CITY OF KLAMATH FALLS

Flexible Spending Account
Plan Document

Effective: 1/1/2015

IRC Section 125 requires that your Plan Document be kept on file.
This document explains in detail the operation and rules that govern your Plan.

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ARTICLE I - Purpose of Plan and Legal Status

CITY OF KLAMATH FALLS (the “Employer”) hereby adopts this Flexible Spending Account (the “Plan”), effective as of the date specified in Section II of the Summary Plan Description, either as an initial establishment of a cafeteria plan or as the restatement of a previously implemented plan.

1.01 Purpose This Plan is a cafeteria plan intended to qualify under Section 125 of the Internal Revenue Code of 1986, as amended (the “Code”), and regulations issued pursuant thereto and shall be interpreted to accomplish that objective. This Plan is designed to permit an Eligible Employee to pay for his or her share of Contributions on a pre-tax salary reduction basis under the Premium Plan, and contribute to the reimbursement benefit(s) on a pre-tax salary reduction basis.

1.02 Limitations on Provisions The provisions of the Plan and any benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other employee benefit plan maintained by the Employer shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

1.03 Nondiscriminatory This Plan will be “nondiscriminatory” as that term is used in Code Section 125 and any subsequently issued regulations thereunder. The Employer reserves the right to take whatever steps are necessary to maintain this Plan as nondiscriminatory and to ensure continued qualification, including the right to adjust the amount of nontaxable benefits elected by Employees. Any such reduction of nontaxable benefits shall be accomplished by reducing proportionately the nontaxable benefits elected by Highly Compensated and/or Key Employees.

ARTICLE II - Definitions

2.01 "Beneficiary" means a person who is eligible to receive benefits under the Plan by reason of another individual's active or former service with the Employer.

2.02 "Benefits" mean cash, flex credits and the various qualified benefits under Section 125(f) of the Code sponsored by the Employer and made available by the Employer through the Plan as described in Article VI.

2.03 "Change in Status" has the meaning described in Article X.

2.04 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended; described in Article III.

2.05 "Code" means the Internal Revenue Code of 1986, as it may be amended.

2.06 "Compensation" means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 132(f)(4), 401(k), 403(b), 408(k) or 457(b) of the Code.

2.07 "Contributions" means the amount contributed to pay for the cost of benefits (including self-funded benefits as well as those that are insured), as calculated under Article VI.

2.08 "Dependent" means: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Plan, and for purposes of the Health FSA Plan), (1) a dependent as defined as in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 26, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCAP Plan, a Qualifying Individual. Notwithstanding the foregoing, the Health FSA Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

2.09 "Dependent Care Assistance Plan" means the Dependent Care Assistance Plan established pursuant to Article 6.03.

2.10 "Effective Date" of this Plan is the date specified in Section II of the Summary Plan Description.

2.11 "Enrollment Form" means the agreement by a Participant authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of obtaining Benefits under the Plan.

2.12 "Electronic Payment Card" means a debit card, stored value card, or credit card that allows a Participant to access funds in a flexible reimbursement arrangement to pay the service provider at the point-of-sale (i.e., the time a service or item is provided).

2.13 "Employee" means an Employee of the Employer as defined under Section 125.

2.14 "Employer" means the Employer designated in Section II of the Summary Plan Description, along with any other entities belonging to a control group (Code § 414(b) and (c)). or an affiliated service group (Code § 414(m)), provided such entities are designated as participating Employers in Section II of the Summary Plan Description.

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

2.16 "Federal Limit for Health FSA" means the limit on annual salary reduction contributions to Health FSA's offered under cafeteria plans as imposed by Section Code 125 (i)(1). Such limitations shall be adjusted for inflation as provided in Code Section 125 (i)(2).

2.17 "FMLA" means the Family and Medical Leave Act of 1993, as amended.

2.18 "FSA" means Flexible Spending Account.

2.19 "FSA Carryover Provision" means unused amounts in a Participant's Health Related Expense Plan or Limited Flexible Spending Account Plan may carry forward and remain available to reimburse eligible healthcare expenses incurred in later years.

2.20 "FSA Use It or Lose It Rule" means unused amounts that remain in a Participant's account after all reimbursements have been made for the period of coverage, the balance shall not be carried over to reimburse the Participant expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

2.21 "GINA" means the Genetic Information Nondiscrimination Act of 2008.

2.22 "Grace Period" means an extension of 2.5 months to incur expenses that can be reimbursed from the prior Plan Year account(s) before they become subject to the FSA "Use It or Lose It" rule and begins immediately following the last day of the Plan Year.

2.23 "Group Sponsored Insurance Plan" means the Group Sponsored Insurance Plan established pursuant to Article 6.01.

2.24 "Health FSA" means a "Health Flexible Spending Account" which is offered as part of a cafeteria plan sponsored by the Employer.

2.25 "Health Insurance, Plan or Coverage" includes health, medical, dental, vision, accident or other similar insurance, plan or coverage

2.26 "Health Savings Account Plan/Limited Flexible Spending Account" means the Health Savings Account Plan/Limited Flexible Spending Account established pursuant to Article 6.05.

2.27 "Highly Compensated Employee" means a highly compensated individual as defined under Section 125.

2.28 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.29 "HITECH" means the Health Information Technology for Economic and Clinical Health Act which was enacted as part of the American Recovery and Reinvestment Act of 2009.

2.30 "HRE" means the Health Related Expense Plan established pursuant to Article 6.02.

2.31 "Key Employee" means any Employee who is a Key Employee as defined in Section 416(i) (1) of the Code at any time during the preceding Plan Year.

2.32 "MHPA" means the Federal Mental Health Parity Act.

2.33 "MHPAEA" means the Federal Mental Health Parity Addiction Equity Act.

2.34 "Michelle's Law" means the Federal law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

2.35 "NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

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

2.37 "Participant" means any Employee who has satisfied the eligibility requirements of Article 3.01, has elected to participate in the Plan, and has not, for any reason, become ineligible to participate in the Plan.

2.38 "Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become Participants in the middle of the Plan Year, it means the portion of the Plan Year following the date Participation commenced, and (b) for Employees who cease to Participate during the middle of a Plan Year, it shall mean the portion of the Plan Year prior to the date participation terminates as set forth in Article III.

2.39 "Plan" means this cafeteria plan, together with any and all amendments and supplements required by the Code.

2.40 "Plan Administrator" means CITY OF KLAMATH FALLS. The contact person is the Human Resources Manager for CITY OF KLAMATH FALLS, who has the full authority to act on behalf of the Administrator, except with respect to appeals, for which the Committee or other designated person(s) have the authority to act on behalf of the Administrator, as described in Article 7.01.

2.41 "Plan Year" means the period of time specified in Section II of the Summary Plan Description.

2.42 "PPACA" means the Patient Protection and Affordable Care Act.

2.43 "Privacy Official" has the meaning described in 45 CFR § 164.530(a).

2.44 "Protected Health Information" (PHI) shall have the meaning described in 45 C.F.R. Section 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

2.45 "QMCSO" means a qualified medical child support order, as defined in ERISA Section 609(a).

2.46 "Qualified Benefits" means one or more of the Plans specified in Section II of the Summary Plan Description under Benefit Options.

2.47 "Qualified Reservist Distribution" means a distribution to a Participant of all or a portion of the balance in the Participant's Health Related Expense Plan account as determined pursuant to Article 3.05.

2.48 "Qualifying Individual" has the meaning described in Article 6.03.

2.49 "Related Employer" means any Employer affiliated with Employer that, under Code Section 414(b), (c), (m) or (o), is treated as a single Employer with Employer for purposes of Code Section 105.

2.50 "Run-Out Period" means a period after the close of a Plan Year or other period during which Participants in a flexible spending account may request reimbursement for expenses incurred during the period of coverage.

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

2.52 "Section 125" means Section 125 of the Code, including the proposed regulations, any final regulations, and all other authoritative guidance thereunder.

2.53 "Spouse" means an individual of same-sex or opposite sex who is legally married to a Participant as determined under applicable federal and/or state law (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the DCE Plan the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

2.54 "Supplemental Premium Account Plan" means the Supplemental Premium Account Plan established pursuant to Article 6.04.

2.55 "Third Party Administrator" means PacificSource Administrators, Inc. ("PSA").

2.56 "Timely Submitted" means, unless the Employer has specific and special cause to alter the definition of this phrase, within 30 calendar days of event that has triggered the change in status as described in Article X.

2.57 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended; as described in Article 3.04.

2.58 "WHCRA" means the Federal Women's Health and Cancer Rights Act.

ARTICLE III - Eligibility and Participation

3.01 General Once an Employee has met the Plan's eligibility requirements; the Employee may commence participation in the Plan as of the Entry date specified by the Employer.

A Participant shall cease to be a Participant in the Plan as of the earliest of:

- The first day of a Plan Year for which the Participant declines to participate in any Plan provided under the Plan;
- In the case of a Participant who ceases to satisfy the eligibility requirements as specified in Section II of the Summary Plan Description, the date as of which the individual ceases to have a right to any benefit under the Plan; or
- The date on which the Plan is terminated.

A former Participant will be reinstated as a Participant if and when he or she again satisfies the eligibility requirements.

