

**ORDER: APPROVE AMENDED FLEXIBLE BENEFIT CAFETERIA
PLAN DOCUMENT**

Motion was made by Mike Pickens, duly seconded by Robert Blackmon, to approve Amended Flexible Benefit Cafeteria Plan document.

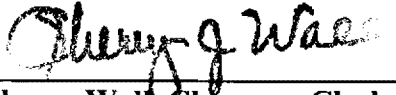
The vote on the motion was as follows:

Supervisor Mike Pickens, voted yes
Supervisor Jeff Busby, voted yes
Supervisor Robert Blackmon, voted yes
Supervisor Chad McLarty, voted yes
Supervisor Mike Roberts, voted yes

After the vote, President Busby, declared the motion carried, this the 19th day of May, 2014.



Jeff Busby, President
Board of Supervisors



Sherry Wall, Chancery Clerk

LAFAYETTE COUNTY, MISSISSIPPI

FLEXIBLE BENEFIT CAFETERIA PLAN DOCUMENT

Prepared by:



Southern Administrators and Benefit Consultants, Inc.

P.O. Box 2449

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WWW.SABCFLEX.COM

AMENDED: January 1, 2014
Five Year full update

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PREAMBLE

The component Benefit Plan(s) or Policy(s) made available hereunder, as described in Article I, are provided pursuant to other plans, contracts, and are incorporated herein. In the event of any inconsistency between the component Benefit Plan(s) or Policy(s) and this Plan, the underlying Benefit Plan(s) or Policy(s) will control. Upon adoption by the Employer, the benefits outlined in Article I may be offered hereunder. The Plan is intended to qualify as a Cafeteria Plan under the provisions of Code §125.

ARTICLE I
ADOPTION AGREEMENT

JANUARY 1, 2014 AMENDED & RESTATED

Effective January 1, 2014, City of Lakeland hereby amends, and restates, its Flexible Benefit Cafeteria Plan (the "Plan") originally established effective January 1, 2007, for its Employees for purposes of providing eligible Employees with the opportunity to choose from among the fringe benefits available under the Plan, and agrees to be bound by all of the terms, provisions, conditions and limitations of this Plan Document.

1.01 Employer/Plan Sponsor Information:

A. Employer's business name is:

Lafayette County, Mississippi

B. Employer's business address is:

**P O Box 1240
Oxford, Mississippi**

C. Employer's federal tax identification number is:

64-6000557

D. The Employer's fiscal year ends:

September 30th

1.02 Name of Plan and Named Fiduciary:

Lafayette County, MS, Flexible Benefit Cafeteria Plan

1.03 Effective Date of the Plan:

January 1, 2007, (Initial Effective Date)
January 1, 2014, (Amended and Restated)

1.04 Anniversary Date/Plan Year:

January 1, thru December 31

1.05 Plan Administrator:

**Joseph Johnson
County Administrator**

1.06 Eligibility Requirements:

All Employees must be working full-time, (-30-) hours or more per week, and must complete (-30-) days of service to be eligible to participate in the Plan.

1.07 Entry Date

All employees are eligible to enter the Plan on the first day of the month, following the completion of eligibility requirements of Section 1.06, above.

1.08 Run-out Period:

All Unreimbursed Medical and/or Dependent Care Spending Plans will have (60) days, following the end of the Benefit Period, or following the date of termination, during which they may submit a claim for reimbursement for a qualified benefit incurred during the Plan.

1.09 Qualified Benefit(s):

Group Health Insurance
Dental Insurance
Vision Insurance
Cancer Insurance
Dependent Care Spending Accounts
Unreimbursed Medical Spending Accounts

1.10 Benefit Plan(s) or Policy(s):

- A. Each Participant shall have available Compensation (as defined in Section 2.11) per plan year, or a pro rata portion for a shorter plan year, with which to purchase benefits pursuant to the applicable Election and Salary Reduction Agreement.
- B. The maximum amount allowable to participate in the insurance listed below is governed by the pro rata policy costs incurred by the plan pursuant to the insurance policies in effect. Policies in effect are:

Group Health Insurance – Blue Cross Blue Shield
Dental Insurance – Guardian
Vision Insurance – Guardian
Cancer Insurance – Humana
Cancer Insurance – National and Southern Farm Bureau (Renewal Only)

- C. The Dependent Care Spending Account Plan is intended to qualify as a Code §129 dependent care assistance plan. The maximum amount of reimbursement permitted pursuant to the Dependent Care Spending Account Plan, shall be \$5,000 for filing a single return or a joint return per family unit, per calendar year, or \$2,500 for a married individual filing a separate return.

D. The Unreimbursed Medical Spending Account Plan is intended to qualify as a Code §105h and §106 medical expense reimbursement plan. The maximum amount of reimbursement for Unreimbursed Medical Spending Account expenses incurred by the Participant shall be no more than **\$2,500.00** per plan year, as maybe increased annually, as indexed based on the rate of inflation.

- (1) The Unreimbursed Medical Plan includes a SABCFlex Card (Electronic Payment Card), as defined by Section 2.17 and 4.07(a) *Prescriptions Only*.
- (2) The Unreimbursed Medical Plan includes a Carryover provision of \$500.00, as defined in Section 2.08 and 4.06.
- (3) The Unreimbursed Medical Benefit Period (as defined in Section 2.53), is treated as provided in Section 4.05(a).

E. Intentionally Left Blank.

F. Intentionally Left Blank.

G. Intentionally Left Blank.

1.11 Unreimbursed Medical Spending Account Participation termination:

In the event of termination, Participant's Unreimbursed Medical Spending Account will be treated as provided in Article VI, Benefits, Section 6.04(b) *Voluntary Plan Year Coverage*.

