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ARTICLE 1.
ESTABLISHMENT AND PURPOSE

1.1. Purpose. The purpose of the Plan is to provide Eligible Employees who may participate in the Plan with the choice between cash compensation and various nontaxable benefits (different combinations of health, dependent care and other benefits as specified in the Plan.) The Plan is established in accordance with the provisions of Section 125 of the Internal Revenue Code and other applicable provisions.

1.2. Qualified Status. The Plan is intended to be a tax-qualified plan under Sections 105, 125, 129, and 132 of the Internal Revenue Code (the “Code”) and shall be interpreted and administered in accordance with the requirements of those Sections.

ARTICLE 2.
DEFINITIONS

2.1. Definitions. Whenever used in the Plan, the following words and phrases shall have the meanings set forth below unless the context plainly requires a different meaning.

(a) Administrator means the individual or the entity appointed by the Company pursuant to Section 11.1.

(b) Benefit Credit means a dollar amount which the Employer may elect to provide under Section 4.3 to cover a portion of the Participant’s premiums for Qualified Benefits under the Plan.

(c) Carryover means the dollar amount attributable to each Participant’s unused Health FSA Account, if any, that may be carried over by a Participant from the prior Plan Year into the immediately following Plan Year. The maximum Carryover amount, if any, elected by the Employer shall be set forth in Section 12 of the Adoption Agreement, and may not exceed the lesser of (1) any unused amount in the Participant’s Health FSA Account from the immediately preceding Plan Year, determined after the Run-Out Period has ended, or (2) $500 (or such lower amount as may be specified by the Employer in Section 12 of the Adoption Agreement). A Carryover option shall not affect the maximum salary contribution amount that may be made by a Participant under the Health FSA Account for a Plan Year. However, use of a Carryover Option shall preclude the Plan from offering a Grace Period under the Health FSA Account applicable to the same Plan Year.

(d) Change in Status means a Change in Status, as defined in Section 4.2(b) of this Plan.

(e) COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.


(g) Company means the Plan Sponsor as indicated in Section 1.a. of the Adoption Agreement and the administrative agent for all Employers participating in the Plan.

(h) Compensation of a Participant means the total wages and salary, including bonuses, commissions and overtime pay, paid to a Participant by the Employer for the Plan Year.
(i) **Contract Administrator** means the third party administrator, if any, that has contracted with the Employer to provide administrative services under the Plan, and its successors. This term is not the same and is not intended to have the same meaning as the term defined in Section 3(16) of ERISA.

(j) **Coverage Amount** means the amount of health care reimbursement coverage elected by the Participant for the Plan Year in accordance with Section 4.1.

(k) **Dependent** means, with respect to the pre-tax payment of any premiums pursuant to Code Section 125 for Qualified Benefits listed in Section 6.a. of the Adoption Agreement or any Health FSA or HSA listed in Section 6.b. of the Adoption Agreement, the Employee’s Spouse and any individual who qualifies as the Employee’s “dependent” for tax purposes pursuant to Code Section 152, without regard to Sections 152(b)(1) and (b)(2), and without regard to Section 152(d)(1)(B). Dependent shall also mean, with respect to the pre-tax payment of any premiums for Employer-sponsored health plan coverage selected in Section 6 of the Adoption Agreement, an Employee’s child (as defined in Section 152(f)(1) of the Code) who is under age 27 as of the end of the taxable year, even if the child does not meet the residency, support or other tests described in 152(c) to qualify as the Employee’s tax dependent.

(l) **Dependent Care FSA Account** means the account established under Section 7.1 for each Participant, as increased under Section 7.2 by allocated Salary Reduction Contributions and as decreased under Section 7.3 by benefit payments made to the Participant.

(m) **Effective Date** means the date indicated in Section 2.d. of the Adoption Agreement.

(n) **Eligible Employee** means any Employee as elected in the Adoption Agreement and/or as defined in the certificates, booklets and plan documents applicable to the benefits offered under this Plan.

(o) **Employee** means any person hired by the Employer as an employee who receives compensation from the Employer. Employee status shall not be considered to be affected by a leave of absence that is Employer-approved or legally required. However, the term Employee shall not include an individual retained directly from or through a third party agency, including a leasing organization within the meaning of Code Section 414(n)(2), to perform services for the Employer (for either a definite or indefinite duration) in the capacity of a temporary service worker, leased worker, independent contractor, consultant or any similar capacity. The term “Employee” shall not include a self-employed individual or a 2 percent or more shareholder of an S corporation.

(p) **Employer** means the entity specified in Section 1 of the Adoption Agreement and each other entity that adopts this Plan as a Participating Employer, as set forth in Section 15 of the Adoption Agreement.

(q) **Employment-Related Dependent Care Expense** means an amount paid by a Participant for household services or for the care of a Qualifying Individual, to the extent that such expense is incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Individuals with respect to the Participant. However, (1) if such amounts are paid for expenses incurred outside the Participant's household, they shall
constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Individual under the age of 13 or for a Qualifying Individual who is not under the age of 13 who regularly spends at least eight hours per day in the Participant's household; (2) if the expense is incurred outside the Participant's home at a facility that provides care for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable laws of the State or local government; and (3) Employment-Related Dependent Care Expenses of a Participant shall not include expenses paid or incurred for services provided by (i) a child of such Participant who is under the age of 19 or (ii) an individual who is a Dependent, as otherwise defined in the first paragraph of Section 2.1(k), of such Participant or such Participant's Spouse.

(r) **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

(s) **FMLA Leave** means a leave of absence provided to an Employee of the Employer under the Family and Medical Leave Act of 1993, as amended.

(t) **Grace Period** means an additional two and one-half month period (or other period, as set forth in Section 12 of the Adoption Agreement), if any, immediately following the end of the Plan Year, as elected by the Employer, in which unused benefits or contributions remaining at the end of the Plan Year may be paid or reimbursed to Plan participants for any qualified Health Care Expense or Dependent Care Expense incurred during the Grace Period.

Notwithstanding the preceding, a Grace Period may not be provided under the Health FSA Account if the Employer elects, in Section 12 of the Adoption Agreement, to permit a Carryover Option.

(u) **Health Care Expense** means an expense related to the diagnosis, cure, mitigation, treatment, or prevention of disease consisting of expenses for medical care within the meaning of Section 213 of the Code, including, but not limited to, payments for the purpose of affecting any structure or function of the body, or for any hospital or nursing charges, optometric, ophthalmologic or auditory care, routine physical examinations, well-baby care, dental and orthodontic care, psychiatric care, prescription drugs, insulin, eyeglasses or contact lenses, hearing-aid appliances, similar prosthetic devices, medical-related transportation or medical or dental insurance out-of-pocket expenses.

The term “Health Care Expense” does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. The term cosmetic surgery means any procedure, which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

The term “Health Care Expenses” shall also include over-the-counter (“OTC”) medicines or drugs, but only if such medicine or drug is prescribed by a physician or is insulin.

(v) **Health FSA Account** means the account established under Section 6.1 for each Participant, as increased under Section 6.2 by allocated Salary Reduction Contributions and as decreased under Section 6.3 by benefit payments made to the Participant. A “Carryover” option shall be available for election by the Plan Sponsor under the Health FSA Account in lieu of a Grace Period, if any.
(w) **Health Savings Account (HSA)** means a health savings account established under Code Section 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by the Employee with a qualified trustee/custodian.

(x) **High Deductible Health Plan (HDHP)** means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code Section 223(c)(2), as described in the materials separately provided by the Employer.

(y) **Highly Compensated Employee** means a highly compensated individual or participant as defined in Code Section 125(e); or a highly compensated employee as defined in Code Section 129(d)(2).

(z) **HSA-Eligible Individual** means an individual who is eligible to contribute to a HSA under Code Section 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying/non-High Deductible Health Plan coverage offered by the Employer.