3.02 Family and Medical Leave Act

(a) Health Benefits Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Group Sponsored Insurance Plan and HRE Plan on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions. An Employer may require Participants to continue all Group Sponsored Insurance Plan and HRE Plan coverage for Participants while they are on paid leave, provided that Participants on non-FMLA paid leave are required to continue coverage. If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax salary reduction basis). In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Group Sponsored Insurance Plan or HRE Plan during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- With after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- Pre-Pay with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);
- Pay-as-you-go with their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations and in a manner approved by the Employer; or

- Under another arrangement agreed upon between the Participant and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

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

If a Participant's Group Sponsored Insurance Plan or HRE Plan coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Group Sponsored Insurance Plan or HRE Plan as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants who’s Group Sponsored Insurance Plan or HRE Plan coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

Notwithstanding the preceding sentence, with regard to HRE Plan a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the HRE Plan at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated HRE Plan will be equal to the amount withheld prior to the period of FMLA leave.

(b) Non-Health Benefits If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCE expenses) is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Article 3.03.

3.03 Non-FMLA Leaves of Absence If a Participant goes on a paid or unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid in one of the following ways:

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

- With their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations; or
- Under another arrangement agreed upon between the Participant and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Article X will apply.

3.04 Uniformed Services Employment and Reemployment Rights Act ("USERRA")
Notwithstanding any provision of the Plan to the contrary, Contributions, service, and benefits with respect to qualified military service will be provided in accordance with Section 414(u) of the Code and the regulations thereunder. In the event a Participant takes an unpaid USERRA leave of absence, each elected healthcare benefit shall continue for the lesser of the period of the leave or twenty-four (24) months, provided that 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. If the applicable Contributions for the elected healthcare benefits are not paid in a timely manner, the elected healthcare benefit shall be suspended during the period of unpaid leave. Upon return from an unpaid USERRA leave before the end of the Plan Year in which the leave commenced active participation in the Plan shall be reinstated and Compensation reduction Contributions and benefits shall resume in accordance with the Enrollment Form in effect immediately prior to the leave. 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 Article 3.01 shall apply.

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 and Article 3.01 shall apply.

3.05 Qualified Reservist Distributions

(a) A Participant who is, by reason of being a member of a reserve component (as defined in 37 U.S.C. §101), ordered or called to active duty for a period of 180 days or more or for an indefinite period may request a Qualified Reservist Distribution by delivering a copy of such order or call to active duty to the Employer. The Employer may rely on the order or call to determine the period that the Participant has been ordered or called to active duty. If the order or call specifies that the period of active duty is for 180 days or more or is indefinite, the Participant is eligible for a Qualified Reservist Distribution, and the Participant's eligibility is not affected if the actual period of active duty is less than 180 days or is otherwise changed. If the period specified in the order or call is less than 180 days, a Qualified Reservist Distribution is not allowed. However, subsequent calls or orders that increase the total period of active duty to 180 days or more will qualify a Participant for a Qualified Reservist Distribution. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(b) The amount available as a Qualified Reservist Distribution under this Article 3.05 shall be the amount contributed to the Health Related Expense Plan as of the date of

the Qualified Reservist Distribution request minus the reimbursements received by the Participant for the Plan Year as of the date of such request.

(c) With respect to expenses incurred after the date a Qualified Reservist Distribution is requested, the Participant may continue to submit claims for reimbursement under the Health Related Expense Plan for the remainder of the Plan Year (and Grace Period, if applicable); provided that the amount reimbursed is not greater than the amount elected for contribution to the Health Related Expense Plan for the Plan Year, less amounts previously distributed and less amounts previously reimbursed.

(d) A Participant must request a Qualified Reservist Distribution on or after the date of the order or call to active duty, and before the last day of the Plan Year (or Grace Period) during which the order or call to active duty occurred. The Employer must pay the Qualified Reservist Distribution to the Participant within a reasonable time, but within 60 days after the request for a Qualified Reservist Distribution has been made. A Qualified Reservist Distribution may not be made with respect to a Plan Year ending before the order or call to active duty.

(e) A Qualified Reservist Distribution is included in the gross income and wages of the Employee, and is subject to employment taxes. The Employer must report the QRD as wages on the Employee's Form W-2 for the year in which the QRD is paid to the Employee.

3.06 Coverage Continuation Participant and each qualified beneficiary who loses coverage under the Health Related Expense Plan as a result of the Participant's termination of employment or cessation of eligibility because of a reduction in hours of employment will be entitled to elect continuation coverage under the Health Related Expense Plan to the extent required by federal law (i.e., Code § 4980B, known as "COBRA continuation rights"). Specifically, these individuals will be eligible for COBRA continuation only if the Participant has a positive Health Related Expense account balance at the time of the qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if eligible for COBRA continuation coverage.

If COBRA continuation coverage is elected, it will be available only for the Plan Year in which the qualifying event occurs, with the COBRA continuation coverage for the Health Related Expense Plan ceasing at the end of the Plan Year, with no ability to continue for the next Plan Year. In addition, COBRA continuation coverage will not be available unless the Employer normally employed 20 or more Employees on a typical business day during the preceding calendar year. The COBRA Administrator shall provide notice to the Participant of his or her right to continuation coverage and shall administer continuation coverage hereunder in accordance with applicable law and regulations.

3.07 Special Enrollment under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") With regard to the health insurance plan (excluding the Health Related Expense Plan and a high deductible health plan) which constitutes a "group health plan", if an Employee or dependent experiences one of the events described in this Article 3.07, the Employee may make a corresponding change to a prior election within sixty (60) days of the occurrence thereof:

(a) Termination of coverage as a result of loss of eligibility for coverage under a state plan for medical assistance under Title XIX of the Social Security Act or a state child health plan under Title XXI of the Social Security Act; or

(b) Becoming eligible to receive financial assistance, with respect to paying for coverage under a plan which is a group health plan (excluding the Health Related Expense Plan and a high deductible health plan), from a state plan for medical assistance under Title XIX of the Social Security Act or a state child health plan under Title XXI of the Social Security Act.

ARTICLE IV - Election Rules and Procedures

4.01 Elections When First Eligible Once an Employee has met the Plan's eligibility requirements, the Employee may enter the Plan on the date the eligibility requirements have been met provided that an Enrollment Form is submitted to the Employer before the first day of the month in which participation will commence.

Eligibility for Group Sponsored Insurance Plan shall be subject to the additional requirements, if any, as specified by the insurance benefits provider(s). The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified by the insurance benefits provider(s).

4.02 Elections During Open Enrollment Period During each Open Enrollment Period with respect to a Plan Year, the Employer shall provide an Enrollment Form to each Eligible Employee. The Enrollment Form shall enable the Employee to elect to participate in the various Benefit Options of this Plan for the next Plan Year and to authorize the necessary salary reductions to pay for the Benefits elected. The Enrollment Form must be returned to the Employer on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year.

The Employer is also authorized to permit elections to be made electronically as supported by PSA. The safe harbor for electronic elections under Treas. Reg. §1.401(a)-21 is available for such electronic elections. Only an Employee or Employer can make an election electronically.

4.03 New and Reinstated Participants Once an Employee becomes eligible, the Employer shall provide an Enrollment Form to the Employee. If the Employee desires the benefits for the balance of the Plan Year in which he or she has become eligible for the Plan, he or she shall so specify on the Enrollment Form and shall agree to a reduction in his or her Compensation as provided in Article 4.02. The Enrollment Form must be completed and returned to the Employer on or before such date as the Employer shall specify, which date shall be no later than 30 days after the Participant has become eligible for the Plan. For an Employee hired after The Plan effective date, salary reduction will begin with the first day of the next period after eligibility requirements are met as provided in Article 4.01.

For a Participant or Employee who terminates employment or becomes ineligible to participate and is later rehired by the Employer (or who returns to employment following an unpaid leave of absence) or later becomes eligible, reinstatement is determined by the length of time the Employee was terminated or ineligible as specified in the Summary Plan Description.

4.04 Enrollment Form

Group Sponsored Insurance The Employee will be deemed to elect for each upcoming Plan Year whatever election is in effect in the current Plan Year, unless the Participant expressly changes his or her election by turning in a completed Enrollment Form prescribed by the Employer.

For example, if the Participant is enrolled in the Group Sponsored Insurance Plan in the current year and wants to remain enrolled in the upcoming year, the Employee need not do anything, but if the Employee wants to stop participating in that Program, the Employee must affirmatively elect not to participate during the open enrollment period for the upcoming Plan Year.

Under all the other Programs, the Employee must make an affirmative election to participate every year by turning in a completed Enrollment Form prescribed by the Employer or the Employee will be deemed to have elected not to participate.

For example, an Employee who fails to return a completed Enrollment Form to the Employer on or before the specified due date for the new Plan Year shall be deemed to have elected not to reduce his or her compensation for such Plan Year. If an Eligible Employee fails to file an Enrollment Form for subsequent Plan Years, then the Employee is considered to have elected not to participate for the new Plan Year and may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Article X.

Under the HRE and LFSA Plan, when the FSA Carryover Provision is permitted and unused amounts are carried forward, you will be deemed as having "elected for each upcoming Plan Year".