1.12 Employer "Plan Administrator or Plan Sponsor," (in accordance with 45 CFR § 164.512; and "the HIPAA Privacy Rule" (as defined in 45 CFR Part 160 and Subparts A and E of Part 164), requiring appropriate safeguards, sets limits and conditions on the uses and disclosures of Protected Health Information "PHI," (personal or protected health information as defined in Section 106.103 of title 45, of the Code), providing Participants with rights over their information, including rights to examine and obtain a copy, and to request corrections), certifies it will comply with the HIPAA Privacy Rule and HIPAA Security Standards Rule, as amended and set forth herein, and shall:

(a) ensure the proper management and administration of a "Business Associate," (A Business Associate means a person or entity that performs certain functions or activities on behalf of the Plan, that may involve the use or disclosure of protected health information, or provides services to a covered entity, covered health care provider, health plan, or health care clearinghouse, or may be a Business Associate of another covered entity. A member of the covered entity's workforce is not a Business Associate), including obtaining a Business Associate agreement, as required by 45 CFR § 164.504(f)(2)(iii) of the HIPAA Privacy Rule;

(b) fulfill any present or future legal responsibilities;

(c) for data aggregation services to the Plan (as defined in 45 CFR § 164.501); or

(d) any use and disclosure of PHI that has been de-identified within the meaning of 45 CFR § 164.514. The Employer ensures that the individual or "Responsible Persons" or "Responsible Employees," by classification or name, described herein, may only use and disclose PHI for Plan administration functions, including those defined in the Employer's

HIPAA Privacy Statement for the Cafeteria Plan, provided they certify they will not violate the provisions as required by 45 CFR §164.504(f)(2)(iii) of the HIPAA Privacy Rule. If individual or persons described herein do not comply with Article XIII, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan shall ensure adequate separation that is required by 45 CFR §164.504(f)(2)(iii) of the HIPAA Privacy Rule, as amended.

In accordance with HIPAA, only the following may be given access to PHI:

Joseph Johnson, County Administrator

Lisa Durham, Comptroller

Plan Administrator – Joseph Johnson, County Administrator

HIPAA Privacy Officer – Lisa Durham, Comptroller

HIPAA Security Officer – Shakethia Shaw, Payroll Clerk

Employer certifies by the information above that they will comply with the privacy procedures set forth in Article XIII and as defined in the Employer's HIPAA Privacy Statement for the Cafeteria Plan. Employer may not use or disclose employee or participants' PHI, other than as provided herein, or as required by law. Employee PHI may not be used by Employer for any employment-related actions, or decisions in connection with any other benefit, or employee benefit plan of the Employer. Employer must report to the Plan any uses or disclosures or violations of employee PHI, of which it becomes aware, that are inconsistent with the provisions set forth in Article XIII and as defined in the Employer's HIPAA Privacy Statement for the Cafeteria Plan.

Employer and Plan will maintain physical, technical, electronic, and procedural safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the physical and electronic PHI that it creates, receives, maintains or transmits on behalf of the employee to comply with federal and state regulations 45 CFR Parts §160, 162 and 164 (HIPAA Security Standards).

The Plan agrees to document any disclosures of PHI and the information related to such disclosures to respond to an accounting of disclosures of PHI if requested by Employer in accordance with 45 CFR §164.528, and to provide such documentation to Employer as it may request from time to time.

- 1.13 "This Plan qualifies as a Non-ERISA Plan," (as defined in Section 6.05).

Sections in this Article I, noted as "Intentionally Left Blank," and items throughout this document referring to those Sections, do not apply, and are not adopted by the Plan.

ARTICLE II
DEFINITIONS

- 2.01 **"Adoption Agreement"** means the agreement executed by the Employer, pursuant to which the Employer provides for the terms of its Plan. An Adoption Agreement will contain only such provisions as are authorized by and consistent with, the provisions of this Plan Document. In the event of any inconsistency with the Adoption Agreement or any insurance contract purchased hereunder, the provisions of the Plan Document shall be controlling.
- 2.02 **"Affiliated Employer"** means any Employer within the context of Code §414(b), (c), or (m) of the Code which will be treated as single Employer for purposes of Code §125.
- 2.03 **"After-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to an Election and Salary Reduction Agreement to purchase coverage(s) available under the Plan on an after-tax basis.
- 2.04 **"Anniversary Date"** means the first day of any Plan Year.
- 2.05 **"Benefit Plan(s) or Policy(s)"** means those Qualified Benefits available to a Participant and non-contributory benefits available under the Plan to a Participant as described in Article I.
- 2.06 **"Auto-Adjudication"** means that a purchase made with an Electronic Payment Card will be adjudicated, at the point of sale, through an inventory information approval system (IIAS), without the need for additional substantiation. It also permits Auto-Adjudication of certain transactions at merchants with health care-related merchant category code (MCC), defined by IRS Revenue Ruling 2004-43.
- 2.07 **"Board of Directors"** means the Board of Directors of the Employer. The Board of Directors, upon adoption of the Plan, appoints a Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.
- 2.08 **"Carryover or Roll Over"** (hereinafter, referred to as "Carryover") of Unreimbursed Medical Spending Funds, permitted by IRS Notice 2013-71 and 2013-47, allows up to the limit (as defined in Section 1.10(D)(2)), of any unused amounts remaining at the end of a Plan Year in a Participant's Unreimbursed Medical Spending Account, to be paid or reimbursed to plan Participants for qualified medical expenses incurred during the following Plan Year. This Carryover does not affect the maximum amount of salary reduction contributions that the Participant is permitted to make under Code §125(i) of the Code, for the current Plan Year, (as defined by Section 1.10(D)). This provision is not applicable for Plans with the Grace Period, and is not applicable for the Dependent Care Spending Plan.
- 2.09 **"Change in Status"** means the events described below and any other events that the Plan Administrator (in its sole discretion) determines to be within prevailing Internal Revenue Services "IRS" guidance:
1. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation (if recognized or allowed in the Participant's domicile state) or annulment;
 2. A change in the Participant's number of dependents, including the birth, adoption or placement for adoption of a child, or death of a Dependent;
 3. A change in employment status of the Participant, the Participant's Spouse or the Participant's Qualified Dependent: (a) including termination or commencement of employment; (b) a strike or lockout, (c) a commencement or return from an unpaid leave of absence; (d) a change in work-site; and (e) a change in employment that effect a loss or gain of eligibility to participate in this Plan or any Benefit Plan available hereunder;
 4. A reduction or increase in hours of employment by the Participant, the Participant's Spouse or the Participant's Qualified Dependent, with the consequence that the employee ceases to be, or becomes eligible for the Plan;
 5. Qualified Dependent satisfies, or ceases to satisfy, the "Qualifying Individual" eligibility requirements for a particular benefit; such as attaining a specified age, (as defined in Section 2.14);
 6. A change in place of residence or work of the Participant, the Participant's Spouse or the Participant's Dependent; and
 7. Refer to Section 4.04(k) for HSA "Change of Status" requirements.