(aa) **Key Employee** means a key employee as defined in Code Section 416(i)(1).

(bb) **Limited-Purpose Health FSA** means a Health FSA that only pays or reimburses permitted coverage benefits (such as vision care, dental care or preventive care) that are not otherwise covered under the HDHP.

(cc) **Participant** means an individual who participates in this Plan as provided in Article 3.

(dd) **Participating Employer** means any entity that is part of a group of entities that includes the Employer, and that constitutes: (1) a controlled group of corporations (as defined in Section 414(b) of the Code); (2) a group of trades or businesses, whether or not incorporated, under common control (as defined in Section 414(c) of the Code); or (3) an affiliated service group (with the meaning of Section 414(m) of the Code), and that adopts the Plan. An unrelated entity may also be a Participating Employer under the Plan, as set forth in Section 16 of the Adoption Agreement.

(ee) **Participation Election Form** means the form described in Section 4.1.

(ff) **Period of Coverage**, with respect to any Plan Year, means that Plan Year plus the Grace Period selected in Section 12 of the Adoption Agreement, if any, which immediately follows the Plan Year. However, for any Employee:

1. who becomes a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the effective date of the Participant's participation and extending through the remainder of the Plan Year and including the Grace Period, if any, which immediately follows the end of the Plan Year, or

2. who ceases being a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the first day of the Plan Year and extending through the last day of the Participant's participation.
(gg) **Plan** means the Cafeteria Plan identified in Section 2.a. of the Adoption Agreement, as amended or restated from time to time. The Plan consists of this Basic Plan Document and the Adoption Agreement.

(hh) **Plan Administrator** means the Employer or such other person(s) designated by the Employer.

(ii) **Plan Year** means the Plan’s accounting year, as specified in Section 2.c. of the Adoption Agreement.

(jj) **Post-Deductible Health FSA** means a Health FSA that only pays or reimburses medical expenses for preventive care or medical expenses incurred after the minimum annual HDHP deductible is satisfied.

(kk) **Qualified Benefit** means any benefit offered under this Plan that, if paid solely by the Employer, would not be includible in the gross income of an Employee by reason of an express provision of Chapter 1, Subtitle A – Income Taxes of the Code (other than Code Sections 117, 119, 127, and 132), and also includes any other benefit offered under this Plan that is permitted under regulations and rulings issued by the Secretary of the Treasury or the Internal Revenue Service. Qualified Benefits include benefits listed in Section 6.a. and 6.b. of the Adoption Agreement.

(II) **Qualified Reservist Distribution** means any distribution to an individual of all or a portion of the balance in the employee’s Health FSA Account if (1) such individual was ordered or called to active duty for a period in excess of 179 days or for an indefinite period, and (2) such distribution is made during the period beginning on the date of such order or call and ending on the last day that reimbursement could otherwise be made under the Health FSA Account for the Plan Year that includes the date of such order or call.

(mm) **Qualifying Individual** as defined under Code Section 21(b)(1), means (1) a dependent of the taxpayer (as defined in Code Section 152(a)(1)) who has not attained age 13, (2) a dependent, of the taxpayer (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B)) who is physically or mentally incapable of self-care and who has the same principal place of abode as the taxpayer for more than ½ of the taxable year, or (3) the Spouse of the taxpayer, if the Spouse is physically or mentally incapable of self-care and has the same principal place of abode as the taxpayer for more than ½ of the taxable year. In the case of an Employee who has been divorced, “Qualifying Individual” shall also mean a child to whom Code Section 21(e)(5) applies.

(nn) **Salary Reduction Contributions** are amounts deducted from a Participant’s Compensation to purchase a Qualified Benefit under the Plan, as elected by a Participant.

(oo) **Spouse** means the person legally married to a Participant. Effective June 26, 2013, a Spouse includes an individual married to a person of the same sex if the marriage was validly entered into in a state whose laws authorize such marriage even if the married couple is domiciled in a state that does not recognize the validity of same-sex marriage. For this purpose, “state” means any domestic or foreign jurisdiction having the legal authority to sanction marriages. This Plan shall comply with any and all applicable legal requirements resulting from the outcome of the Supreme Court decision in United States v Windsor, including without limitation, Rev. Rul. 2013-17, 2013-38 I.R.B. 201 and IRS Notice 2014-19, 2014-17 IRB 979. Specifically, the term Spouse shall not include individuals (whether of the opposite sex...
or same sex) who have entered into a registered domestic partnership, civil union, or other similar formal relationship recognized under state law that is not denominated as a marriage under the laws of the state. A Spouse shall not include individuals of the same sex for periods prior to June 26, 2013, for any purpose under this Plan.

USERRA Leave means a leave of absence approved by the Employer in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, including all regulations promulgated thereunder.

ARTICLE 3.
PARTICIPATION

3.1. **Commencement of Participation.** An Employee shall be eligible to participate in the Plan as of the date specified in Sections 5, 9, 10, or 11 of the Adoption Agreement, as applicable.

3.2. **Cessation of Participation.** Participation in the Plan shall cease as of the earliest of the following dates:

   (a) the date on which the Plan terminates;
   (b) the date on which the Participant’s election expires or is terminated under the Plan;
   (c) the date on which the Participant revokes coverage as provided in Section 4.2, 4.4, or 4.5; or
   (d) the date on which the Participant terminates employment with all Employers.

3.3. **Only Employees May Participate.** Only Employees of an Employer are eligible to be Participants. Spouses and Dependents of Employees are not themselves eligible to become Participants, but they may receive benefits under the Qualified Benefit Plans as a Spouse, Dependent or beneficiary of a Participant based upon the eligibility rules of the Qualified Benefits selected by the Participant.

3.4. **Participation Following Termination of Employment.** If a Participant terminates his employment for any reason and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 4.1.

ARTICLE 4.
ELECTION OF BENEFITS

4.1. **Enrollment.**

   (a) A Participant shall designate on the Participation Election Form the amount of his or her Compensation to be used to purchase the Qualified Benefit that he or she elects to receive. The Participant’s Compensation, offset by available Benefit Credits, if any, shall be reduced each payroll period during the Plan Year in an amount necessary to provide the designated Qualified Benefits.
(b) A newly hired Employee shall complete a Participation Election Form within 30 days following the date he or she becomes eligible to participate in the Plan. Subject to the elections in Sections 6.c. and 6.d. of the Adoption Agreement, if a Participant does not submit a completed Participation Election Form, he or she will not be eligible to participate in the Plan until the next Plan Year.

4.2. Revocation or Change.

(a) Any election made under the Plan, including an election made through inaction as provided for in Sections 6.c. and 6.d. of the Adoption Agreement, shall be irrevocable by the Participant during the Plan Year, except as otherwise provided in this Section 4.2 and in Sections 4.4 and 4.5.

(b) Change in Status

(1) If the Participant has a Change in Status (as defined in Subsection (A) below), he shall be entitled to revoke or change his benefit election in a manner that is consistent with such Change in Status (as defined in Subsection (B) below), by providing written notice to the Plan Administrator within 30 days of the status change. An election change in a Participant’s coverage under a Qualified Benefit, attributable to the birth or adoption of a child, may be effective up to 30 days retroactively. Any other authorized change in the Participant's Qualified Benefit election due to a Change in Status shall be effective the first day of the first month following the Plan Administrator’s receipt of the written notice of the Change in Status.

(A) A Change in Status is an event that falls into one of the following categories:

(i) Legal Marital Status Changes: including marriage, death of Spouse, divorce, legal separation and annulment.

(ii) Changes in Number of Dependents or Qualifying Individuals: including birth, death, adoption and placement for adoption.

(iii) Employment Status Changes of the Participant or the Participant’s Spouse or Dependents Which Affects Eligibility for Coverage Under an Employer’s Plan: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave of absence, change of work-site or change in employment status.