4.05 Irrevocability of Elections Unless an exception applies, as described in Article X, a Participant's election under the Plan is irrevocable for the duration of the period of coverage to which it relates.

ARTICLE V - Benefit Options and Method of Funding

5.01 Benefits Offered The Employee may elect to reduce his or her salary or wages as of his or her entry date in the Plan to participate in one or more of the following benefit Plans. Refer to Section II of the Summary Plan Description to determine which of the following Plans are available to elect:

- Group Sponsored Insurance Plan
- Health Related Expense Plan
- Dependent Care Assistance Plan
- Supplemental Premium Account Plan
- Limited Flexible Spending Account Plan

In no event shall benefits under the Plan be provided in the form of deferred compensation.

5.02 Participant Contributions Participants who elect Benefits under the Plan may pay for the cost of that coverage on a pre-tax salary reduction basis by completing an Enrollment Form.

(a) Salary Reductions The salary reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to the annual Contributions for such Benefits (elected under the Plan as applicable), divided by the number of pay periods in the period of coverage or an amount deemed appropriate by the Employer (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which salary reductions are applied may fluctuate).

(b) Considered Employer Contributions for Certain Purposes Salary reductions are applied by the Employer to pay for the Participant's share of the Contributions for the benefits elected under the Plan and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

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

5.03 Employer Contributions An Employer may provide non-elective contributions in the form of Employer Funding. To the extent designated in Section II of the Summary Plan Description, the Employer is required or permitted to make non-elective contributions, which shall be credited to the accounts of some or all Participants in the amounts and manner designated in Section II of the Summary Plan Description. Such contributions shall be prorated for Participants who begin participating in the middle of a Plan Year unless Section II of the Summary Plan Description specifies otherwise. If available, the Employer designates the account(s) that are eligible to receive the funding. The Participant may elect to have the amount of the Employer Funding applied to the Plans indicated in Article 5.01.

When Employers contribute to a Health FSA or make matching contributions on behalf of participants, these contributions generally do not count toward the annual Federal Limit for Health FSA. However, if an Employer's Plan offers a "cash-out" option, which allows Participants to receive non-elective contributions in cash or as taxable benefit, then the

contributions will be treated as salary reductions and will count toward the Federal Limit when contributed to the Health FSA.

5.04 Funding This Plan The Plan shall be funded with amounts withheld from Salary or Wages, Employer contributions as designated in Section IV of the Summary Plan Description as allocated pursuant to Enrollment Forms from Participants. All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or PSA to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an independent third-party paying agent to make Benefit payments on its behalf.

5.05 Maximum Contribution The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions, as described in Section II of the Summary Plan Description.

5.06 Debit and Credit Cards Participants may, subject to a procedure established by the Employer, use debit and/or credit (stored value) cards ("Cards") provided by the Employer and the Plan for payment of expenses. The stored value is determined by a Participant's election and is subject to the maximum annual value per the following terms:

(a) Participant Certification Each Participant issued a Card shall certify upon issuance and each Plan Year thereafter that the Card shall only be used for eligible expenses. The Participant shall also certify that any expense paid with the Card has not already been reimbursed by any other plan or source, and that the Participant will not seek reimbursement under any other plan covering health benefits.

(b) Issuance and Revocation of Card Such Card shall be issued upon the Participant's commencement of participation and reissued (or remain active) for Coverage Periods during which the Participant remains a Participant in the Plan. Such Card shall be automatically cancelled if the Participant dies, terminates employment or otherwise ceases to be an eligible Employee for any reason.

(c) Maximum Expenses Payable with the Card The maximum dollar amount of expenses payable with the Card shall be the maximum dollar amount of coverage available in the Participant's Health Related Expense account, or such lesser amount as set forth in Section II of the Summary Plan Description. The Cards shall only be used for the purchase of eligible expenses.

(d) Only Approved Merchants The Cards shall be ineffective (i.e., rejected) except at those merchants and service providers authorized by the Employer. The Employer's authorization of merchants and service providers shall comply with IRS guidance governing the use of Cards, including Rev. Rul. 2003-43, Notice 2006-69, Notice 2007-2, and such superseding or additional guidance as may be promulgated by the IRS.

(e) Substantiation of Expenses All purchases with the Cards must be substantiated by PSA and may be substantiated in any manner allowed by applicable IRS guidance. Without limiting the generality of the preceding sentence, the following rules apply:

(e1) General Rule Except as otherwise allowed by IRS guidance, substantiation will be made by submission of a receipt from a merchant or service provider describing the service or product, the date of the purchase and the amount.

(e2) Co-payment Match Substantiation Method To the extent permitted by IRS guidance, charges shall be considered substantiated if they satisfy the "co-payment match substantiated method" as set forth in Rev. Rul. 2003-43, Notice 2006-69, Notice 2007-2 and superseding or additional IRS guidance. Under that method, a charge is considered substantiated without the need for submission of a receipt or further review if the Group Sponsored Insurance Plan has co-payments in specific dollar amounts, and the dollar amount of the transaction at a healthcare provider (as identified by its merchant category code), or other merchant/service provider as otherwise allowed by IRS guidance, equals an exact multiple of not more than five times the dollar amount of the co-payment for the specific service (i.e., pharmacy benefit co-payment, co-payment for a physician's office visit, etc.) under the Group Sponsored Insurance Plan covering the specific Participant. In addition, if a health plan has multiple co-payments for the same benefit (e.g., tiered co-payments for a pharmacy benefit), exact matches of multiples or combinations of the co-payments (but not more than the exact multiple of five times the maximum co-payment) will similarly be fully substantiated without the need for submission of a receipt or further review.

(e3) Recurring Expenses To the extent permitted by IRS guidance, charges shall be considered substantiated without the need for submission of a receipt or further review if they match expenses previously approved as to amount, provider and time period (e.g., for a Participant who refills a prescription drug on a regular basis at the same provider for the same amount).

(e4) Real Time Substantiation To the extent permitted by IRS guidance, charges shall be considered substantiated without the need for submission of a receipt or further review if the merchant, service provider, or other independent third party (e.g., pharmacy benefit manager), at the time and at the point of sale, provides information to verify to PSA (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for an expense.

(e5) Inventory Information Approval System Charges shall be considered substantiated without the need for submission of a receipt or further review if they are made through an "inventory information approval system" as set forth in Section III.B of Notice 2006-69 and additional or superseding IRS guidance.

(e6) Direct Third-Party Substantiation Charges shall be considered substantiated without the need for submission of a receipt or further review by submission of information from an independent third party (such as an "Explanation of Benefits" from an insurance company) indicating the date of the service or product and the Participant's responsibility for payment (e.g., co-insurance payments and amounts below the plan's deductible).

(f) Conditional Until Substantiated; Correction Methods All charges on the Card shall be conditional pending substantiation. If a charge is later determined by PSA not to be an eligible expense, PSA, in its discretion, shall use one or more of the following correction methods to make the Plan whole:

(f1) Repayment of the improper amount by the Participant;

(f2) Claims substitution or offset of future claims until the amount is repaid; and

(f3) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law.

If those corrections prove unsuccessful or are otherwise not available, the Participant shall remain indebted to Employer for the amount of the improper payment. In that event and consistent with its business practices, Employer will treat the payment as it would any other business indebtedness. Until the amount is repaid, PSA shall take further lawful action to ensure that further violations of the terms of the Card do not occur, up to and including denial of access to the Card, as may be directed by the Employer.

ARTICLE VI - Benefits

6.01 Group Sponsored Insurance Plan Upon becoming eligible, a Participant may elect in writing on an Employee Enrollment Form provided and filed with the Administrator or the Administrator's representative (an "Enrollment Form") (a) to reduce his or her salary or wages each pay day by an amount equal to the Participant's, spouse's and dependents' premiums otherwise payable by the Participant for the Qualified Benefits that constitute Group Sponsored Insurance Plans, and (b) to have the Employer apply the amount of the salary reduction to pay such premiums on a pre-tax basis. The premium insurance benefits that may be offered under the Group Sponsored Insurance Plans for premium-type benefits pursuant to an insurance policy issued by an insurance company, or a contract with a point of service organization are medical, dental, vision, or other qualified benefits under Section 125.

Notwithstanding any other provision in this Plan, the premium insurance benefits are subject to the terms and conditions of the respective insurance policy. No changes can be made with respect to such premium insurance benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable insurance policy. Unless an exception applies, as described in Article X, such election is irrevocable for the duration of the period of coverage to which it relates.

If a Participant does not elect upon initial enrollment to pay such premiums on a salary reduction pre-tax basis, he or she may later elect to do so by executing an Enrollment Form during the next Enrollment Period, effective as of the start of the next Plan Year. Once an election is made, a Participant may change that election only during the Enrollment Period, except as provided in Article X.

(a) Tax Compliance Any insurance program covered in this section shall comply with the applicable sections of the Code to obtain the desired tax benefits. For example, a group-term life insurance program shall comply with Code Section 79, to the extent the Employer desires pre-tax treatment and pre-tax treatment is available.

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

(c) Medical Insurance Benefits; COBRA Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her spouse and dependents, as applicable, whose coverage terminates under the medical insurance plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the medical insurance plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for medical insurance benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the

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

(d) Grace Period No Grace Period applies to the Group Sponsored Insurance Premiums of this Plan.