- 2.10 "Code" means the Internal Revenue Code of 1986, as amended.
- 2.11 "Compensation" means the cash wages or salary paid to an Employee by the Employer. Compensation shall include:
- (a) any Employer contributions made to the Plan pursuant to a Participant's Election and Salary Reduction Agreement;
 - (b) any elective contribution to any plan maintained by the Employer as a result of a salary reduction agreement entered into by the Participant under Code § 401(k); and
 - (c) any Employer contribution to a tax-deferred plan under Code § 403(b), sponsored by the Employer as a result of a salary reduction agreement entered into by the Participant for such purpose.
- 2.12 "Computation Period" means the units of time used in determining an Employee's service for Plan Entry purposes, (as specified under Section 1.06).
- 2.13 "Death" means the permanent ending of all life in a person. The Plan Administrator may require medical reports and other evidence, which are necessary, to certify the fact and/or date of Death.
- 2.14 "Dependent(s)" means an individual who is a child of a Participant, who is considered eligible under Code §105(b), as amended and as defined in Code §106: (a) for purposes of accident or health coverage (to the extent funded under the a premium payment component, and for purposes of the Unreimbursed Medial Plan component): (1) a dependent as defined in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; (2) any child who is the son, daughter, stepson, or stepdaughter of the Participant, and a child includes both a legally adopted individual of the Participant and an individual who is lawfully placed with the Participant for legal adoption by the Participant and includes an eligible foster child, (as defined in Code § 152(f)(1), as amended), of the Participant, who as of the end of the taxable year, has not attained age twenty-seven (27); and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who received 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 Dependent Care Plan, a "Qualifying Individual." Notwithstanding the foregoing, the Unreimbursed Medial Plan will provide benefits in accordance with the applicable requirements of any QMCSO, (as defined in Section 2.50).
- 2.15 "Dependent Care Spending Account" shall have the meaning assigned to it by Code §129, and Section 6.01(c) of this Plan.
- 2.16 "Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Employee Compensation (such as disability or wage continuation benefits), but does not include: (a) any amounts received pursuant to any dependent care assistance program under Code §129(e)(2); (b) any amount received as a pension or annuity; or (c) workers' compensation.
- 2.17 "Electronic Payment Card" (SABCFlex Cards), is a prepaid benefit card or special-purpose debit card, (as defined by IRS Revenue Ruling 2003-43, IRS Revenue Procedures 2004-43 and IRS Notice 2006-69, IRS Notice 2007-2 and 2008-104 and 2007 proposed regulations), providing the Participant with an automatic way to pay for qualified Medical Care Expenses. The Card allows the Participant to electronically access the pre-tax amount set aside in a Participants Unreimbursed Medical Spending Account. Cards may be for RX prescription only expenses, or open for all eligible Medical Care Expenses, as defined herein.
- 2.18 "Eligible Medical Expenses" means those expenses incurred for Unreimbursed Medical Spending Accounts by the Employee, or the Employee's Spouse and/or Dependents, unless restricted or limited by other coverage, after the date of the Employee's participation in the Unreimbursed Medical Spending Account, and otherwise allowable as deductions under Code §213 (without regard to the limitations contained in §213(a)) or Section 4.05, but shall not include: 1) an expense incurred for the payment of premiums under a health insurance plan; or 2) expenses for qualified long-term care services (as defined in Code §7702B(c)). For purposes of the Plan, an expense is "incurred" when the Participant and/or beneficiary is furnished the medical care or services, giving rise to the claimed expense.
- 2.19 "Eligibility or Waiting Period" (*hereinafter, may also be referred to as Eligibility Period*) is a defined period

that must pass before an employee or dependent may enroll in eligible benefit coverage. The employee must be able to elect coverage that becomes effective, on or before, the ninety-first (91st) day after the start of the Waiting Period. Under Patient Protection and Affordable Care Act (P.L. 111-148, PPACA, as amended by the Health Care and Education Act, P.L. 111-152, or the ACA Act), effective January 1, 2014, Section 2708 to the PHS Act, and prohibits eligibility waiting periods in excess of ninety (90) days for Plans, and must be able to elect coverage that becomes effective, on or before, the ninety-first (91st) day after the start of the waiting period. This applies to all grandfathered and non-grandfathered plans. Eligibility Period for this Plan is as defined in Article I, Section 1.06.

*Amended January 1, 2014
ACA Waiting Period*

- 2.20 "Effective Date of the Plan" means the date specified in Article I when the Plan is deemed to commence.
- 2.21 "Election and Salary Reduction Agreement" means the actual or deemed agreement pursuant to which an eligible Employee or Participant enrolls in the specific component Benefit Plans or Policies with Pre-tax Contributions in accordance with Article I.
- 2.22 "Employer" means the name as stated in Article I, Section 1.01 herein, and any Affiliated Employer authorized by the Employer that adopts this Plan. The term "Employer" shall mean only the Employer or Affiliated Employers defined in Article I, Section 1.01.
- 2.23 "Employee(s)" means any individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including, but not limited to, those individuals defined in Code §414(n)), or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, for the period during which such individuals is so classified, whether or not any such individual is on the Employer's W-2 payroll, or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer, but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.
- 2.24 "Entry Date" means the day specified under Article I as to when an Employee may become a Participant in the Plan.
- 2.25 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.
- 2.26 "Fiscal Year" means the Employer's fiscal year as specified in Article I.
- 2.27 "Grace Period" a set number of days following the end of the Plan Year, for two (2) and a half (½) months (two months and fifteen (15) days, ending on the fifteenth (15th) day of the third month, following the close of the Plan Year. During which time a Participant may use remaining Unreimbursed Medical Spending Account funds to reimburse eligible expenses incurred during the Grace Period and have those expenses reimbursed from the previous year's balance. A Grace Period is not applicable for the Dependent Care Spending Plans.
- 2.28 "Health Savings Accounts" (HSA), is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary (employee), who for the months for which contributions are made to an HSA, who is covered under a High Deductible Health Plan (HDHP). The HSA pays for out-of-pocket expenses such as (deductibles, co-payments and other amounts, as defined by "permitted coverage" and "permitted insurance"). The maximum contributions are based on single or family coverage HDHP, as of the first day of such month, indexed by Code § 223(g). Eligible individuals, who become covered under an HSA-eligible plan in a month other than January, maximum contributions for the year, are based on their health coverage level, in the last month of the year, (as defined by Code § 223).
- 2.29 "Herein" and "hereunder" or similar terms, refer to this document, unless otherwise qualified by the context.
- 2.30 "High Deductible Health Plan" means a health plan with an annual deductible limit that meets the requirements

by Code § 223(g), as indexed annually.