(iv) Dependent/Qualifying Individual Satisfies or Ceases to Satisfy the Requirements for Dependents, such as change in student status or Dependent/Qualifying Individual no longer qualifies because of age.

(v) Change in Residence Which Affects Eligibility For Coverage Under An Employer’s Plan: change in place of residence of the employee, Spouse or Dependent/Qualifying Individual.

(vi) Nondependent children under age 26 newly eligible for coverage.
(B) For accident or health coverage, the election change is consistent with the Change in Status only if the election change is on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer’s plan. For example, where a Dependent of the employee enrolls in college in another state outside the coverage area for the HMO elected by the employee, a Change in Residence has occurred and the employee could make an election change to drop the Dependent (but not the employee or other family members) from the HMO. In contrast, a move by the employee to another residence within the HMO coverage area would not constitute a Change in Residence under the Plan.

For other Qualified Benefits, the election change is consistent with the Change in Status only if it meets one of the following conditions:

(i) The election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer’s plan or a private disability plan.

(ii) The election change is on account of and corresponds with a change in status that affects expenses described in Code Section 129 with respect to the Dependent Care FSA.

The consistency rule of this Subsection shall be interpreted in accordance with the special consistency rules of applicable law.

(c) Special Events

(1) A Participant may revoke or modify his benefit election during the current Plan Year if the revocation or modification is on account of a Qualified Medical Child Support Order (QMCSO) or other Judgments or Orders under 29 USC Section 1169(a); on account of the Special Enrollment Rights of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); on account of an employee, Spouse or Dependent becoming entitled to coverage under Part A or Part B of Medicare or Medicaid; or on account of a COBRA qualifying event.

(2) A Participant, on account of an unpaid FMLA Leave, may revoke his benefit elections. When he returns from unpaid FMLA Leave after having revoked his benefit elections on account of taking FMLA Leave he may have his benefit elections reinstated on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. A reinstated Participant shall not have a greater right to benefits for the remainder of the Plan Year than a Participant who is continuously working during the Plan Year.

(3) A Participant, as part of the Special Enrollment Rights of HIPAA, may now also revoke or modify his benefit election during the current Plan Year if the revocation or modification is on account of an Employee, Spouse or Dependent: (i) losing coverage under a Medicaid Plan under Title XIX of the Social Security Act; (ii) losing coverage under a State Children’s Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (iii) becoming eligible for group health plan premium assistance under Medicaid or SCHIP, provided the Participant provides a written election notice
to the Plan Administrator within 60 days of the loss of coverage or eligibility for premium assistance.

(4) If so elected in Section 6.f. of the Adoption Agreement, a Participant may prospectively revoke or modify his/her group health plan election (that is not a health FSA election) once during the Plan Year (for himself/herself and any related individuals) if he/she:

(A) is reasonably expected to average at least 30 hours of service per week and experiences a reduction in the number of hours worked so that the average expected hours are less than 30 per week (even if that reduction would not cause the employee to cease eligibility under the group health plan), and the employee enrolls or intends to enroll in another plan that provides minimum essential coverage; or

(B) revokes an election of coverage for himself/herself and any related individuals because he/she is eligible to and enrolls or intends to enroll in a Qualified Health Plan offered through an Exchange during a special enrollment period or annual enrollment period offered through the Exchange.

(d) Cost/Coverage Changes

(1) Cost Changes

(A) The Employer may modify a Participant’s contribution in accordance with the automatic adjustment in Section 5.2.

(B) If the cost of coverage of an Employer-sponsored Qualified Benefit selected in Section 6.a. of the Adoption Agreement significantly increases, a Participant who is covered under that Employer-sponsored Qualified Benefit plan may choose to pay the increased or decreased premium or revoke coverage under the Qualified Benefit plan for which the premiums are being increased and elect coverage under a plan providing similar coverage, if available.

If the cost of coverage of an Employer-sponsored Qualified Benefit selected in Section 6.a. of the Adoption Agreement significantly decreases, an Eligible Employee who is not a Participant may choose to commence participation in the Qualified Benefit plan with the decrease in cost.

(C) With respect to a Dependent Care FSA under Article 7, a Participant may modify a benefit election if the cost for service provided by a dependent care provider, who is not a relative of the Participant, increases or decreases.

(D) Cost changes covered by this Section include but are not limited to, cost changes initiated by the Eligible Employee or the Employer.

(2) Coverage Changes

(A) If coverage provided under a Qualified Benefit plan described in Section 6.a. of the Adoption Agreement is significantly curtailed but is not a loss of coverage, a Participant who is covered under that Qualified Benefit plan shall be entitled
to change his benefit election by revoking coverage under the Qualified Benefit plan being curtailed but must elect coverage under a Qualified Benefit plan providing similar coverage, if available.

(B) If coverage provided under a Qualified Benefit plan described in Section 6.a. of the Adoption Agreement is significantly curtailed and is a loss of coverage, a Participant who is covered under that Qualified Benefit plan shall be entitled to change his benefit election by revoking coverage under the Qualified Benefit plan being curtailed and electing coverage under a Qualified Benefit plan providing similar coverage, if available.

(C) If during a Period of Coverage, a new Qualified Benefit plan is added or an existing Qualified Benefit option is significantly improved, an Eligible Employee may elect the new Qualified Benefit plan or improved Qualified Benefit plan and make a corresponding election change with respect to other Qualified Benefit plans providing similar coverage.

(D) A Participant may make a change in such Participant’s benefit election if such change is on account of and corresponds with a change made under another employer plan if: (a) such change is permitted under the other employer’s cafeteria plan (or qualified benefit plan) and Code requirements applicable to such change; or (b) this Plan permits participants to make an election for a Period of Coverage which is different from the period of coverage under the other cafeteria plan (or qualified benefit plan).

(3) This Section 4.2(d) does not apply to an election change with respect to the Health FSA Account described in Article 6.

(e) A Participant who separates from the service of the Employer during a Period of Coverage shall be deemed to have revoked existing benefit elections and terminated the receipt of Plan benefits for the remaining portion of the Period of Coverage.

(f) Notwithstanding the provisions of Section 4.2(c) and 4.2(d), no change shall be permitted unless both the old and the new Qualified Benefit plans permit such change.

**4.3. Benefit Credits and Reduction in Compensation.**

(a) For any Plan Year the Employer provides Benefit Credits on behalf of a Participant, such Benefit Credits will be allocated in accordance with Section 8(1) of the Adoption Agreement. To the extent Benefit Credits are not used to pay for the cost of Qualified Benefits, the remaining amount shall be applied in accordance with Section 8(1)(vi) of the Adoption Agreement.

To the extent that the cost of Qualified Benefits exceeds the Benefit Credits allotted to a Participant, the Employer shall reduce a Participant’s Compensation for the Plan Year by an amount determined based upon the Participant’s selection of Qualified Benefits, as indicated on the Participation Election Form or as provided in Sections 6.c. and 6.d. of the Adoption Agreement. Such amounts shall be used to provide the Qualified Benefits selected by the Participant. Except as otherwise provided in Sections 6.c. and 6.d. of the Adoption Agreement, any Participant who elects not to have Compensation reduced is deemed to have...
elected to receive Compensation rather than to have his or her Compensation reduced to pay for Qualified Benefits available under the Plan.

(b) If no Benefit Credits are provided under the Plan, the Employer shall reduce a Participant’s Compensation for the Plan Year by an amount determined based upon the Participant’s selection of Qualified Benefits. Such amounts shall be used to provide to the Participant the Qualified Benefits available under the Plan. Except as otherwise provided in Sections 6.c. and 6.d. of the Adoption Agreement, any Participant who elects not to have Compensation reduced is deemed to have elected to receive Compensation rather than to have his or her Compensation reduced to pay for Qualified Benefits available under the Plan.

