Plan Year.

D. REQUESTS FOR REIMBURSEMENT

To receive a reimbursement, you must submit to the Plan Administrator (or designee of the Plan Administrator, if applicable) a request for reimbursement according to procedures established by the Plan Administrator, along with such evidence as the Plan Administrator (or designee of the Administrator, if applicable) deems necessary as to the amount, nature, and payment of the reimbursement. You must submit the request by no later than 90 days following the close of the Plan Year during which the expense was incurred or by such earlier date as is designated by the Plan Administrator.

The Plan Sponsor may provide you with a debit card to pay for eligible expenses that may be reimbursed from your Dependent Care Flexible Spending Account. The debit card may be used only to reimburse incurred expenses that have been substantiated according to IRS regulations.

To be reimbursed, expenses must be incurred while you are eligible for the Dependent Care Flexible Spending Account. However, if during the Plan Year, you separate from service or change employment status so that you are no longer eligible to participate in the Dependent Care Flexible Spending Account, you may only submit requests for expenses incurred on or before the date your employment terminates or status changes. Any such requests for reimbursement must be submitted by the date designated by the Plan Administrator.

E. REQUESTS EXCEEDING ACCOUNT BALANCE

Requests for reimbursement of eligible expenses which exceed the accrued balance in your Dependent Care Flexible Spending Account will be held in suspense until the account has been credited with sufficient amounts to permit the reimbursement, provided that such additional credits are made within the Plan Year to which the reimbursement is chargeable.

F. FORFEITURES

Any amount in your Dependent Care Flexible Spending Account at the end of the Plan Year against which amount liabilities have not been accrued during the Plan Year will be forfeited and, to the extent not used to defray reasonable administrative expenses, returned to the Plan Sponsor. In addition, the Administrator may establish reasonable procedures for forfeiting reimbursement checks that are not cashed within one year of issuance.

G. DEATH OF A PARTICIPANT

Any amount payable from a participant's Dependent Care Flexible Spending Account after the participant's death will be paid to the participant's surviving spouse, or if there is no spouse, to the participant's estate. Payments made pursuant to this Section will completely discharge the Plan, the Plan Administrator and the Plan Sponsor.

H. DISCLOSURE

Pursuant to Code Section 129, on or before each January 31 during which this Plan is in effect, the Plan Administrator will furnish you with a written statement, which may be your W-2, showing the amounts paid or expenses incurred by the Plan Sponsor in providing dependent care assistance to you during the previous calendar year.