- 2.31 **"Highly Compensated Individual"** means an individual defined under Code §105(h), 125(e) or 414(g) of the Code, (as applicable, and indexed annually), is a "highly compensated individual" or a "highly compensated Employee."
- 2.32 **"HIPAA"** refers to the Health Insurance Portability and Accountability Act of 1996, (Pub. L. 104-191), as amended, and includes HIPAA Privacy Rules, initially effective April 14, 2004, HIPAA Security Standards effective April 20, 2005, (April 20, 2006 for small health plans), the American Recovery and Reinvestment Act ("ARRA") of 2009 ("the Act"), for the HIPAA Health Breach Notification, effective September 23, 2009, and the Health Information Technology for Economic and Clinical Health "(the HITECH Act), enacted February 17, 2009, and final March 26, 2013, as amended.
- Amended March 26, 2013*
- 2.33 **"Insurer"** means any legal reserve life insurance company which may issue a contract or contracts to the Plan Administrator, the Employer or Participant in conjunction herewith.
- 2.34 **"Key Employee"** means an individual who is a "key employee" as defined in Code §125(b)(2), indexed annually.
- 2.35 **"Limited Purpose Plan"** means an Unreimbursed Medical Flexible Spending Account where eligible expenses are limited to qualifying dental and/or vision expenses only. Limited Purpose Plans excludes Medical Care Expenses, and insurance premiums.
- 2.36 **"Medical Care Expense"** means amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of a disease; for the purpose of affecting any structure or function of the body; or for transportation primarily for or essential to such care or services.
- 2.37 **"Non-Taxable Benefits"** means benefits the Employer may provide on behalf of Participants, which are excludable from the gross income of the Participant.
- 2.38 **"Participant"** means an Employee who enters the Plan in accordance with the provisions of Article I.
- 2.39 **"Permitted coverage"** for Health Savings Accounts (*whether through insurance or otherwise*) is coverage for accident, disability, dental care, vision care or long-term care. Prescription drug benefits are not listed as permitted insurance or as permitted coverage under Code 223(c)(1)(B).
- 2.40 **"Permitted insurance"** for Health Savings Accounts is coverage under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other periods) for hospitalization.
- 2.41 **"Plan"** means this Flexible Benefit Cafeteria Plan.
- 2.42 **"Plan Administrator"** means the person or entity who is appointed by a Board of Directors, government agency or Employer, with authority and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.
- 2.43 **"Plan Sponsor"** means the person or entity, as defined at Section 3(16)(B) of ERISA, 29 U.S.C. §1002(16)(B) and Section 1.05 herein.
- 2.44 **"Plan Year"** means the Employer's plan year as specified in Section 1.04.
- 2.45 **"Intentionally Left Blank"** means this Section does not apply to the Plan.
- 2.46 **"Pre-tax Contribution(s)"** means any amount withheld from the Employee's Compensation pursuant to an actual or deemed salary reduction election, which is intended to be paid on a pre-tax basis. This amount shall not exceed the Participant Contribution attributable to the most costly Benefit Plan or Policy options afforded hereunder, and for purposes of Code §125, shall be treated as an Employer contribution (*this amount may, however, be treated as an Employee contribution for purposes of state insurance laws*).

- 2.47 **"Qualified Benefit(s)"** means any benefit excluded from the Employee's taxable income under Code §125 (f) (other than §106(b), 117, 124, 127, or 132) and any other benefit permitted by the Income Tax Regulations (*i.e.*, any group term life insurance coverage that is includible in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code §79). Long-term care insurance shall not be a qualified benefit for any component hereunder, but shall qualify for Health Savings Accounts.
- 2.48 **"Qualifying Employment-Related Expenses"** means those expenses that would be considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services, (as defined in Section 2.51).
- 2.49 **"Qualifying Individual"** means:
- (a) a tax dependent of the Participant (as defined in Code §152), who is under the age of thirteen (13) and who is the Participant's qualifying child as defined in Code §152(1)(1);
 - (b) a tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participants 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. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code §216(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of §152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.
- 2.50 **"QMCSO" or "Qualified Medical Child Support Order"** requires any child of a participant in a group health plan, who is recognized under a medical child support order as having a right to enrollment under the plan, with respect to such participant, is an alternate recipient. This provision of the Child Support Performance and Incentive Act (CSPIA) of 1998 require church plans to comply, as well as the State and local government plans.
- 2.51 **"Qualifying Services"** means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed and which are performed:
- (a) in the Participant's home; or
 - (b) outside the Participant's home for: 1) the care of a Dependent of the Participant who is under age thirteen (13); or 2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center; (*i.e.*, a facility that provides care for more than six [6] individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.
- 2.52 **"Regular Full-Time or Regular Part-Time Employee"** means a regular full-time or regular part-time Employee of an Employer (excluding Employees covered under a collective bargaining agreement) as classified by the Employer under its standard personnel practices, and/or may be specified in Article I.
- 2.53 **"Reimbursement Account(s) or Account(s)"** shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Medical and/or Dependent Care Reimbursements. Except for Health Savings Accounts, these amounts may either be retained by the Employer, or sent to a third party Service Provider. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).
- 2.54 **"Restricted Coverage"** coverage which is restricted or is for a limited purpose (dental/vision/preventative care), unreimbursed medical spending account or an employee-only unreimbursed medical spending account (which allow only for reimbursements of Code § 213(d) medical expenses that were incurred by the employee) in order to satisfy regulations regarding participation in other plans, (*i.e.* Health Savings Accounts, and/or Health Reimbursement Arrangements).