4.4. Contribution during Leave. With respect to Participants who go on a leave of absence which is Employer-approved or unpaid FMLA Leave, contributions required or permitted to be made by them under the Plan may be made by one of the following methods, which must be nondiscriminatory, as agreed between the Employee on leave and the Plan Administrator before the commencement of the leave of absence or the applicable coverage period:

(a) Contributions may be made by the Employee on leave on a regular basis (generally on an after-tax basis).

(b) Contributions may be made by the Employee on leave by pre-payment (generally on a pre-tax basis with respect to the same Plan Year during which the leave occurs).

(c) Contributions advanced by the Employer on behalf of an Employee on leave may be re-paid by the Participant when he or she returns from leave on either a pre-tax basis with respect to the same Plan Year during which the leave occurs or on an after-tax basis.

4.5. Qualified Military Leave. Notwithstanding any provision of the Plan to the contrary, in the event a Participant takes a USERRA Leave, contributions, service and benefits with respect to qualified military service will be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

In such event, each elected health care benefit may continue for the lesser of the period of the USERRA Leave or twenty-four (24) months, provided that the applicable contributions for such benefits are timely paid by the Participant. The Participant may elect to pay the contributions on an after-tax basis as due, or on a pre-tax basis prior to commencing the leave, or on a payroll deduction basis, if the leave is a paid USERRA Leave. A Participant may elect not to continue Qualified Benefits while on USERRA Leave, in which case Plan participation will cease for the duration of the USERRA Leave.

Upon return from an unpaid USERRA Leave before the end of the Plan Year in which the USERRA Leave commenced, active participation in the Plan may be reinstated as provided in Section 3.4. Upon return from an unpaid USERRA Leave after the end of the Plan Year, the Participant shall be treated as a newly Eligible Employee and may immediately reenter the Plan. If a Participant does not return to active employment at the conclusion of an unpaid USERRA Leave, the Participant shall no longer be considered an Eligible Employee.

4.6. Changes by Administrator. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement or any limitation on benefits imposed by the Code or regulations or rulings thereunder, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants,
to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections made by Highly Compensated Employees or Key Employees (as defined by the Code for purposes of the nondiscrimination requirement in question), with or without the consent of such Employees.

4.7. **Use of Contributions.** If more than one Qualified Benefit is selected by the Participant, reductions in the Participant’s Compensation elected to be used with respect to a particular Qualified Benefit may not be used to fund benefits under other Qualified Benefit plans selected by the Participant, even if not fully used with respect to the initially selected Qualified Benefit. Such amounts shall be forfeited and used in accordance with Section 9.1 of the Plan, except as otherwise provided under the Carryover option described in Section 2.1(c) applicable solely to the Health FSA Account.

ARTICLE 5.
QUALIFIED BENEFITS

5.1. **Qualified Benefit Plans.** A Participant may elect coverage for the Plan Year under Articles 6, 7, and 8 hereof, as well as any of the plans selected in Section 6.a. of the Adoption Agreement. The Participant may elect to pay through this Plan the portion of the premium that must be paid by the Participant for coverage of himself or herself and/or his or her Dependents, if applicable. Benefits payable under the Qualified Benefit plans shall be governed under the terms of such plans.

The actual terms and conditions of the Qualified Benefit options selected are provided in separate, written documents and/or insurance-related contracts which are hereby incorporated, by reference, into this Plan. In the event of any conflict involving the relevant benefit and this Plan, the substantive content of the relevant Qualified Benefit plan shall govern.

5.2. **Automatic Adjustments.** If during the Plan Year the cost of an Employer-sponsored Qualified Benefit plan described in Section 5.1 above which is selected by a Participant changes and the change is not significant, the Participant's benefit election shall, with respect to premium payments for that plan, automatically be adjusted to reflect such change. A Participant shall not be permitted to change coverage during a Plan Year because of change in the cost of coverage, except as otherwise provided in Article 4.

ARTICLE 6.
HEALTH FSA ACCOUNTS

6.1. **Health FSA Accounts.** The Plan Administrator will establish and maintain a Health FSA Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Health Care Expenses.

6.2. **Crediting of Accounts.** There shall be credited to a Participant’s Health FSA Account for each Plan Year, as of the beginning of such Plan Year, an amount equal to the Participant’s Coverage Amount for such Plan Year, as well as any Benefit Credits allocated on behalf of the Participant in accordance with Section 4.3. Except as otherwise required by law, the amount credited for each Plan Year to each such Health FSA Account shall be paid out pursuant to Section 6.3.

6.3. **Debiting of Accounts.** The balance in a Participant's Health FSA Account for a Plan Year shall be reduced by the amount of any benefits paid to a Participant under Section 6.4.
6.4. **Health Care Benefits.** Subject to limitations contained in other provisions of this Plan, a Participant who elects the benefit option under this Article 6 and who incurs Health Care Expenses attributable to himself, his Spouse or his Dependents during his Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses to the extent of the full amount of the Participant's elected Coverage Amount for that Plan Year.

6.5. **Reimbursement Procedures.** Except as provided in Section 9.f. of the Adoption Agreement, in order to receive reimbursement for Health Care Expenses under this Article 6:

(a) The Participant must complete a Claim Form, attach (i) an itemized billing statement from the health care provider; (ii) an explanation of benefits from the Participant’s insurer; (iii) a pharmacy receipt; or (iv) other satisfactory proof of claim, and forward the documents to the Contract Administrator or Plan Administrator, as applicable. The Participant must provide additional information reasonably requested by the Administrator.

(b) A request for reimbursement must relate to Health Care Expenses incurred during the Participant's Period of Coverage. For this purpose, the term “incurred” refers to when the health care services were provided, and not when paid. Except as provided in (c) below, in no event may claims incurred in one Period of Coverage be paid from the Coverage Amount contributed for the following Plan Year, nor shall any unpaid claims be the liability of the Plan, the Employer, the Contract Administrator or the Plan Administrator.

(c) A request for reimbursement for Health Care Expenses incurred during a Period of Coverage must be received by the Administrator either during the Period of Coverage or on or before the end of the Run-Out Period selected in Section 13 of the Adoption Agreement.

In determining the Carryover amounts, if any (as described in Section 2.1(c)) available for use under the Health FSA Account in the current Plan Year, the Plan will determine the maximum amount available for carryover (not to exceed $500) after the Run-Out Period has ended. The Plan may treat reimbursements of claims for expenses incurred in the current Plan Year as reimbursed first from unused amounts credited for the current Plan Year and, only after exhaustion of all current Plan Year amounts, as then reimbursed from any Carryover amounts carried over from the preceding Plan Year. Any unused amounts from the preceding Plan Year used to reimburse a current Plan Year expense will (1) reduce the amounts available to pay prior Plan Year expenses during the Run-Out Period, (2) must be counted against the permitted carryover of $500 (or such lesser amount elected by the Employer in Section 12 of the Adoption Agreement, if applicable), and (3) cannot exceed the permitted carryover amount.

(d) Reimbursement, if made, shall be made by the Administrator directly to the Participant, upon which the Employer, the Plan, the Plan Administrator and the Contract Administrator shall be relieved of all further responsibility with respect to the expenses reimbursed.

Upon presentation of a claim, a Participant shall expressly represent that the item for which a claim is made is not subject to reimbursement under any policy described in Article 5 or from any other source and such item will not be used as a deduction under Section 213 of the Code.

(e) The Administrator shall process requests for reimbursement on at least a monthly basis.
6.6. **Limitations on Health Care Benefits.** Despite the provisions of this Article 6, no benefits shall be paid under this Article:

(a) If and to the extent that such reimbursement or payment is covered under any insurance policy or policies, whether paid for by the Employer or the Participant, or under any other health and accident plan by whomever maintained. In the event that there is such a policy or plan in effect providing for such reimbursement or payment, in whole or in part, then to the extent of the coverage under such policy or plan, the Employer and the Plan shall be relieved of any liability.