6.02 Health Related Expense Plan To the extent designated in Section II of the Summary Plan Description, upon becoming eligible, a Participant may elect in writing on an Enrollment Form to reduce his or her Salary or Wages each pay day and to have the amount of the reduction contributed to a Health Related Expense account on such Participant's behalf. Such an election shall be filed with the Employer, or its representative, prior to the date the Participant is enrolled in this Plan. Such election may not elect to reduce the Participant's Salary or Wages, during the course of a Plan Year, by more than the dollar amount designated in Section II of the Summary Plan Description. Once an election is made, a Participant may change that election only during the Enrollment Period, except as provided in Section II. If a Participant elects not to establish a Health Related Expense account, he or she may later elect to establish such an account during the Enrollment Period, effective as of the start of the next Plan Year.

The Employer will establish and maintain, or cause to be established and maintained, a Health Related Expense account for each Participant who elects to establish such an account. From amounts credited to a Participant's Health Related Expense account during the Plan Year, there shall be paid from time to time reimbursement of expenses incurred by the Participant, the Participant's spouse, and dependents during the Plan Year.

As designated in Section II of the Summary Plan Description, a Participant's participation in the Health Related Expense Plan will end on the day on which he or she terminates employment or otherwise ceases to be an eligible Employee, whichever occurs first. In the alternative (and again, as designated in Section II of the Summary Plan Description), an Employee electing to participate in the Health Related Expense Plan must agree to maintain his or her Health Related Expense account and make the elected contributions for the entire Plan Year, regardless of whether the Employee remains employed or continues to be an eligible Employee for the entire Plan Year. If the latter alternative above applies (i.e., participation continues through the remainder of the Plan Year), then in the event the Employee terminates employment or otherwise ceases to be an eligible Employee, the Participant's Enrollment Form must (a) authorize the Employer to withdraw the remaining unpaid elected contributions for the Plan Year from the Participant's final or continuing payment(s) from the Employer, and (b) require the Participant to pay any remaining contributions for the Plan Year (after deductions under (a) above) to his or her Health Related Expense account in equal monthly payments following the date the Participant terminated employment or otherwise ceased to be an eligible Employee.

The maximum amount which a Participant may receive for any Plan Year for reimbursement of expenses (as defined below) shall be the amount credited to his or her Health Related Expense account during the Plan Year. The Employer shall credit to a Participant's Health

Reimbursement Expense account as of the first day of the Plan Year the maximum dollar amount for which the Participant shall have subscribed for such Plan Year (not to exceed the maximum dollar limit, prorated for Participants who commence participation in the middle of the Plan Year unless otherwise specified in Section II of the Summary Plan Description), plus any Employer non-elective contributions to be made to the Participant. Such amount shall be available to a Participant at all times during the Plan Year while a Participant is covered by this Plan (reduced as of any time for prior reimbursements).

(a) Healthcare Expense Except as set forth below, amounts paid for medical care as defined in Code Section 213(d) for the Participant, his or her spouse and dependents. Notwithstanding the foregoing, the following expenses shall not qualify as healthcare expenses: (1) any expense that is not reimbursable under a health flexible spending arrangement due to the rules in IRC Section 125, Prop. Treas. Reg. 1.125-2, Q-7(b) (4), or other additional or superseding IRS guidance as applicable from time to time; and (2) any expense that is reimbursed by any other plan or source.

For purposes of (2) above, if an expense would otherwise be reimbursable under this Plan and a plan of the Employer qualifying as a “health reimbursement arrangement” (HRA), as set forth in IRS Notice 2002-45 and Revenue Ruling 2002-41, or additional or superseding guidance, then the HRA is not available for reimbursement of such expense until after all amounts available for reimbursement under the Health Related Expense Plan have been exhausted, unless Section II of the Summary Plan Description provides otherwise. Without limiting the generality of (3) above, if the Employer so designates in Section IV of the Summary Plan Description, healthcare expenses for all Participants shall be limited to healthcare expenses as defined above that constitute permitted coverage or preventive care. For these purposes, “permitted coverage” is coverage specified in IRC Section 223(c)(1)(B)(ii) and implementing guidance, and “preventive care” shall have the meaning given that term in IRC Section 223(c)(2)(C) and implementing guidance. In the alternative, if Section IV of the Summary Plan Description so designates, the limitation of healthcare expenses to permitted coverage and preventive care as set forth in the preceding two sentences shall be applied only to Participants who, as permitted by the Employer on a form or forms provided by the Employer, elect to have such limitation applied to them, elect to have salary reduction contributions under this Plan made to a Health Savings Account, have Employer non-elective contributions made to a health savings account, or are otherwise eligible individuals (as defined in IRC Section 223(c)(1)) and inform the Employer that they want to participate in the Health Related Expense Plan without losing that status. Under the alternative described in the preceding sentence, the definition of healthcare expenses applied to all other Participants shall not be limited to permitted coverage and preventive care.

(b) Exclusions-Healthcare Expenses That Are Not Reimbursable From the Health FSA The following healthcare expenses are not reimbursable, even if they meet the definition of "medical care" under Code Section 213(d):

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- 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 a disfiguring disease. "Cosmetic surgery" means any procedure that 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 salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or dependent's inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code Section 213(d).
- Any item that is not reimbursable under Code Section 213(d) due to the rules in Prop. Treas. Reg. Section 1.125-2, Q-7(b) (4) or other applicable regulations.

(c) Reimbursement In order to obtain reimbursement for expenses, a Participant shall submit an application in writing to PSA, in such form and in such detail as PSA may prescribe with the following information:

- The amount, date and nature of the expense.
- The name of the person, organization or entity to which the expense was or is to be paid.
- Such other information as PSA may from time to time require.

The Participant must provide a written statement from an independent third party verifying the expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed and are not reimbursable under any other health plan.

This Plan shall reimburse the Participant from the Participant’s Health Related Expense account for expenses incurred during the Plan Year while a Participant, and for which the Participant submits documentation in accordance with this Article 6.02. Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses that were incurred before the Effective Date or before the date the Participant commenced participation in this Plan will not be reimbursed.

A Participant has through the end of the run out period following the earliest of (a) the last day of the Plan Year, (b) the date on which the Participant terminates employment, or (c) the date on which the Participant ceases to be eligible to participate in the Plan, to obtain reimbursement for expenses incurred through the

earliest of those dates. Any amounts still credited to the Participant's Health Related Expense account after the run out period shall be forfeited and remain the assets of the Employer.

A Participant shall be entitled at least monthly to seek reimbursement for expenses up to the total amount credited to a Participant's Health Related Expense account for the Plan Year, reduced by prior reimbursements for expenses for the same Plan Year. For reimbursement claims that are denied, see the appeals procedure in Article 11.02.

The Health Related Expense Plan portion of this Plan is a Health Related Expense Plan intended to qualify under Code Section 105(h) and is to be interpreted in a manner consistent with the requirements of such section. All Participants under this Plan are eligible to receive benefits under the Health Related Expense Plan, consistent with the eligibility requirements outlined in Section III of the Summary Plan Description.

(d) Grace Period The Grace Period applies to the Health Related Expense Plan as designated in Section II of the Summary Plan Description.

(e) FSA Carryover Provision When the FSA Carryover Provision is permitted unused amounts in a Participant's Health Related Expense Plan carry forward and remain available to reimburse eligible healthcare expenses incurred in later years. The amount allowed to carryover is subject to a maximum dollar which could prevent a carryover of all unused amounts. Any unused amounts in excess of the maximum dollar amount are forfeited. During the run-out period, potential carryover amounts may be used either for prior-year or current-year claims.

(f) FSA "Use It or Lose It" Rule This Plan follows the FSA "Use It or Lose It" rule. If any balance remains in the Health Related Expense account after all reimbursements have been made for the period of coverage, the balance shall not be carried over to reimburse the Participant expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(g) Health Related Expense Plan Provisions

(f1) Mental Health Parity Benefits under the Health Related Expense Plan shall be provided in compliance with the Mental Health Parity Act of 1996. Any aggregate lifetime limit on such benefits shall apply both to medical and surgical benefits and to mental health benefits.

(f2) Maternity Benefits Benefits under the Health Related Expense Plan for any hospital length of stay in connection with childbirth for the mother or newborn child following a normal vaginal delivery shall not be restricted to less than 48 hours. Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child following a Cesarean section shall not be restricted to less than 96 hours. The foregoing shall not apply in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay is made by the attending provider (e.g. a physician, nurse, midwife, or physician assistant) in consultation with the mother. The Health Related Expense Plan 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. No provider shall be required to obtain authorization from the Health Related Expense Plan for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce out-of-pocket costs, a Participant may be required to obtain pre-certification.

(f3) Medicaid Benefits under the Health Related Expense Plan shall be provided in compliance with Section 609(b) of ERISA.

(f4) Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") Benefits under the Health Related Expense Plan and Group Sponsored Insurance Plan shall be provided in compliance with and as mandated by the provisions of USERRA applicable to health plans.

(f5) Claims Procedures for Health Related Expense Plan Claims procedures for claims under the Health Related Expense Plan shall be as set forth in the Summary Plan Description for the Health Related Expense Plan.