- 2.55 **"Run-out Period"** is set number of days or period, following the end of the Plan Year, or following any Grace Period, or a Participants date of termination, during which a participant can submit a claim for reimbursement for a qualified benefit incurred during the coverage period.
- 2.56 **"Security Incidents"** has the meaning set forth in 45 CFR §164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with systems operations in an information system.
- 2.57 **"Spouse"** means an individual who is legally married to a Participant (and who is treated as a spouse under the Code or as defined by Windsor Revenue Ruling Notice 2013-17, and Notice 2013-61; exceptions may apply for state rules, and may differ state to state, and Plans must adopt the Federal rule to be applicable), but for purposes of the Dependent Care Spending Account provisions, shall not include an individual legally separated from the Participant under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.
- 2.58 **"Student"** means an individual who is a full-time student, enrolled for the number of hours or courses the school considers to be full-time attendance and attends for any five (5) or more calendar months during the Plan Year.
- 2.59 **"Taxable Benefits"** means benefits provided to the Participant, which are not Non-Taxable Benefits, as provided in Section 1.10.
- 2.60 **"Trustee or Custodian"** means a financial institution or bank as defined by Code § 408(n), a life insurance company as defined by Code § 816, or a "person that demonstrates to the satisfaction of the Secretary of the Treasury Department," that the manner in which such person will administer the trust will be consistent with the requirements of Code § 223.
- 2.61 **"Unreimbursed Medical Spending Account"** shall have the meaning assigned to it by Section 6.01(b) of the Plan.
- 2.62 **"Unreimbursed Medical Benefit Period"** means the period of coverage for Unreimbursed Medical Spending Accounts to begin the date of the Employees participation in Unreimbursed Medical Spending Accounts and for a period, generally, not to exceed beyond the Plan Year ending date for which the Election and Salary Reduction Agreement is in effect, and during which such expense(s) must be incurred in order to be eligible for reimbursement. This Unreimbursed Medical Benefit Period may include the Grace Period defined Section 2.27, if specified in Article I.
- 2.63 **"Year of Service"** means a twelve (12) month period during which an Employee completes at least one thousand (1,000) hours of service. As to each Employee, Year of Service for eligibility purpose shall be measured by the Plan Entry Computation Periods described in Section 2.19. For all purposes of this Plan, hours of service shall be credited for leave under Family Medical Leave Act (FMLA) and Uniform Services Leave as required by FMLA and Uniformed Services Employment and Reemployment Rights Act ("USERRA"), respectively.
- 2.64 **"Uniformed Services Leave"** means a period of absence from work while serving in any type of uniformed service in the United States Armed Forces, including the Coast Guard, the reserves of any of the Armed Forces, the Army National Guard, the Air National Guard and the commissioned corps of the Public Health Service, when engaged in active duty for training, inactive duty training, or full-time duty, and any other category of persons who have held a civilian job for as little as one day, have reemployment rights under , USERRA, (as defined by Section 2.65).
- 2.65 **"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended January 18, 2006.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.01 ELIGIBILITY TO PARTICIPATE

Each Employee who completes the service requirement specified in the Article I, Section 1.06, shall be eligible to participate in the Plan; and may enter the Plan upon meeting their date of eligibility, as defined by Article I, and Section 1.07.

3.02 TERMINATION OF PARTICIPANT

Participation shall terminate, *(with exceptions as defined by provision under Section 1.11 for Unreimbursed Medical Spending Account Plans)*, on the earliest of: 1) the date an Employee ceases to be an Employee *(because of retirement, termination of employment, layoff, or a reduction of hours)*; 2) when an Employee ceases to meet the eligibility requirements of Section 3.01 of this Plan; 3) the date this Plan is amended to exclude the Employee or is terminated; and 4) the effective date of the Employees election not to Participate pursuant to Section 4.03 or 4.04. Subject to any specific limitations for any particular benefit which the Participant has elected: a) participation shall be continued during a leave of absence for which the Participant continues to receive a salary from his/her employer, and b) participation shall terminate during an unpaid leave of absence; and 5) the Employers termination of this Plan.

Notwithstanding the foregoing, for purposes of COBRA coverage, (COBRA means the continuation coverage requirements of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended Pub. L. 99-272, Title X, Section 10002; 100 Stat 227; 29 U.S.C. 1161-1168), certain benefits may be continued based on Employee eligibility, for special limited COBRA and for certain periods; on the terms and subject to the restrictions described in Section 6.06, with exceptions as defined by provision under Section 1.11, and Section 6.04(b) for Unreimbursed Medical Spending Account Plan). Termination of Participation in this Plan will automatically revoke the Participant's election(s). Insurance benefits will terminate as of the date specified in the Insurer's plan, unless continued by the election of COBRA. Certain eligible employees may continue eligibility for certain periods, by the terms and restrictions defined by each insurance benefit.

Participants with an Electronic Payment Card, (SABCFlex Card) will have their card deactivated at the point they cease to be a Participant in the Unreimbursed Medical Spending Account Plan, or at such point the Participant neglects to provide requested substantiated medical statements/receipts as requested by the Plan, by the specified date. Should the SABCFlex Card be deactivated due to Participants termination of employment, the Participant would be required to submit manual claims to the Plan for any eligible expenses, (as defined in Section 6.04), to be reimbursed from any remaining Unreimbursed Medical Spending Account balances. If the Participant's SABCFlex Card is deactivated/suspended, due to a non-substantiated expense, the Card would only be reactivated upon receipt of requested medical statements or receipt, or until the amount of the improper payment is recovered.

In the event a Participant, who participates in an HSA terminates during the Plan Year, the HSA benefit does not terminate, as the account is owned by the individual participant; however, any Employer contributions would terminate. The Participants right to continue contributions to the account on a pre-tax basis are terminated; however, the Participants right to contribute on an after-tax basis are (defined by Code §223).

HSA funds are non-forfeitable and automatically carry forward (rollover) from year to year for future medical expenses. Rollovers are not subject to annual contribution limits as defined by Code §223(f)(5). Rollovers are limited to once every twelve (12) months. However, the trustee or custodian may not accept annual contributions to any HSA that exceed the sum of; (1) the dollar amount in effect under Code §223(b)(2)(B)(i), (i.e., the maximum family coverage deductible) plus; (2) the dollar amount in effect under Code §223(b)(3)(B) (i.e., the catch-up contribution amount). Employees, who wish to transfer their HSA funds to another custodian/trustee, may do so (as defined by Code §223) and the terms of current trustee account agreement.

3.03 DATE OF PARTICIPATION

An Employee shall enter the Plan on the Entry Date specified in Article I. Any Employee, who is eligible to participate in the Plan as of the Effective Date of the Plan, shall be deemed to have entered the Plan on that date. However, in order to

enter the Plan or to reenter the Plan, pursuant to Section 3.04 below, an individual must be in the service of the Employer on the date his participation in the Plan becomes effective.

3.04 PARTICIPATION AFTER A BREAK IN SERVICE

A former Participant who returns to work within thirty (30) days or less, after a break in service due to termination of employment or an unpaid leave of absence, will be reinstated in the Plan with the same election(s), such individual had before the break in service, (except for Unreimbursed Medical Spending Account Plan as provided in Section 1.11(b) and 6.06 or as otherwise provided in Article I). If a former Participant is rehired more than thirty (30) days following a break in service or an unpaid leave of absence of employment and is otherwise eligible to participate in the Plan, the individual may make a new election, (as provided in Section 1.06).