(b) To the extent that an expense has been submitted for reimbursement from a Participant's Dependent Care FSA Account.

(c) For any expenses incurred for medical insurance premiums.

6.7. **Reimbursements Under the Limited Purpose Health FSA and Post-Deductible FSA.** Notwithstanding any provision of the Plan to the contrary, if a Limited Purpose Health FSA and/or a Post-Deductible Health FSA has been selected in Section 6.b. of the Adoption Agreement, a HSA Eligible Individual will be limited to the medical expense reimbursements available under the Limited Purpose Health FSA and/or Post-Deductible Health FSA.

6.8. **Continuation of Health FSA Plan Coverage.** To the extent required by COBRA, a qualified beneficiary (as defined in Section 607 of ERISA) who would lose coverage under the Health FSA upon the occurrence of a COBRA qualifying event (as described in Section 603 of ERISA) shall be permitted to continue coverage under the Health FSA by electing to pay the applicable premiums, on an after-tax basis, in accordance with procedures established by the Plan Administrator that are consistent with Part 6 of Title I of ERISA and any regulations under that Part. The Plan Administrator shall provide notice to each Participant and Spouse of their rights under COBRA in accordance with applicable law and the regulations thereunder.

6.9. **Additional Requirements for Group Health Plans.** The Health FSA shall be interpreted and administered so as to provide coverage, under written procedures established by the Plan Administrator, with respect to individuals for which coverage is required by the applicable provisions of ERISA Section 609 and any regulations under those provisions.

6.10. **Separate Written Plan.** For purposes of the Code, this Article shall constitute a separate written plan providing for the reimbursement of Health Care Expenses. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in this Article 6.

**ARTICLE 7.**

**DEPENDENT CARE FSA PLAN**

7.1. **Dependent Care FSA Account.** The Plan Administrator shall establish and maintain a Dependent Care FSA Account for each Plan Year with respect to each Participant who has elected to receive dependent care assistance for the Plan Year.

7.2. **Crediting of Accounts.** There shall be credited to a Participant’s Dependent Care FSA Account
for each Plan Year, as of each pay period for the Participant in such Plan Year, an amount equal to the reduction, if any, made in the Participant’s Compensation for such pay period in accordance with the Participant’s election under Section 4.1 as well as any Benefit Credits allocated on behalf of the Participant in accordance with Section 4.3. All amounts credited to each such Dependent Care FSA Account shall be paid out pursuant to Section 7.3.

7.3. **Debiting of Accounts.** The balance in a Participant's Dependent Care FSA Account for a Plan Year shall be reduced by the amount of any benefit paid to or on behalf of a Participant under Section 7.4.

7.4. **Dependent Care Benefits.** Subject to limitations contained in other provisions of this Plan, a Participant who elects the benefit option under this Article 7 and incurs Employment-Related Dependent Care Expenses during his Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses to the extent of the amount contained in the Participant's Dependent Care FSA Account for that Plan Year pursuant to Section 7.5(b). However, no reimbursement shall be paid pursuant to this Article to the extent that an expense has been submitted for reimbursement from a Participant's Health FSA Account.

7.5. **Reimbursement Procedures.** In order to receive reimbursement for Employment-Related Dependent Care Expenses under this Article 7:

(a) The Participant must complete a Claim Form, attach a statement of service from the dependent care provider or other proof of claim, and forward the documents to the Contract Administrator or Plan Administrator, as applicable. The Participant must provide additional information reasonably requested by the Administrator.

(b) A request for reimbursement that exceeds the balance in the Participant's Dependent Care FSA Account shall be processed only to the extent of the amount of the account balance. The excess shall be carried over to the following reimbursement period and processed at that time. However, after the Participant's Dependent Care FSA Account has been exhausted, claims remaining unpaid at the end of the Period of Coverage shall be canceled. Except as provided in (d) below, in no event may these claims be resubmitted during the following Plan Year, nor shall any unpaid claims be the liability of the Plan, the Employer, the Plan Administrator or the Contract Administrator.

(c) A request for reimbursement must relate to Employment-Related Dependent Care Expenses incurred during the Participant's Period of Coverage, as set forth in Section 10.f. of the Adoption Agreement. For this purpose, the term “incurred” refers to when the dependent care services were provided, and not when paid.

(d) A request for reimbursement for Dependent Care Expenses incurred during a Period of Coverage must be received by the Administrator either during the Period of Coverage or on or before the end of the Run-Out Period selected in Section 13 of the Adoption Agreement.

(e) Reimbursement, if made, shall be made by the Administrator directly to the Participant, which shall cause the Employer, the Plan, the Plan Administrator and the Contract Administrator to be relieved of all further responsibility with respect to the expense reimbursed.

(f) The Employer may establish a minimum reimbursement amount.
7.6. **Separate Written Plan.** For purposes of the Code, this Article shall constitute a separate written plan providing a program for the reimbursement of Dependent Care Expenses. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in this Article 7.

**ARTICLE 8.**
**RESERVED**

**ARTICLE 9.**
**FORFEITURES**

9.1. **Account Forfeitures.** Any amounts contributed to a Participant's Health FSA Account or Dependent Care FSA Account which have not been used to pay claims for benefits incurred by the end of each Period of Coverage after the Run-out Period has expired shall be forfeited by a Participant, except as provided under the Carryover option described under Section 2.1(c) applicable solely to the Health FSA Account. Any amounts forfeited under this Section may be used in one or more of the following ways:

(a) To reduce required Salary Reduction Contributions for the immediately following Plan Year, on a reasonable and uniform basis;

(b) Returned to Participants on a reasonable and uniform basis;

(c) To defray administrative expenses of the Plan; or

(d) To provide Plan benefits to Participants.

9.2. **Limitation on Contributions and Benefits for Certain Participants.** The Plan Administrator shall determine, before or during any Plan Year, whether the Plan fails to satisfy for the Plan Year any nondiscrimination requirement imposed by the Code, or any limitation on benefits provided to Employees who are considered Highly Compensated Employees, Key Employees and/or 5% owners under applicable Code provisions. The Plan Administrator shall take action that it deems appropriate, under rules uniformly applied to similarly situated Participants, to assure compliance with such requirements or limitations. Such action may include, without limitation, a modification of elections by Highly Compensated Employees, Key Employees and/or 5% owners with or without the consent of such Employees.

**ARTICLE 10.**
**CLAIMS REVIEW PROCEDURES**

10.1. **Determinations.** The Plan Administrator or Contract Administrator, as applicable (see Section 14 of the Adoption Agreement), shall notify a Participant in writing within 30 days of his written application for benefits of his eligibility or non-eligibility for benefits under the Plan unless special circumstances require an extension of time for perfecting the claim. Notice must be given to the claimant of the extension within 30 days of his submission of the claim. The notice must specify the reason for the extension of the date with which a decision is expected to be rendered.

10.2. **Notice.** If the Administrator determines that a Participant is not eligible for all or part of the benefits, the notice shall set forth (a) the specific reasons for such denial, (b) a specific reference to the provision of the Plan on which the denial is based, (c) a description of any additional information or material necessary for the claimant to perfect his claim and a description of why it is needed, and (d) an explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken in the
event the participant wishes to submit the denied claim for review including the right to review relevant documents and other information, and the right to file suit under ERISA (where applicable) with respect to a claim denial.

10.3. **Review.** If a Participant is determined by the Administrator to be ineligible for benefits, or if the Participant believes that he is entitled to greater or different benefits, he shall have the opportunity to have his denied claim reviewed by filing a petition for review with the Administrator within 60 days after he received the claim denial notice, provided, however, that where the denied claim was for reimbursement of Health Care Expenses under Article 6, the Participant shall have 180 days to file such petition. The petition shall state the specific reasons, which the Participant believes, entitle him to benefits or to greater or different benefits. After the Administrator receives the petition for review, the Administrator shall afford the Participant (and his counsel, if any) an opportunity to present his position to the Administrator orally or in writing (at the discretion of the Administrator), and the Participant (or his counsel) shall have the right to review the pertinent documents.