(f6) Qualified Medical Child Support Order The Plan shall provide benefits under the Health Related Expense Plan in accordance with any QMCSO received by the Plan with respect to any Participant or beneficiary who is eligible to receive benefits from the Health Related Expense Plan. A "Qualified Medical Child Support Order" is a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or beneficiary is eligible under the Health Related Expense Plan, and which clearly specifies the following:

(i) The name and last known mailing address of the Participant and the name and mailing address of each Alternate Recipient covered by the Order, except that, to the extent provided in the Order, the name and mailing address of an official of a state or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient.

(ii) A reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined.

(iii) The period to which the Order applies.

An "Alternate Recipient" is any child of a Participant who is recognized under the Medical Child Support Order as having a right to enrollment under the Health Related Expense Plan with respect to the Participant.

Notwithstanding any other Health Related Expense Plan provision, the following procedures shall apply when any Medical Child Support Order is received by the Health Related Expense Plan with respect to a Participant:

(i) The Employer shall promptly notify the Participant, and each Alternate Recipient of the receipt of such Order and the Plan's procedures for

determining whether Medical Child Support Orders are Qualified Medical Child Support Orders. The Employer shall permit each Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

(ii) The Employer shall promptly after receipt of the Order determine whether the Order is a Qualified Medical Child Support Order, as defined in Section 609(a)(2)(A) of ERISA. The Employer shall promptly notify the Participant and each Alternate Recipient of its decision.

(iii) An Alternate Recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the Plan.

(iv) Any payment for benefits made by the Health Related Expense Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

If each Alternate Recipient and the Participant (or their attorneys) stipulates in a manner acceptable to the Employer that an Order is a Qualified Medical Child Support Order and the notice of the Employer's determination states that the Order so qualifies, any further determination, notice, claims, and review procedures with respect to the Employer's determination that the Order so qualifies shall cease to apply.

6.03 Dependent Care Assistance Plan Upon becoming eligible, and to the extent authorized by Section II of the Summary Plan Description, a Participant may elect in writing on an Enrollment Form to reduce his or her Salary or Wages each pay day and to have the amount of the reduction contributed to a Dependent Care Expense account on such Participant's behalf. Such an election shall be filed with the Employer prior to the date the Participant is enrolled in the Plan. Such election may not elect to reduce the Participant's Salary or Wages by more than $5,000 per Plan Year ($2,500 in the case of married individuals filing separate returns. Once an election is made, the Participant may change that election only during the Enrollment Period, except as provided in Article X. If a Participant elects not to establish a Dependent Care Expense account upon initially becoming eligible, he or she may later elect to establish an account during an Enrollment Period, effective as of the start of the next Plan Year.

The Employer will establish and maintain a Dependent Care Expense account for each Participant who elects to establish such an account. From amounts credited to a Participant's Dependent Care Expense account during the Plan Year, there shall be paid from time to time reimbursement of dependent care expenses incurred by the Participant during the Plan Year.

The maximum amount which a Participant may receive in any Plan Year for reimbursement of dependent care expenses shall be the lesser of (a) the amount credited to his or her Dependent Care Expense account for the Plan Year which may include Participant non-elective contributions, (b) the Participant's earned income or (c) the earned income of the Participant's spouse as defined in Code Section 32(c) (2).

(a) Dependent Care Expenses Expenses incurred by a Participant which (a) are incurred to enable the Participant to be gainfully employed for any period during

which the Participant has one or more dependents, (b) are paid or payable to a Dependent Care Service Provider, and (c) are incurred for the care of a dependent of the Participant or for related household services that include the care of the dependent. Dependent care expenses shall not include expenses incurred for services outside the Participant's household for the care of a dependent unless such dependent is (a) under the age of 13 and with respect to whom the taxpayer is entitled to a deduction under Code Section 151(c) or regularly spends at least eight hours each day in the Participant's household, (b) a tax dependent of the Participant as defined in Code Section 152 who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year, or (c) a Participant's spouse who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year. Dependent care expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

Notwithstanding the foregoing, in the case of divorced parents, a Qualifying Individual who is a child shall, as provided in Code Section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code Section 152(e)(3)(A)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

(b) Dependent Care Service Provider A person who provides care or other services described above, but shall not include (i) a dependent care center (as defined in Code Section 21(b)(2)(D)), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or (ii) a related individual described in Code Section l29(c).

Exclusions Dependent care expenses do not include amounts paid to an individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant or his or her spouse; a Participant's spouse; or a Participant's child (as defined in Code Section 152(f) (1)) who is under 19 years of age at the end of the year in which the expenses were incurred.

(c) Reimbursement In order to obtain reimbursement for dependent care expenses, a Participant shall submit an application in writing to PSA, in such form as PSA may prescribe, setting forth:

- The amount, date and nature of the expense.
- The name of the person, organization or entity to which the expense was or is to be paid, and taxpayer identification number (Social Security number, if an individual); and
- Such other information as PSA may from time to time require.

A Participant must provide a written statement from an independent third party verifying the dependent care expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed under any other Dependent Care Assistance Plan.

PSA will issue a reimbursement to the Participant from the Participant's Dependent Care Expense account for dependent care expenses incurred during the Plan Year for which the Participant submits documentation in accordance with this Article 6.03. Dependent care expenses will be treated as having been incurred

when the care is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses that were incurred before the Effective Date or before the date of the Participant's participation in the Dependent Care Assistance Plan will not be reimbursed.

A Participant's participation in the Dependent Care Assistance Plan will end on the day on which he or she terminates employment or ceases to be an eligible Employee, whichever occurs first during a Plan Year, and no further salary reductions shall be made or dependent care credits given. A Participant who terminates employment or ceases to be an eligible Employee during a Plan Year shall be entitled to reimbursement of dependent care expenses from his or her Dependent Care Expense account for expenses incurred through the end of that Plan Year. A Participant has through the end of the run out period following the end of the Plan Year to obtain reimbursement for dependent care expenses incurred during the preceding Plan Year. Any amounts still credited to the Participant's Dependent Care Expense account after the run out period expires shall be forfeited and remain the assets of the Employer.

No reimbursement or payment under this Article 6.03 of dependent care expenses incurred during a Plan Year shall at any time exceed the balance of the Participant's Dependent Care Expense account for the Plan Year at the time of the reimbursement or payment. The amount of any dependent care expenses not reimbursed or paid as a result of the preceding sentence shall be carried over to subsequent month(s) during the same Plan Year and reimbursed or paid only if and when the balance in such account permits such reimbursement or payment.

(d) **Grace Period** The Grace Period applies to the Dependent Care Assistance Plan as designated in Section II of the Summary Plan Description.

(e) **FSA Carryover Provision** The FSA Carryover Provision is not permitted and therefore unused balances are subject to the FSA "Use It or Lose It" rule discussed below.

(f) **FSA "Use It or Lose It" Rule** This Plan follows the FSA "Use it or Lose It" rule. If any balance remains in the Dependent Care Expense account after all reimbursements have been made for the period of coverage, the balance shall not be carried over to reimburse the Participant expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

6.04 Supplemental Premium Account Plan Upon becoming eligible, and to the extent authorized by Section III of the Summary Plan Description, a Participant may elect in writing on an Enrollment Form to reduce his or her Salary or Wages each pay day and to have the amount of the reduction contributed to a Supplemental Premium Account Plan on such Participant's behalf. Such an election shall be filed with the Employer prior to the date the Participant is enrolled in the Plan. Such election may not elect to reduce the Participant's Salary or Wages, during the course of a Plan Year, by more than the dollar amount designated in Section II of the Summary Plan Description. Once an election is made, a Participant may change that election only during the Enrollment Period, except as provided in Article X. If a Participant elects not to establish a Supplemental Premium account, he or she may later elect to establish such an account during the Enrollment Period, effective as of the start of the next Plan Year.

The Employer will establish and maintain, or cause to be established and maintained, a Supplemental Premium account for each Participant who elects to establish such an account. From amounts credited to a Participant's Supplemental Premium account during the Plan Year, there shall be paid from time to time reimbursement of premiums. Eligible insurance premiums include supplemental policies not purchased thru the Employer. In order to be eligible, the supplemental policy must be in the name of the Eligible Employee and the Employer must require an accounting of the money to verify that the amounts are in fact being used for supplemental premiums.

As designated in Section II of the Summary Plan Description, a Participant's participation in the Supplemental Premium Account Plan will end on the day on which he or she terminates employment or otherwise ceases to be an eligible Employee, whichever occurs first.

The maximum amount which a Participant may receive in any Plan Year for reimbursement of Supplemental Premium Expenses shall be the lesser of (a) the amount credited to his or her Supplemental Premium account for the Plan Year which may include Employer non-elective contributions, (b) the Participant's earned income or (c) the earned income of the Participant's spouse as defined in Code Section 32(c) (2).

(a) Supplemental Premium Expenses Premium expenses incurred by a Participant which are defined as supplemental premiums made available through the Plan, and are paid for on a post-tax basis.

(b) Reimbursement In order to obtain reimbursement for premium expenses, a Participant shall submit an application in writing to PSA in such form and in such detail as PSA may prescribe with the following information:

- The amount, date and nature of the expense.
- The name of the person, organization or entity to which the expense was or is to be paid.
- Such other information as PSA may from time to time require.