3.05 QUALIFYING LEAVE UNDER FAMILY AND MEDICAL LEAVE ACT

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under FMLA, (FMLA means the Family and Medical Leave Act of 1993, Public Law 103-3 (February 5, 1993), 107 Stat 6 (29 U.S.C. 2601 et seq., as amended) to the extent required by the FMLA, as amended by the National Defense Authorization Act for 2008, Section 585, and National Defense Authorization Act for Fiscal Year 2010, Pub. L. No. 111-84. The Employer will continue to maintain the Participant's Group Health Insurance and/or the Unreimbursed Medical Spending Account Plan on the same terms and conditions as though he were still an active Employee, (i.e., the Employer will continue to pay its share of the Group Health Insurance premium to the extent the Employee opts to continue his coverage, the Employee may pay his share of the premium with after-tax dollars while on leave), (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his/her share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave Compensation, by making a special election to that effect prior to the date such Compensation would normally be made available to him/her (provided, however, except as provided under 5.05, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis within the benefit limitations of each plan, which the Employee was participating in the Plan prior to his leave, or as otherwise required, by the FMLA.

If a Participant goes on an 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: 1) paid by pre-payment before going on leave, 2) paid by after-tax contributions while on leave, or 3) with catch-up contributions after the leave ends, as may be determined by the Plan Administrator.

3.06 QUALIFIED LEAVE UNIFORMED SERVICES LEAVE

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on qualifying unpaid Uniformed Services Leave, to the extent required by USERRA, the Participant may, at his/her option, continue to participate under this Plan in the Group Health Insurance Plan and/or the Unreimbursed Medical Spending Account Plan, so long as the Participant continues to make his/her required premium payments. During such absence, the Employee may choose to make his/her required premium payments under any of the options provided in Section 3.05 above for payments in connection with unpaid leave under FMLA. In addition, above Participants in Unreimbursed Medical Spending Account expenses are allowed to continue for a regular period of eighteen (18) months. Upon return from such Uniformed Services Leave, the Participant will be permitted to reenter the Plan on the same basis within the benefit limitations of each plan, which he/she was participating, prior to such leave, or as otherwise required, by USERRA.

Participants on Paid Uniformed Services Leave must be allowed to elect to continue to pay for coverage, including Unreimbursed Medical Spending Accounts, on a pre-tax basis. A Participant is allowed to make a new election for benefits, either upon leaving employment for a qualifying Uniformed Services Leave or subsequent reemployment.

If a Participant has not made an election at the time of his/her departure, then the Plan may cancel coverage upon the Participant's departure, subject to retroactive reinstatement of coverage during the election period, established by the Plan. If the Participant's failure to provide advance notice is excused because such notice was impossible, unreasonable, or

precluded by military necessity, without any exclusions or waiting periods, (other than certain illness or injuries determined to be incurred in or aggravated by performance of military services), then the Plan must retroactively reinstate coverage upon the Participant's election of continuation coverage and payment of the required premiums.

USERRA Continuation of Coverage - Elections for USERRA Continuation of Coverage after a Participant returns from Uniform Service Leave, must be made within sixty (60) days after returning from leave, and the required premium(s) must be paid timely. Initial Payment should be made within forty-five (45) days after electing coverage, and thereafter, monthly premiums must be sent within thirty (30) days of the due date. The premium due date shall coincide with the pay dates for Unreimbursed Medical Spending Accounts, as already established by the Employer's Plan. Failure to pay the continuation of coverage premium(s) shall terminate coverage, (pursuant to Section 4.03 or 4.04), subject to any specific limitations for any particular benefit which the Participant has elected, (as defined by Section 1.10) and to the extent provided in Section 3.04, 4.03, 4.04 6.04, and 6.06.

ARTICLE IV BENEFIT ELECTIONS

4.01 ELECTION OF BENEFITS

A Participant may elect any combination of Pre-tax Contributions or After-tax Contributions, as described more fully below, and in Articles I, to fund any Benefit(s) or Policy available under the Plan, provided however, that only Qualified Benefits may be funded with Pre-tax Contributions. The board and/or Plan Administrator may amend, modify, or change contribution rates for the component Benefit Plans or Plan Policies described in Article I.

4.02 INITIAL ELECTION PERIOD

- (a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Plan, as of the Effective Date, must complete, sign and file an Election and Salary Reduction Agreement with the Plan Administrator during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Election and Salary Reduction Agreement shall be effective, subject to Section 4.04, for the Plan Year beginning on the Effective Date.
- (b) **New Employees and Employees who have not yet satisfied the Plan's waiting period.** An Employee who becomes eligible to become a Participant after the Effective date of the Plan, must complete, sign and file an Election and Salary Reduction Agreement with the Plan Administrator on, or prior to, the day the Employee first becomes eligible to participate in the Plan. The elections made by the Participant on this initial Election and Salary Reduction Agreement shall be prospectively effective as of the first pay period coinciding with, or immediately following, the date that the Election and Salary Reduction Agreement is filed (or if later, the date of the Employee's eligibility under the Plan) and, subject to Section 4.04, ending on the last day of the Plan Year in which such participant began. Coverage under the component Benefits Plan or Policies will be effective in accordance with the eligibility requirement contained in such Benefits Plans or Policies.
- (c) **An eligible Employee who fails to complete, sign and file an Election and Salary Reduction Agreement** with the Plan Administrator in accordance with paragraphs (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 4.03 or 4.04.

4.03 ANNUAL ELECTION PERIOD

Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan, shall be notified, prior to each Anniversary Date of this Plan of his right to become a Participant in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right. Such period of time shall be known as the "annual election period." An election shall be made by submitting an Election and Salary Reduction Agreement to the Plan Administrator during the election period, and shall be effective for the entire Plan Year beginning on the Anniversary Date. The Plan Administrator may promulgate procedures for annual re-enrollment

elections. Except as otherwise provided for in such procedures, a Participant or Employee who fails to complete, sign and file an Election and Salary Reduction Agreement (as required by this Section 4.03), shall be deemed to have elected to continue the same coverage(s), (unless otherwise stipulated by Plan Sponsor in enrollment instructions), under this Plan, then in effect for such Participant or Employee. Exception to this requirement may apply as defined in Article I, Section 1.10 F.