10.4. **Decision.** The Administrator shall notify the Participant of its final decision in writing within the 60-day period after receiving the request for review stating specifically in writing the basis of the decision in a manner calculated to be understood by the Participant and the specific provisions of the Plan on which the decision is based. If, due to special circumstances (such as the need for a hearing), the 60-day period is not sufficient, the final decision may be deferred for up to another 60-day period at the election of the Administrator and notice of this deferral shall be given to the Participant prior to the commencement of the extension. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim. The identity of the medical expert consulted in connection with the appeal will be provided. If a Participant dies, the same procedure shall apply to his beneficiaries.

10.5. **Notice Upon Review.** If the Administrator determines, upon review, that a Participant is not eligible for all or part of the benefits, the notice shall set forth (a) the specific reasons for the denial, (b) a specific reference to the provision of the Plan on which the denial is based, (c) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claimant’s claim, (d) if an internal rule, guideline, protocol, or other similar criterion is relied on making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request, and (e) a statement that the claimant has a right to bring a civil action under Section 502(a) of ERISA, if applicable.

ARTICLE 11.
ADMINISTRATION AND FINANCES

11.1. **Administration.** The Plan shall be administered by one or more individuals appointed by the Employer who shall be the named fiduciaries (as described in Section 402 of ERISA) and the Plan Administrator (as described in Section 3(16)(A) of ERISA) under the Plan.

11.2. **Powers of the Plan Administrator.** The Plan Administrator shall have the following powers, rights and duties in addition to those vested in it elsewhere in the Plan:
To adopt rules of procedure and regulations it determines may be necessary for the proper and efficient administration of the Plan, consistent with the provisions of the Plan.

To enforce the Plan in accordance with its terms and with rules and regulations adopted by the Plan Administrator.

To determine all questions arising under the Plan, including claims for benefits, interpret the Plan, and to remedy ambiguities, inconsistencies or omissions.

To maintain adequate records concerning the Plan and its administration.

To furnish the Employer with such information with respect to the Plan as they may require for tax or other purposes.

A written statement by a majority of Members or by an authorized Member that the Plan Administrator has taken or authorized any action shall be conclusive in favor of the person relying on the statement.

11.3. **Delegation by the Plan Administrator.** The Plan Administrator may employ agents and counsel (who may also be employed by or represent the Employer) and delegate to them such powers as the Plan Administrator deems desirable. Any such delegations shall be in writing and shall describe the advice to be rendered or the functions and duties to be performed by the delegate.

11.4. **Uniform Rules.** The Plan Administrator shall uniformly apply rules and regulations adopted by it to all persons similarly situated.

11.5. **Information to be furnished to Plan Administrator.** The Employer shall furnish the Plan Administrator such information as may be required by the Plan Administrator. The records of the Employer as to an Employee's or Participant's period of employment, termination of employment, and compensation will be conclusive on all persons unless determined by the Plan Administrator to be incorrect. Participants and other persons entitled to benefits under the Plan shall furnish to the Plan Administrator such evidence or information as it considers desirable to carry out the Plan.

11.6. **Plan Administrator Decisions Final.** To the extent permitted by law, any interpretation of the Plan and any decision on any matter within the discretion of the Plan Administrator made by it in good faith are binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable.

11.7. **Compensation and Expenses.** No compensation shall be paid to any individual as such. However, the reasonable expenses of an individual incurred in the performance of a Plan Administrator function shall be reimbursed by the Employer in such proportions as the Employer decides.

11.8. **Interested Individual.** An individual may not decide any matter or question concerning his own benefits under the Plan unless such decision would be made by him under the Plan if not a member.

11.9. **Resignation or Removal of Plan Administrator.** An individual may resign as a Plan Administrator at any time by giving advance written notice to the Employer. The Employer may remove an individual at any time by giving advance written notice to him and the other individuals acting as Plan Administrator.
11.10. Appointment of Successor Plan Administrator Member. The Employer shall fill any vacancy in the membership of the Plan Administrator committee within a reasonable period of time and shall give prompt written notice thereof to the Plan Administrator committee members. While there is a vacancy in the membership of the Plan Administrator committee, the remaining Plan Administrator committee members shall have the same powers as the full Plan Administrator committee until the vacancy is filled.

11.11. Indemnification of the Plan Administrator. To the extent permitted by law, the Plan Administrator committee and its individual members shall be indemnified by the Employer, and held harmless by the Employer against, any and all liabilities, losses, costs, or expenses (including legal fees and expenses) of whatsoever kind and nature that may be imposed on, incurred by, or asserted against the Plan Administrator committee or its members at any time by reason of the performance of a Plan Administrator function, but only if the Plan Administrator committee or its designated members did not act dishonestly or in a willful violation of the law or regulation under which such liability, loss, cost, or expense arose.

11.12. Funding. The costs of the Plan shall be borne by the Employer and paid out of the Employer’s general assets unless otherwise designated in Section 14 of the Adoption Agreement. Neither the Employer nor the Plan Administrator shall be required to maintain any fund or segregate any amount for the benefit of a Participant. For purposes of this Plan, Salary Reduction Contributions shall be deemed to be contributions by the Employer.

ARTICLE 12.
AMENDMENTS AND TERMINATION

12.1. Amendments. The Plan Sponsor (see 1.a. of the Adoption Agreement) may amend the Plan, in full or in part, at any time. Any amendment shall be timely filed with the Plan documents and reasonable notification provided to Employees.

12.2. Benefits Provided Through Third Parties. In the case of any Qualified Benefit provided pursuant to any insurance policy or other contract with a third party, the Plan Sponsor may amend the Plan by changing insurers, policies or contracts without changing the language of this Plan document, provided that copies of the contracts or policies are filed with the Plan documents and the Participants are reasonably informed (to the extent required by law) as to the effects of any such changes. If there is any perceived conflict or inconsistency at any given point in time among the description of benefits contained in the contract or policy and the other Plan documents, the terms of the contract or policy shall control.

12.3. Termination. The Plan Sponsor intends the Plan to be permanent, but necessarily must, and does, reserve the right to terminate the Plan at any time. In the event of a Plan termination, Salary Reduction Contributions will cease. Thereafter neither the Employer nor any of its Employees shall have any further financial obligations under the Plan except such that have accrued up to the date of termination and have not been satisfied.

ARTICLE 13.
MISCELLANEOUS

13.1. Headings. The Article and Section headings contained within this document are included only for convenience of reference, and should not be construed to limit or define the contents contained therein.

13.2. Exclusive Benefit. The Plan has been established and shall be maintained for the exclusive benefit
of Participants, Dependents or Beneficiaries. Benefits shall be paid only in accordance with the Plan's terms. Reasonable expenses of administering the Plan may be paid only in accordance with the Plan's terms.

13.3. **No Guaranty of Employment.** The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Employer and any Employee. Nothing contained in the Plan shall give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time, nor shall it give the Employer the right to require any Employee to remain in its employ or to interfere with the Employee's right to terminate his employment at any time.

13.4. **No Guarantee of Tax Consequences.** The Employer makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant’s gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether amounts paid to or for the benefit of a Participant under this Plan are excludable from his or her gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

13.5. **Limitation on Liability.** The Employer does not guarantee benefits payable under any insurance policy or other similar contracts described or referred to in the Plan, and any benefits thereunder shall be the exclusive responsibility of the insurer or other entity that is required to provide such benefits under the policy or contract. If any Participant receives one or more payments or reimbursements under this Plan that are not for payments of Qualified Benefits, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security and Medicare taxes from such payments or reimbursements, including, but not limited to, any liability for taxes, penalties and interest.

13.6. **Non-Alienation.** No benefit, right or interest of any Participant, Dependent or beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments.