The Participant must provide a written statement from an independent third party verifying the premium expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed and are not reimbursable under any other plan.

This Plan shall reimburse the Participant from the Participant's Supplemental Premium account for premium expenses incurred during the Plan Year while a Participant, and for which the Participant submits documentation in accordance with this Article 6.04. Premium expenses will be treated as having been incurred when the coverage is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses for coverage periods incurred before the Effective Date or before the date the Participant commenced participation in this Plan will not be reimbursed.

A Participant's participation in the Supplemental Premium Account Plan will end on the day on which he or she terminates employment or ceases to be an eligible Employee, whichever occurs first during a Plan Year, and no further salary reductions shall be made or Health Premium Credits given. A Participant who terminates employment or ceases to be an eligible Employee during a Plan Year

shall be entitled to reimbursement of premium expenses from his or her Supplemental Premium account for expenses incurred through the end of that Plan Year. A Participant has through the end of the run out period following the end of the Plan Year to obtain reimbursement for premium expenses incurred during the preceding Plan Year. Any amounts still credited to the Participant's Supplemental Premium account after the run out period expires shall be forfeited and remain the assets of the Employer.

No reimbursement or payment under this Article 6.04 of premium expenses incurred during a Plan Year shall at any time exceed the balance of the Participant's Supplemental Premium account for the Plan Year at the time of the reimbursement or payment. The amount of any premium expenses not reimbursed or paid as a result of the preceding sentence shall be carried over to subsequent month(s) during the same Plan Year and reimbursed or paid only if and when the balance in such account permits such reimbursement or payment.

(c) **Grace Period** The Grace Period applies to the Supplemental Premium Account Plan as designated in Section II of the Summary Plan Description.

(d) **FSA Carryover Provision** The FSA Carryover Provision is not permitted and therefore unused balances are subject to the FSA "Use It or Lose It" rule discussed below.

(e) **FSA "Use It or Lose It" Rule** This Plan follows the FSA "Use It or Lose It" rule. If any balance remains in the Supplemental Premium Account Plan after all reimbursements have been made for the period of coverage, the balance shall not be carried over to reimburse the Participant expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

6.05 Limited Flexible Spending Account Plan To the extent designated in Section II of the Summary Plan Description, upon becoming eligible, a Participant may elect in writing on an Enrollment Form to reduce his or her Salary or Wages each pay day and to have the amount of the reduction contributed to an Health Related Expense account and have elected to participate in a Health Savings Account, they may only enroll in the Limited Flexible Spending Plan, not the standard Health Related Expense Plan. Such an election shall be filed with the Employer, or its representative, prior to the date the Participant is enrolled in this Plan. Such election may not elect to reduce the Participant's Salary or Wages, during the course of a Plan Year, by more than the dollar amount designated in Section II of the Summary Plan Description. Once an election is made, a Participant may change that election only during the Enrollment Period, except as provided in Article X. If a Participant elects not to establish a Limited Flexible Spending Account, he or she may later elect to establish such an account during the Enrollment Period, effective as of the start of the next Plan Year.

The Employer will establish and maintain, or cause to be established and maintained, a Limited Flexible Spending Account for each Participant who elects to establish such an account. From amounts credited to a Participant's Limited Flexible Spending Account during the Plan Year, there shall be paid from time to time reimbursement of expenses incurred by the Participant, the Participant's spouse, and dependents during the Plan Year.

As designated in Section II of the Summary Plan Description, a Participant's participation in the Limited Flexible Spending Account will end on the day on which he or she terminates

employment or otherwise ceases to be an eligible Employee, whichever occurs first. In the alternative (and again, as designated in Section II of the Summary Plan Description), an Employee electing to participate in the Limited Flexible Spending Plan must agree to maintain his or her Limited Flexible Spending Account and make the elected contributions for the entire Plan Year, regardless of whether the Employee remains employed or continues to be an eligible Employee for the entire Plan Year. If the latter alternative above applies (i.e., participation continues through the remainder of the Plan Year), then in the event the Employee terminates employment or otherwise ceases to be an eligible Employee, the Participant's Enrollment Form must (a) authorize the Employer to withdraw the remaining unpaid elected contributions for the Plan Year from the Participant's final or continuing payment(s) from the Employer, and (b) require the Participant to pay any remaining contributions for the Plan Year (after deductions under (a) above) to his or her Limited Flexible Spending Account in equal monthly payments following the date the Participant terminated employment or otherwise ceased to be an eligible Employee.

The maximum amount which a Participant may receive for any Plan Year for reimbursement of expenses (as defined below) shall be the amount credited to his or her Limited Flexible Spending Account during the Plan Year. The Employer shall credit, or cause to be credited, to a Participant's Limited Flexible Spending Account as of the first day of the Plan Year the maximum dollar amount for which the Participant shall have subscribed for such Plan Year (not to exceed the maximum dollar limit, prorated for Participants who commence participation in the middle of the Plan Year unless otherwise specified in Section II of the Summary Plan Description), plus any Employer non-elective contributions to be made to the Participant. Such amount shall be available to a Participant at all times during the Plan Year while a Participant is covered by this Plan (reduced as of any time for prior reimbursements).

(a) Eligible Expense The LFSA will reimburse expenses only for certain permitted coverage (e.g., vision and dental expenses) and preventative care, but may not reimburse expenses that would disqualify an individual from contributing to an HSA.

If Section IV of the Summary Plan Description so designates, the limitation of expenses to permitted coverage and preventive care shall be applied only to Participants who, as permitted by the Employer on a form or forms provided by the Employer, elect to have such limitation applied to them, elect to have salary reduction contributions under this Plan made to a health savings account, have Employer non-elective contributions made to a health savings account, or are otherwise eligible individuals (as defined in IRC Section 223(c)(1)) and inform the Employer that they want to participate in the Health Related Expense Plan without losing that status. Under the alternative described in the preceding sentence, the definition of expenses applied to all other Participants shall not be limited to permitted coverage and preventive care.

(b) Reimbursement In order to obtain reimbursement for eligible expenses, a Participant shall submit an application in writing to PSA in such form and in such detail as PSA may prescribe with the following information:

- The amount, date and nature of the expense.
- The name of the person, organization or entity to which the expense was or is to be paid.
- Such other information as PSA may from time to time require.

The Participant must provide a written statement from an independent third party verifying the eligible expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed and are not reimbursable under any other health plan.

This Plan shall reimburse the Participant from the Participant's Limited Flexible Spending Account for eligible expenses incurred during the Plan Year while a Participant, and for which the Participant submits documentation in accordance with this Article 6.05. eligible expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses that were incurred before the Effective Date or before the date the Participant commenced participation in this Plan will not be reimbursed.

A Participant has through the end of the run out period following the earliest of (a) the last day of the Plan Year, (b) the date on which the Participant terminates employment, or (c) the date on which the Participant ceases to be eligible to participate in the Plan, to obtain reimbursement for expenses incurred through the earliest of those dates. Any amounts still credited to the Participant's Limited Flexible Spending Account after the run out period shall be forfeited and remain the assets of the Employer.

A Participant shall be entitled at least monthly to seek reimbursement for expenses up to the total amount credited to a Participant's Limited Flexible Spending Account for the Plan Year, reduced by prior reimbursements for eligible expenses for the same Plan Year. For reimbursement claims that are denied, see the appeals procedure in Article XI.

The Limited Flexible Spending Plan portion of this Plan is a reimbursement plan intended to qualify under Code Section 105(h) and is to be interpreted in a manner consistent with the requirements of such section. All Participants under this Plan are eligible to receive benefits under the Limited Flexible Spending Plan, consistent with the eligibility requirements outlined in Section II of the Summary Plan Description.

(c) **Grace Period** The Grace Period applies to the Limited Flexible Spending Plan as designated in Section II of the Summary Plan Description.

(d) **FSA Carryover Provision** When the FSA Carryover Provision is permitted unused amounts in a Participant's Limited Flexible Spending Account Plan carry forward and remain available to reimburse eligible healthcare expenses incurred in later years. The amount allowed to carryover is subject to a maximum dollar which could prevent a carryover of all unused amounts. Any unused amounts in excess of the maximum dollar amount are forfeited. During the run-out period, potential carryover amounts may be used either for prior-year or current-year claims.

(e) **FSA "Use It or Lose It" Rule** This Plan follows the FSA "Use It or Lose It" rule. If any balance remains in the Limited Health FSA after all reimbursements have been made for the period of coverage, the balance shall not be carried over to reimburse the Participant expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

ARTICLE VII - Administration

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

7.02 Delegation The Employer shall have the right to delegate a Third Party Administrator ("TPA") to carry out any and/or all of its responsibilities for control and management of the operation and administration of the Plan. The Employer has designated PacificSource Administrators ("PSA") to act as the Third Party Administrator. PSA may resign at any time or may be removed or replaced by the Employer at any time.