4.04 CHANGE OF ELECTION DURING THE PLAN YEAR

Except as provided in Section 3.04 and 4.03, and 4.04(a-l), a Participant shall not make any changes to the Pre-tax Contribution amount elected under the Plan, except as provided herein:

- (a) **Change in Status.** A participant may change or terminate his/her actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of, and is consistent with, the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account and consistent with a Change in Status.
- (1) **Group term life insurance benefit.** With respect to any group term life insurance (as defined in Code §79), a participant may change his/her election only if the change is consistent with the Change in Status, as set forth below:
 - (i) In the case of a Participant's marriage or the birth, adoption or placement for the adoption of a child, a Participant may elect to increase life insurance coverage, but not decrease such coverage.
 - (ii) In the case of a Participant's divorce, legal separation, annulment, or the death of a Participant's Spouse or Dependent, a Participant may elect to decrease life insurance coverage, but not increase it.
- (2) **Accident and health benefits as defined in Code §106.** With respect to any accident and health benefits, a Participant may change his/her Election and Salary Reduction Agreement election only if: (i) the Change in Status results in the Participant, the Participant's Spouse, or the Participant's Dependent gaining or losing eligibility for the benefit (or a particular benefit option) under the Plan or the Participant's Spouse's or Dependent's Employer's Plan; and (ii) the election change corresponds with such gain or loss of coverage. Notwithstanding the foregoing, if the Participant, the Participant's spouse (but not ex-spouse) or the Participant's Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's Plan, the Participant may increase his/her election to pay for such coverage.
- (3) **Dependent Care Spending Account.** With respect to the Dependent Care Spending Account, a Participant may change or terminate his/her election only if such change or termination is made on account of, and is consistent with, the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is consistent with, and attributable to, a Change in Status.
- (b) **Special Health Insurance Portability and Accountability Act (HIPAA) Enrollment Rights.** If a Participant, a Participant's Spouse or a Participant's Dependent is entitled to special enrollment rights under a group health plan, as required by Code §9801(f), and medical coverage and eligibility for such coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period, or a new Dependent is acquired as a result of marriage, birth, adoptions, or placement for adoption, then a Participant may revoke a prior election for health or accident coverage and make a new election, provided that the election corresponds with such enrollment right and only to the extent required by Code §9801, and the states children's health insurance program ("CHIP"), under Title XXI of the Social Security Act, Reauthorization Act of 2009, effective April 1, 2009:
 - (1) Special Enrollment Rights based CHIP allows Employees to enroll under two additional circumstances, which are:
 - (a) termination of Medicaid or CHIP coverage resulting from loss of eligibility and the employee requests coverage under the plan; or
 - (b) becoming eligible for a premium assistance subsidy in the employer-provided group health plan under Medicaid or CHIP.

For the Special Enrollment Rights change for CHIP, an Employee must request coverage within sixty (60) days of termination, or the date it is determined the Participant is eligible for assistance, in order to be entitled to these special enrollment rights.

- (c) **Certain judgments, decrees and orders.** If a judgment, decree, or order (an "order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage for a Participant's child, a Participant may; (1) change his/her election to provide coverage for the child (provided that the order requires the Participant to provide coverage); or (2) change his/her election to revoke coverage for the child if the order requires that the former spouse provide coverage under the former spouse's plan.
- (d) **Medicare and Medicaid.** If the Participant, the Participant's Spouse, or the Participant's Dependent, who is enrolled in a health or accident benefit under this Plan, becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under §1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. In addition, if the Participant, the Participant's Spouse or the Participant's Dependent, who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Participant may make, on a prospective basis, an election to commence or increase coverage of that Participant, Participant's Spouse or Participant's Dependent under a health or accident plan.
- (e) **Significant Change in cost or coverage.** A Participant may revoke a prior election with respect to Pre-tax contributions, and in lieu thereof, receive on a prospective basis, coverage under another health plan with similar coverage, if any independent third-party provider of medical benefits previously elected by the Participant either significantly increases the premiums for such coverage, or significantly curtails the coverage(s) available under such plans, during the Plan Year coverage period. (Note: If any mid-year premium increase by the third-party provider is insignificant, the Participant's salary reduction election may be automatically adjusted by the Plan Administrator.) Alternatively, in the event there is a significant curtailment that is a loss of coverage (*as defined in Treasury Regulation §1.125-4*), the Participant may elect to revoke a prior election and drop coverage if no similar benefit is available. Additionally, in the event there is a significant decrease in the cost of a benefit, a Participant may elect to commence participating under such benefit on a prospective basis. The provisions of this paragraph are applicable with regard to changes under the Dependent Care Assistance Account Plan only if the cost change is imposed by a dependent care provider who is not a relative (*as defined in Code §1.52(a)*) of the Participant.
- (f) **Significant Change in Health Coverage attributable to Spouse's Employment.** A Participant may revoke a prior election and make a new election, where there has been a significant change in the health coverage of the Participant or the Participant's Spouse attributable to the Spouse's employment. Such change is allowed only if the change is consistent (i.e., necessary or appropriate as a result of the significant change in health coverage attributable to the Spouse's employment). The Plan Administrator (in its sole discretion) shall determine whether a requested change is consistent with, and attributable to a significant change in health coverage attributable to a Participant's Spouse's employment.
- (g) **Addition or improvement of a Benefit Plan or option.** If the Plan adds a new Benefit Plan or option thereunder, or if coverage under an existing Benefit Plan or option thereunder, is significantly improved during the Plan Year, Participants (whether or not they have previously made an election under the Plan, or have previously elected the Benefit Plan or option thereunder) may revoke their election under this Plan, and, in lieu thereof, elect on a prospective basis coverage under the new or improved Benefit Plan.
- (h) **Changes in coverage under another Employer Plan.** A participant (or an Employee who has not made a previous election under this Plan for a particular Plan Year) may make a prospective election change that is on account of, and corresponds with, a change made under another employer plan (including a plan of the Employer or of another employer) if the other cafeteria plan or Benefit Plan allows participants to make an election change that would be permitted under the rules of Treasury Regulations §1.125-4(c).
- (i) **Loss of other Group Health Plan coverage.** A Participant (or an Employee who has not made a previous election under this plan for a particular Plan Year) may make an election on a prospective basis to add coverage under this Plan for the Participant or other Employee, Spouse, or Dependent if the Participant, Employee, Spouse, or Dependent loses coverage under any group health coverage sponsored by a government or educational institution, including:

- a. a state's children's health insurance program (CHIP) under Title XXI of the Social Security Act;
- b. a medical care program of an Indian tribal government (as defined in Code §7701(a)(40)), the Indian health service, or a tribal organization;
- c. a state health benefit risk pool;
- d. a foreign government group health plan; or
- e. an event that qualifies for "Michelle's Law," (H.R. 2851), (Designed to ensure that dependent college student, who take a medical necessary leave of absence, do not lose health insurance coverage). Health premiums dropped, now qualifying for Michelle's Law, are permitted to be reinstated under the Plan, at the same level as the prior coverage the Participant was before.

An older dependent, "Adult Child(ren)" eligible for the employees' group health plan and/or Unreimbursed Medical expenses, up to age twenty-six (26), as provided by the Patient Protection and Affordable Care Act (The ACA Act). Under the Act, Participants may offer dependent coverage to a dependent child, until he/she reaches the age of twenty-six (26); both married and unmarried children qualify for this coverage. Children up to age twenty-six (26) may stay on their parent's plan, even if they have another offer of coverage through an employer or their job. Therefore, once they reach to age twenty-six (26), the Participant would be eligible for a Status Change. If the dependent child is not on the Parents plan and loses coverage, the dependent adult may enroll in the parents plan; provided the dependent child has not yet reached to age twenty-six (26).