13.7. **Gender and Number.** Except as otherwise indicated by context, masculine terminology also includes the feminine, and vice versa, and terms used in the singular may also include the plural.

13.8. **Mistake of Fact.** In the event of any mistake of fact as to an Employee’s eligibility or participation, or with regard to the allocations to or the distribution of amounts attributable to the Participant’s Dependent Care FSA Account or Health FSA Account, the Plan Administrator shall, in its discretion, cause to be allocated to or adjusted or withheld from the account of the Participant any such amount it deems necessary to correct such mistake of fact, so that the Participant is afforded with the credits or distributions to which he is entitled. Actions taken by the Plan Administrator may include requesting the Employer to withhold any amounts due the Plan or the Employer from the Employee’s Compensation paid by the Employer.

13.9. **Severability.** Should a court of competent jurisdiction invalidate any part of this Plan, the remainder of the Plan shall be given effect to the maximum extent possible.

13.10. **Mental or Physical Incompetence.** All persons entitled to receive or to claim benefits under this Plan shall be presumed to be mentally and physically competent and of age unless the Plan Administrator
13.11. Post-Mortem Payments. In the event of a Participant’s death, any benefits payable under the Plan to such Participant after death shall be paid to his surviving Spouse, if any, or otherwise, to his estate. If there is any doubt as to the right of a beneficiary to receive such amounts, the Plan Administrator may retain such amounts, without liability for any interest, until the right of the beneficiary is determined.

13.12. Inability to Locate Payee. If the Plan Administrator is unable to ascertain the whereabouts or identity of a Participant or other person to whom payment is due under the Plan after reasonable efforts have been made to locate such Participant or other person, such payment and all subsequent payments, if any, otherwise due the Participant or other person shall be forfeited, provided such forfeiture occurs within a reasonable period of time, as determined by the Plan Administrator, following the date such payment first became payable.

13.13. Compliance with Federal Laws. The Plan is intended to comply with applicable requirements of the Mental Health Parity Act, the Women’s Health and Cancer Rights Act, the Newborns’ and Mothers’ Health Protection Act of 1996, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). Further, the Plan will honor the requirements of a valid Qualified Medical Child Support Order (“QMCSO”). If any of the above-referenced laws do not apply to the Plan, the Plan shall not be required to comply with them.

13.14. Applicable Law. The Plan and all rights under the Plan shall be governed by and construed according to the laws of the State in which the Plan Sponsor of this Plan maintains its principal offices, except to the extent preempted by Federal Law.

ARTICLE 14.
HIPAA PRIVACY COMPLIANCE

14.1. Preamble. This Article is to allow the Health FSA (the “Health FSA”) described in Article 6, to disclose Protected Health Information to the Employer in certain situations as permitted by HIPAA. References in this Article to disclosures from the Health FSA Plan made to the Employer include disclosures to employees of the Employer, as described below.

14.2. Disclosures of Summary Health Information. The Health FSA Plan may disclose Summary Health Information to the Employer if the Employer requests this information in order to obtain premium bids for health insurance coverage under the Health FSA Plan, or in order to modify, amend or terminate the Health FSA Plan.

14.3. Enrollment and Disenrollment Information. The Health FSA Plan may disclose information to the Employer concerning whether or not an Individual is participating in the Health FSA Plan, or has enrolled or disenrolled from a Health Insurance Issuer or HMO offered by the Health FSA Plan.

14.4. Disclosures Pursuant to an Authorization. The Health FSA Plan may disclose Protected Health Information to the Employer if the disclosure is made pursuant to a valid Authorization and the information is used as described in the Authorization. In particular, the Health FSA Plan may disclose Protected Health Information to the Employer pursuant to an Authorization to assist employees and their beneficiaries in connection with their claims under the Health FSA Plan, or to help them understand the terms of the Health FSA Plan as they may relate to a particular condition or claim.
14.5. Disclosures for Administration Purposes...The Health FSA Plan may disclose Protected Health Information to the Employer so it can carry out its Administration functions under the Health FSA Plan. These functions include Payment and Health Care Operations, including without limitation, quality assurance, claims processing, processing and deciding appeals, claims auditing, claims monitoring, monitoring and managing carve-out plans such as vision and dental coverages, procuring stop-loss coverage, and reminding participants and beneficiaries of appointments or advising them of potential alternative treatments or services. For purposes of this Section, Administration functions do not include any of the matters described in Sections 3, 4, or 5 above, do not include any employment-related functions or functions in connection with any other benefit or benefit plans of the Employer, and do not include any disclosures which otherwise conflict with the Privacy Rules. Disclosures of Protected Health Information for Health FSA Plan Administration purposes may only be made if the conditions described in Sections 15.5(a) and (b) below are met.

(a) The Employer must agree and comply with the following requirements before the Health FSA Plan may disclose Protected Health Information to the Employer for Health FSA Plan Administration purposes:

(1) the use or disclosure must be described in the Health FSA Plan’s Notice of Privacy Practices issued pursuant to 45 CFR 164.520;

(2) The Employer must certify that the Health FSA Plan documents have been amended as required by 45 CFR 164.504, and that it agrees to adhere to the requirements of these Amendments;

(3) The Employer may not use or further disclose Protected Health Information provided to it except as permitted by the Health FSA Plan documents (as amended to comply with HIPAA), or as required by law;

(4) The Employer will insure that any agents or subcontractors to whom it provides Protected Health Information received from the Health FSA Plan will agree to the same restrictions and conditions on the use and disclosure of this information that apply to the Employer;

(5) The Employer will not use or disclose Protected Health Information received from the Health FSA Plan for any employment-related actions or decisions, or in connection with any other benefit or benefit plan it maintains;

(6) The Employer will report to the Health FSA Plan any use or disclosure of PHI which it has received from the Health FSA Plan and which is inconsistent with allowed uses and disclosures, to the extent it becomes aware of such uses and disclosures;

(7) The Employer will make the Protected Health Information it receives from the Health FSA Plan available to Individuals as required by 45 CFR 164.524 (pertaining to inspection and copying); 45 CFR 164.526 (pertaining to amendment); and 45 CFR 164.528 (pertaining to accounting);

(8) The Employer will make its internal practices, books and records relating to the use and disclosure of PHI it receives from the Health FSA Plan available to the Secretary of Health and Human Services or his or her designee, to determine the Health FSA Plan’s compliance with the Privacy Rules;
(9) The Employer will, if feasible, return or destroy all Protected Health Information received from the Health FSA Plan in any form, and retain no copies, when the information is no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Employer will limit further uses and disclosures of the Protected Health Information to those purposes which make the return or destruction infeasible.

(b) The Employer must provide for adequate separation between itself and the Health FSA Plan. To do so, only the employees or persons under the Employer’s control and listed in Section 4.e. of the Adoption Agreement will have access to Protected Health Information from the Health FSA Plan:

Access to Protected Health Information by the above person(s) shall be restricted so that such person(s) receives only the minimum Protected Health Information necessary to accomplish the Administrative functions which he or she performs for the Health FSA Plan. If this person(s) or other employees of the Employer do not comply with the requirements of the Health FSA Plan in respect to the use and disclosure of Protected Health Information, the Employer will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. These sanctions will be imposed in accordance with the Employer’s normal disciplinary policies, and can include termination of employment.

14.6. No Other Disclosures of Protected Health Information. The Health FSA Plan will not disclose Protected Health Information to the Employer (and will not cause a Health Insurance Issuer or HMO to disclose Protected Health Information to the Employer) except as described in this Amendment.

14.7. Definitions.

(a) Authorization. A document signed by an Individual authorizing disclosure of Protected Health Information and complying with the requirements of 45 CFR 164.508.