7.03 Powers and Duties The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. It shall have the exclusive right to interpret the Plan and to decide all matters and all determinations of the Employer with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Employer shall have the following discretionary authority:

(a) To construe and interpret the provisions of the Plan;

(b) To decide all questions of eligibility and participation, and question of benefits under this Plan;

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

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

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

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

(g) To receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Employer deems necessary or appropriate to comply with governmental laws and regulations to the maintenance of records, notifications to Participants, filing with the Internal Revenue Service and U.S. Department of Labor, and all other such requirements applicable to the Plan;

(h) To employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

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

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

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

7.04 Notification to Employees The Employer shall provide reasonable notification to Employees of the availability and terms of the Plan in time for Participants to sign and return Enrollment Forms on a timely basis. The Employer will make available to each Participant such of its records under the Plan as pertain to such Participant, for examination at reasonable times during normal business hours.

7.05 Exclusive Benefit and Uniformity It shall be a principal duty of the Employer to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. In operating and administering the Plan, the Employer shall apply all rules of procedure and decisions uniformly and consistently, in a nondiscriminatory manner, so that all persons similarly situated will receive substantially the same treatment.

7.06 Third Party Administrator Reliance on Others PSA may rely upon any direction, information or action of a Participant under the Plan, and is not required under the Plan to inquire into the propriety of any such direction, information or action. PSA shall be responsible only for the proper exercise of the powers, duties; responsibilities and obligations granted it under the Plan and shall not be responsible for any act or failure to act of the Plan Administrator or any Employee of the Employer. When adjudicating a claim, PSA shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.

7.07 Required Information to be Furnished Each Participant and Beneficiary will furnish to the Plan Administrator such information as the Employer considers necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Participant or Beneficiary of such true, full and complete information as the Employer may request. Any communication, statement or notice to a Participant and Beneficiary addressed to the last post office address filed with the Employer, or if no such address was filed with the Employer, then to the last post office address of the Participant or Beneficiary as shown on the Employer's records, will be binding on the Participant or Beneficiary for all purposes of this Plan and neither the Employer or PSA shall be obliged to search for or ascertain the whereabouts of any Participant or Beneficiary.

7.08 Indemnification of the Third Party Administrator and Plan Administrator PSA shall be indemnified by the Plan Administrator against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim relating thereto.

7.09 Expenses of Administration The usual and reasonable expenses of PSA shall be paid

by the Employer or the Participant, and any expenses not paid by the Employer or the Participant shall not be the responsibility of PSA.

7.10 Named Fiduciary The Employer is the named fiduciary for the Plan for purposes of ERISA Section 402(a). The fiduciary shall be bonded to the extent required by ERISA.

7.11 Insurance Contracts The Employer shall have the right to: (a) enter into a contract with one or more insurance companies for the purpose of providing any benefits under the Plan, on any terms and conditions it may choose in its sole discretion; and (b) replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

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

7.13 Effect of Mistake In the event of a mistake as to the eligibility or participation of an Employee, the Employer or PSA shall to the extent that it deems administratively possible affect such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action may include withholding of any amounts due to the Plan or the Employer from compensation paid by the Employer.

7.14 Establishment of FSA The Employer will establish and maintain a FSA with respect to each Participant for each Plan Year or other period of coverage that has elected to participate in the Plan, but it will not create a separate fund or otherwise segregate assets for this purpose. The account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Article 8.11.

(a) Crediting of Accounts A Participant's account for a Plan Year or other period of coverage will be credited periodically during such period with an amount equal to the Participant's salary reductions elected to be allocated to such account.

(b) Debiting of Accounts A Participant's account for a Plan Year or other period of coverage will be debited for any reimbursement of eligible expenses incurred during such period.

(c) Available Amount Not Based on Credited Amount As described in Article VI, the amount available for reimbursement of eligible expenses is the Participant's annual benefit amount, reduced by prior reimbursements for eligible expenses incurred during the Plan Year or other period of coverage. Thus, a Participant's account may have a negative balance during a Plan Year or other period of coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

ARTICLE VIII - General Provisions

8.01 Amendment or Termination of the Plan The Employer has established the Plan with the intention and expectation that it will be continued, but the Employer will have no obligation to maintain the Plan, and the Employer may terminate all or any part of this Plan at any time hereafter without liability. Upon termination of the Plan, all elections and reductions in compensation relating to the Plan shall terminate, and reimbursements shall be made as if all Employees had terminated employment. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business.

8.02 Governing Law The Plan shall be construed, administered and enforced in accordance with law of the State where the Employer is headquartered, to the extent not superseded by the Code, ERISA, or any other federal law.

8.03 Code and ERISA Compliance It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all regulations issued thereunder. Participants in the Plan (not including the Dependent Care Assistance Plan, which is not covered by ERISA) are entitled to certain rights and protections under ERISA. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

To the extent applicable, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, including USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, GINA, and PPACA.

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

8.05 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, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Employer if the Participant has any reason to believe that such payment is not so excludable.

If a Participant receives a reimbursement and it is later determined that the payment was made in error (e.g., reimbursement for an expense that is later paid by an insurance plan), the Participant will be required to refund the improper payment to the Plan. If the refund is not received for the improper payment, the Plan reserves the right to offset future reimbursement equal to the improper payment or, if that is not feasible, to withhold such funds from his or her pay. If all other attempts to recoup the improper payment are unsuccessful, the Employer may treat the overpayment as a bad debt, which may have income tax consequences to the Participant.

8.06 No Contract of Employment Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

8.07 Limitation of Rights Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Employee or other person any legal or equitable right against PSA or the Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Employee be modified or in any way be affected hereby.

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

8.09 Titles for Convenience Only The headings of the Articles of this Plan are inserted for convenience only and shall not be deemed to constitute a part of this Plan nor used in the interpretation or construction thereof.

8.10 Severability If any provision of the Plan is declared invalid or unenforceable, such provision will not affect the remainder of the Plan which shall be construed as if such provision had not been inserted.

8.11 Use of Forfeitures All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the contributions paid by such Participants through salary reductions; second, to reduce the cost of administering the Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Employer); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Employer deems appropriate, consistent with applicable regulations.

8.12 Substantiation Every expense incurred by an Employee under a qualified benefit during the Plan Year (and Grace Period) is subject to the substantiation rules in accordance with Section 125.

ARTICLE IX - HIPAA Provisions of Health FSA

9.01 Adequate Separation Between Plan and Employer The Employer shall allow the following persons access to Protected Health Information (PHI):

a. Privacy Official;
b. Employees in the Employer's Human Resources Department;
c. Employees in the Employer's Office of General Counsel; and
d. Any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Plan (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals).

No other persons shall have access to PHI. These specified Employees (or classes of Employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that any of these specified Employees does not comply with the provisions of this section, that Employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's Employee discipline and termination procedures. The Employer will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

When this health information is provided from the Health HRA to the Employer, it is PHI. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article.

PHI means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of healthcare to a Participant; or the past, present, or future payment for the provision of healthcare to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased. The Employer shall have access to PHI from the HRA only as permitted under this Article or as otherwise required or permitted by HIPAA.

The Health Information Technology for Economic and Clinical Health Act passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized healthcare clinicians and staff."

9.02 Permitted Disclosure of Enrollment/Disenrollment Information The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

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

"Summary Health Information" means information (a) that summarizes the claims history, claims

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

9.04 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes Unless otherwise permitted by law, and subject to the conditions of disclosure described in Article 9.05 and obtaining written certification pursuant to Article 9.07, the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).

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

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA's privacy requirements;
- If feasible, return or destroy all PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between the Health FSA and the Employer (i.e., the "firewall"), required in 45 CFR Section 504(f) (2) (iii), is satisfied.

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

9.06 Certification of Plan Sponsor The Health FSA shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Article 9.05.

ARTICLE X - Irrevocability of Elections; Exceptions

10.01 Irrevocability of Elections Except as described in this Article, a Participant's election under the Plan is irrevocable for the duration of the period of coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the period of coverage regarding:

- Participation in this Plan;
- Salary reduction amounts; or
- Election of particular Benefit Package Options (including the various Health FSA Options).

10.02 Procedure for Making New Election if Exception to Irrevocability Applies

(a) Timeframe for Making New Election A Participant (or an Eligible Employee who, when first eligible under Article 3.01 or during the Open Enrollment Period under Article 4.02, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Article X, as applicable, but only if the election under the new Enrollment Form is made on account of and is consistent with the event and if the election is made within any specified time period. Notwithstanding the foregoing, a change in status (e.g., a divorce) that results in a beneficiary becoming ineligible for coverage under the Group Sponsored Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

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

(c) Effect of New Election Upon Amount of Benefits For the effect of a changed election upon the maximum and minimum benefits under the Health FSA, see Article VI.

10.03 Change in Status Defined A Participant may change an election upon the occurrence of certain events as described below, including a change in status, for the applicable Plan, but only if such election change is made on account of and corresponds with a change in status that affects eligibility for coverage under a plan of the Employer or a plan of the spouse's or dependent's Employer (referred to as the general consistency requirement). A change in status that affects eligibility for coverage under a plan of the Employer or a plan of the spouse's or dependent's Employer includes a change in status that results in an increase or decrease in the number of an Employee's family members (i.e., a spouse and/or dependents) who may benefit from the coverage. In addition, except as provided otherwise in Section II of the Summary Plan Description, changes in status shall not permit a decrease in the amount of the Participant’s

salary reduction contributions to the Health Related Expense account below the amount of usage in the prior portion of the Plan Year.

"Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code Section 125 or regulations issued thereunder, which the Employer, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) Open Enrollment Period A Participant may change an election during the Open Enrollment Period in accordance with Article 4.02.

(b) Termination of Employment A Participant's election will terminate under the Plan upon termination of employment in accordance with Article 3.01, as applicable.

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

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

(e) Employment Status Any of the following events that change the employment status of the Participant or his or her spouse or dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other Employee benefits plan of the Participant or his or her spouse or dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other Employee benefits plan, such as if a plan only applies to salaried Employees and an Employee switches from salaried to hourly-paid, union to non-union, full-time to part-time (or vice versa), or a reduction or increase in hours of employment with the consequence that the Employee ceases to be eligible for the Plan;

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

(g) Change in Residence A change in the place of residence of the Participant or his or her spouse or dependents that causes the gain or loss of eligibility for coverage option.

(h) Leaves of Absence A Participant may change an election under the Plan upon FMLA leave in accordance with Article 3.02 and upon non-FMLA leave in accordance with Article 3.03.

Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified change in status:

(h.1) Loss of Spouse or Dependent Eligibility; Special COBRA Rules For a

change in status involving a Participant's divorce, annulment or legal separation from a spouse, the death of a spouse or a dependent, or a dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the spouse involved in the divorce, annulment, or legal separation; (b) the deceased spouse or dependent; or (c) the dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that change in status.

Notwithstanding the foregoing, if the Participant or his or her spouse or dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Article III), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

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

(i) HIPAA Special Enrollment Rights If a Participant or his or her spouse or dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

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

(i.2) a new dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible dependents as a result of the acquisition of a new spouse or dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special

enrollment attributable to the birth, adoption, or placement for adoption of a new dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

An election change on account of a HIPAA special enrollment attributable to an Employee or dependent becoming eligible for a state premium assistance subsidy under the plan from Medicaid or SCHIP may, subject to the provisions of the underlying group health plan be effective retroactively (up to 60 days).

(j) Certain Judgments, Decrees and Orders If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage for a Participant's child (including a foster child who is a dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's spouse or former spouse) provide coverage under that individual's plan and such coverage is actually provided.

(k) Medicare and Medicaid If a Participant or his or her spouse or dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid.

(l) Change of Cost A Participant may change a premium payment election for Qualified Benefits other than coverage under the Health Related Expense Plan, in the event of a significant cost change. Affected Participants may either make a corresponding prospective increase in the elected reduction in his or her Salary or Wages or may revoke his or her election and in lieu thereof receive on a prospective basis similar coverage offered under this Plan. For purposes of this section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a Health FSA is not similar coverage with respect to an accident or health plan that is not a Health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another Employer, such as a spouse's or dependent's Employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(m) Increase or Decrease for Insignificant Cost Changes Participants are required to increase their elective contributions (by increasing salary reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Employer will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Employer, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected Employees' elective contributions on

a prospective basis.

(n) Significant Cost Increases If the Employer determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) significantly increases during a period of coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing salary reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage.

(o) Significant Cost Decreases If the Employer determines that the cost of any Benefit Package Option significantly decreases during a period of coverage, then the Employer may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option (such as an HMO, but not the Health FSA) other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Group Sponsored Insurance Plan); and (b) Employees who are otherwise eligible under Article 3.01 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option.

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

(q) Change in Coverage For purposes of this section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a Health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another Employer, such as a spouse's or dependent's Employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(r) Significant Coverage Changes Without Loss of Coverage If the Employer determines that coverage under the Group Sponsored Insurance Plan or the Dependent Care Assistance Plan is significantly curtailed, an affected Participant may revoke his or her election under this Plan and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing similar coverage. Coverage under a Group Sponsored Insurance Plan is deemed “significantly curtailed” only if there is an overall reduction in coverage so as to constitute reduced coverage to Participants generally. The Employer (in it’s sole discretion) will decide in accordance with prevailing IRS guidance, whether a curtailment is “significant” and whether substituted coverage is “similar”, based upon all the surrounding facts and circumstances.

(s) Significant Coverage Changes With Loss of Coverage If the Employer determines that coverage under the Group Sponsored Insurance Plan or the Dependent Care Assistance Plan is significantly curtailed to the extent that it constitutes a loss of coverage, then the affected Participant may revoke his or her election under this Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. For purposes of this Plan, a "loss of coverage" means a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). In addition, the Employer may, in its discretion, treat the following as a loss of coverage:

(s1) A substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(s2) A reduction in the benefits of a specific type of medical condition or treatment with respect to which the Employee or the Employee's spouse or dependent is currently in a course of treatment; or

(s3) Any other similar fundamental loss of coverage.

(t) Addition or Improvement of a Benefit Package Option If during a Plan Year a new benefit package option or other coverage option is added, or an existing benefit package option or other coverage option is significantly improved, an affected Participant (whether or not he or she has previously made an election under this Plan or previously elected the benefit package option) may elect to revoke a prior election under this Plan and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved benefit package option.

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

(v) Change in Coverage Under Another Employer Plan A Participant may make a prospective election change that is on account of and corresponds with a change made under an Employer plan (including a plan of the Employer or a plan of the spouse's or dependent's Employer), so long as:

(v1) the other cafeteria plan or qualified benefits plan permits its Participants to

make an election change that would be permitted under applicable IRS regulations; or

(v2) the plan permits Participants to make an election for a period of coverage that is different from the Plan Year under the other cafeteria plan or qualified benefits plan.

(w) Reduction of Hours (Applies Only to Group Sponsored Insurance Plan as specified in Section V of the Summary Plan Description). A Participant who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Group Sponsored Insurance Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the Group Sponsored Insurance Plan coverage is revoked.

(x) Exchange Enrollment (Applies Only to Group Sponsored Insurance Plan as specified in Section V of the Summary Plan Description**).** A Participant who is eligible to enroll for coverage in a government-sponsored Exchange during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Group Sponsored Insurance Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Group Sponsored Insurance Plan coverage.

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

ARTICLE XI - Appeals Procedure

11.01 Procedure if Benefits are Denied under this Plan If a claim for reimbursement or benefit under this Plan is wholly or partially denied, such claim shall be administered in accordance with the procedure set forth below and in the Summary Plan Description of this Plan. The Appeals Committee, separate and distinct from the individual(s) that adjudicate the claims, shall act on behalf of the Employer with respect to appeals. An external review process shall be provided as legally required and as further set forth below.

If PSA denies a claim, in whole or in part, the Employee will be notified in writing within 30 days of the date PSA receives the claim. The 30-day period may be extended for an additional 15 days for matters beyond PSA's control, such as situations where a claim is incomplete. PSA will provide written notice of any extension, describing the reasons for the extension and the date by which he or she can expect a decision. Where a claim is incomplete, the extension notice will describe the information still needed by PSA and allow 45 days from receipt of the notice to provide the additional information. If this happens, it will have the effect of suspending any decision on the claim until the specified information is provided.

If PSA denies a claim, the Employee will receive a notice that includes the following elements:

- The specific reason or reasons for the denial;
- The specific Plan provision or provisions that support the denial;
- A description of any items or information the Employee would need to validate the claim and an explanation of why the added material is necessary; and
- A description of the steps to appeal the denial, including the Employee's right to submit written comments, his or her right to review (upon request and at no charge) relevant documents and other information, and the Employee's right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of the claim.

11.02 Appeals The Employee may appeal a claim denial by submitting a Request for Review (or other written appeal request) to PSA within 180 days of the date of notice of the claim denial. If the Employee does not appeal on time, he or she will lose the right to appeal the denial and the right to file suit in court. The written appeal should state the reasons that he or she feels the claim should not have been denied, and should include any additional items or information that he or she feels supports the claim. The appeal process will provide the Employee with the opportunity to ask additional questions and make written comments, and he or she may review (upon request and at no charge) documents and other information relevant to the appeal.

To the extent a dispute arises under the terms of one of the insurance plans, such as a group medical or dental insurance plan offered by the Employer, the ability to appeal decisions under the insurance plan will be outlined in the Summary Plan Description or similar explanatory booklet available from the insurer.

11.03 Decision on Review PSA will review the Employee's appeal in a reasonable time, but within 60 days after receiving the request. PSA may, in its discretion, hold a hearing on the denied claim. If PSA consults with a medical expert to help analyze the appeal, the expert will be different from, and not subordinate to, any expert that was consulted in connection with the initial claim denial. If upon review a decision is reached to affirm the original denial of the claim, the Employee will receive a notice of that determination, which will include the following elements:

(a) The specific reason or reasons for the decision on review;

(b) The specific Plan provision or provisions that motivated the decision;

(c) A statement of the Employee's right to review (upon request and at no charge) relevant documents and other information;

(d) If "internal rules, guidelines, protocols, or other similar criteria" (collectively referred to as "internal guidelines") are relied on in making the decision on review, a description of the specific internal guidelines, or a statement that such internal guidelines were relied on, and a copy of the internal guidelines will be provided free of charge to the Employee upon request; and

(e) A statement of the Employee's right to bring suit under ERISA Section 502(a) (where applicable).

CITY OF KLAMATH FALLS has caused this Plan to be executed in its name and on its behalf, effective as of **1/1/2015**.