(b) Health Care Operations. “Health Care Operations” mean:

(1) Any of the following activities of the Plan:

(A) conducting quality assessment and improvement activities, including outcomes evaluations and development of clinical guidelines specific to the Plan;

(B) population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, contacting Health Care Providers and patients with information about treatment alternatives, and related functions which do not involve Treatment;

(C) reviewing the competence or qualification of health care professionals, evaluating practitioner or provider performance, training of students or practitioners in which the students or practitioners learn under supervision to practice or improve their professional skills, training non-health care professionals, and accreditation, certification, licensing or credentialing activities;
(D) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a health insurance contract or health benefits, as well as ceding, securing or placing a stop-loss or excess loss insurance contract relating to health claims (as long as the requirements of 45 CFR 164.514 are met);

(E) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(F) business planning and development, such as conducting cost-management and planning which pertain to running the Plan, including developing and administering formularies and administering, developing or improving methods of payment or coverage policies; and

(G) business management and general Plan administrative activities, including but not limited to:

(i) management activities related to HIPAA privacy compliance;

(ii) customer service, including providing data analysis for plan sponsors, as long as PHI is not disclosed in the process;

(iii) resolution of internal grievances;

(iv) merger or consolidation of the Plan with another health plan, and due diligence related to the merger or consolidation; and

(v) consistent with the requirements of 45 CFR 164.514, creating de-identified health information or a limited data set.

(c) Health Care Provider. The term “Health Care Provider” means a provider of services, including a provider of medical or health services, as defined in the Social Security Act, and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business.

(d) Health Information. “Health Information” means any information, whether oral or recorded in any form or medium, that:

(1) is created or received by a Health Care Provider, health plan, public health authority, the Employer, life insurer, school, university or health care clearing house; and

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

(e) Health Insurance Issuer. The term “Health Insurance Issuer” means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance. The term does not include a group health plan.
(f) **Individual or Individuals.** An “Individual” is the person who is the subject of PHI.

(g) **Individually Identifiable Health Information.** The term “Individually Identifiable Health Information” means Health Information, including demographic information, taken from an Individual which either identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

(h) **Payment.** “Payment” means:

1. the activities of the Plan (or another health plan) to obtain premiums or to determine or fulfill its responsibility for coverage or providing benefits; or

2. the activities of the Plan or a Health Care Provider to obtain or provide reimbursement for providing health care.

Examples of Payment activities include, but are not limited to:

(A) determination of eligibility or coverage, including coordination of benefits or determining cost sharing amounts;

(B) determining subrogation of health claims;

(C) risk adjusting amounts due based on an Individual’s health status and demographic characteristics;

(D) billing, claims management, collection activities, obtaining payment under a stop-loss or excess loss insurance policy, and related health care data processing;

(E) review of health care services to determine medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(F) utilization review activities, including precertification or preauthorization of claims and concurrent or retrospective review of services; and

(G) disclosure to consumer reporting agencies of any of the following information relating to collection of premiums or reimbursement:

   (i) name and address;

   (ii) date of birth;

   (iii) social security number;

   (iv) payment history;

   (v) account number; and

   (vi) name and address of the Plan or of a Health Care Provider.
(i) **Privacy Rule or Rules.** The terms “Privacy Rule” or “Privacy Rules” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E.

(j) **Protected Health Information.** The term “Protected Health Information” means Individually Identifiable Health Information, excluding information contained in employment records of the Employer that is transmitted or maintained in any form or medium.

(k) **Summary Health Information.** The term “Summary Health Information” means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses, or type of claims experienced by Individuals under the Plan, and from which information described in 45 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

**ARTICLE 15. HIPAA SECURITY COMPLIANCE**

**15.1. Preamble.** This Article modifies all group health plans maintained by the Employer and on account of which the Employer is responsible for compliance with the Security Rules of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). For simplicity, these plan(s) are collectively referred to herein as the “HIPAA Plan(s)”. This Article allows the Employer to create, receive, maintain or transmit Electronic Protected Health Information (“ePHI”) in certain circumstances on behalf of its HIPAA Plan(s).

**15.2. Safeguards.** The Employer will put into place and follow Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any ePHI that the Employer creates, receives, maintains or transmits on behalf of the HIPAA Plan(s), except as stated in Section 16.6 below.

**15.3. Adequate Separation.** The Employer will put into place and follow reasonable and appropriate security measures to ensure that access to and use of ePHI is restricted to its employees or group of employees who are required to Access or use such ePHI for the proper administration of the Employer’s HIPAA Plan(s), or for such other reasons as may be proper under HIPAA Security Rules. The Employer will provide an effective mechanism for resolving any issues of non-compliance with such Security measures by ensuring that appropriate sanctions are imposed against any employee who violates or fails to follow them.

**15.4. Control of Agents and Subcontractors.** The Employer will require that any of its agents or subcontractors to whom it provides ePHI relating to the HIPAA Plan(s), agrees to implement reasonable and appropriate security measures to protect the ePHI.

**15.5. Reporting Security Incidents.** The Employer will report to the HIPAA Plan(s) any Security Incident of which it becomes aware.

**15.6. Exceptions.** The terms of this HIPAA Security Article shall not apply if ePHI is disclosed to the Employer pursuant to an Authorization which meets the requirements of the HIPAA Privacy Rules described at 45 CFR § 164.508, or if the ePHI is Summary Health Information which the Employer has requested in order (a) to obtain premium bids from health insurers for providing health insurance coverage under the HIPAA Plan(s); or (b) to amend or terminate any of the HIPAA Plan(s). In addition, the terms
of this HIPAA Security Article shall not apply if the ePHI disclosed to the Employer is information concerning whether an Individual is participating in any of the HIPAA Plan(s), or is enrolled or disenrolled from a health insurance issuer or HMO offered by any of the HIPAA Plan(s).

15.7. Definitions.

(a) Access “Access” means the ability or the means necessary to read, write, modify or communicate data/information or otherwise use any system resource.

(b) Administrative Safeguards “Administrative Safeguards” are administrative actions and policies and procedures, to manage the selection, development, implementation and maintenance of security measures to protect Electronic Protected Health Information, and to manage the conduct of the HIPAA Plan(s) or their workforce in relation to the protection of that information.

(c) Electronic Protected Health Information “Electronic Protected Health Information” or “ePHI” is Protected Health Information which is transmitted by Electronic Media or maintained in Electronic Media. For this purpose the term “Electronic Media” means (i) electronic storage media, including memory devices and computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disc, optical disc or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including transmissions of paper, via facsimile and of voice, via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

(d) Health Information “Health Information” means any information, whether oral or recorded in any form or medium, that:

   (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school, university or health care clearing house; and

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

(e) HIPAA Privacy Rule or Rules The terms “HIPAA Privacy Rule” or “HIPAA Privacy Rules” shall mean the Standards for Privacy of Individually Identifiable Health Information published at 45 CFR Parts 160 and 164, subparts A and E.

(f) Individual An “Individual” is the person who is the subject of Protected Health Information.

(g) Individually Identifiable Health Information The term “Individually Identifiable Health Information” means Health Information, including demographic information, taken from an Individual which either identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.
(h) **Physical Safeguards** “Physical Safeguards” are physical measures, policies, and procedures to protect the HIPAA Plan(s)’ electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

(i) **Protected Health Information** The term “Protected Health Information” means Individually Identifiable Health Information, excluding information contained in employment records of the employer that is transmitted or maintained in any form or medium.

(j) **Security Incident** “Security Incident” means an attempted or successful unauthorized Access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

(k) **Security Rule or Rules** Means the Security Standards for the protection of Electronic Protected Health Information published at 45 CFR Parts 160 and 164, subparts A and C.

(l) **Summary Health Information** The term “Summary Health Information” means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses, or types of claims experienced by Individuals under the HIPAA Plan(s), and from which information described in 45 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

(m) **Technical Safeguards** “Technical Safeguards” mean the technology and the policies and procedures for its use that protect Electronic Protected Health Information and control Access to it.