- (j) **Changes Due to Family Medical Leave Act, "FMLA" Leaves.** A Participant who takes *FMLA* leave shall have the right to make any election change under an Employer-sponsored group health plan option as may be provided for under *FMLA*, as amended by the National Defense Authorization Act for 2008, Section 585 and the National Defense Authorization Act for Fiscal Year 2010, Pub.L.No.111-84.
- (k) **Changes under a Cafeteria Plan for Health Savings Accounts, "HSA."** Employees, regardless of family status, can make tax favored contributions to a HSA for an eligible individual. Employees contributions in an HSA, under a Cafeteria Plan can be changed at any time, and for any reason, so long as the change is prospectively effective no sooner than the first day of the month following the date the election change is made, and the annual contributions do not exceed the limits for the plan determined on a month-by-month basis, rather than on an annual basis. An employee who elects to make HSA contributions under a Cafeteria Plan, may start or stop the election, or increase or decrease the election, at any time as long as the change is effective prospectively (i.e., after the request for the change is received).

Employees are permitted to elect an HSA mid-year, only if made the first day of the month, on a prospective basis, as he/she becomes eligible for a new qualifying HDHP under the employer's Cafeteria Plan. However, the HSA election does not permit a change or revocation for any other coverage under the Cafeteria Plan unless the change is permitted by Treas. Reg. §1.125-4. Thus, while an HSA may be offered to and elected by the Employee mid-year, the employee may have other coverage under the Cafeteria Plan that cannot be changed, (e.g., coverage under an unreimbursed medical spending account), which may prevent the Employee from being an eligible individual.

No Participant shall be allowed to reduce his/her election for Unreimbursed Medical, and/or Dependent Care Spending Reimbursement Account to a point where the annualized contribution for such benefit is less than the amount already reimbursed. In addition, any change in an election affecting annual Plan Contributions Unreimbursed Medical, and/or Dependent Care Spending Reimbursement Account, pursuant to this Article, also will change the Maximum Reimbursement Benefits for the period of coverage remaining in the Plan Year. Such Maximum Reimbursement Benefits for the period of coverage following an election change shall be calculated by adding the balance (if any) remaining in each of the Participant's Reimbursement Accounts as of the end of the portion of the Plan Year, immediately preceding the change in election, to the total Plan Contributions scheduled to be made by the Participant during the remainder of such Plan Year to such Account(s).

An Employee who is eligible to become a Participant, but declined to become a Participant during the initial election period pursuant to Section 4.02 of this Plan Document (a) or (b), may become a Participant and file a pre-tax election within ninety (90) days of the occurrence of an event described in Section 4.04 (a), (b), (c), (d), (e) and (f) above, but only if the election under the new Election and Salary Reduction Agreement is made on account of, and is consistent with, the event (as described above). Except for Health Savings Accounts, a Participant otherwise entitled to make a new election under this Section must do so within ninety (90) days of the event (e.g., Change in Status, significant change in coverage,

Medicare or Medicaid eligibility, special enrollment right or judgment, decree, or order). Subject to the provisions of the underlying group health plan, elections made to add medical coverage for a newborn or newly adopted dependent child, pursuant to HIPAA special enrollment rights may be retroactive for up to thirty (30) days. All other new elections shall be effective no sooner than the first day of the payroll period coincident with, or immediately following, the date the Participant files his/her new Election and Salary Reduction Agreement with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election was made, unless a subsequent event allows a further election change.

4.05 UNREIMBURSED MEDICAL BENEFIT PERIOD

The period of coverage for Unreimbursed Medical Spending Accounts to begin the date of the Employees participation in the Unreimbursed Medical Spending, in accordance with Section 1.06 and 1.07, and not to exceed the:

- (a) Period of coverage for Unreimbursed Medical Spending Accounts to begin the date of the Employees participation in the Unreimbursed Medical Spending Accounts, in accordance with Section 1.06 and 1.07, for a period not to exceed beyond the Plan Year ending date, (as defined in Section 1.04), for which the Election and Salary Reduction Agreement is in effect, and during which such expense(s) are required to be incurred, in order to be eligible for reimbursement.
- (b) "Grace Period", (as defined by Section 2.27), for a period not beyond the fifteenth (15) day of the third (3rd) calendar month, (two (2) and a half (½) months after the Plan Year ending date), (as defined in Section 1.04), for which the Election and Salary Reduction Agreement is in effect, and during which such expense(s) are required to be incurred, in order to be eligible for reimbursement, as permitted under IRS Notice 2005-42.

4.06 CARRYOVER PROVISION

Notwithstanding any provisions of the Plan to the contrary, unused amounts of up to the limit as defined by IRS Notice 2013-71 and 2013-47, remaining in a Participant's Unreimbursed Medical Spending Account, at the end of the Plan Year, following the Run-out Period, (defined by Section 2.55), may be used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year. The following conditions shall apply to Unreimbursed Medical Spending Account Carryovers:

- a) No more than the limit as defined by IRS Notice 2013-71 and 2013-47, of a Participant's unused Unreimbursed Medical Spending Account funds for any Plan Year, may be carried over for use in the next Plan Year
- b) The Carryover will occur after the Run-out Period for submitting claims has expired. Any Unreimbursed Medical balance in excess of the allowed limit as defined by IRS Notice 2013-71 and 2013-47, (unspent during the Plan Year, or the subsequent Run-out Period), will be forfeited (as defined in Section 11.16).
- c) Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit or annual salary reduction limit under the Unreimbursed Medical Spending Account, (as defined in Section 1.10 D).
- d) Additionally, Unreimbursed Medical Expenses that incur during the Run-out Period must utilize the current Plan Year funds. If the current year funds are exhausted, then previous years funds, up to the limit as defined by IRS Notice 2013-71 and 2013-47, may be used to reimburse eligible Medical Care Expenses.

4.07 SABCFlex CARD (ELECTRONIC PAYMENT CARD)

Electronic Payment Card reimbursements, ("SABCFlex Cards"), (as defined in Section 2.17), are used to electronically pay for eligible medical purchases, (as defined by Code §213(d)).

The SABCFlex Card debits the Participant's Unreimbursed Medical Spending Accounts (URM) at the point of sale, and payment is based exclusively on the Participants annual election for the URM Plan Year, pursuant to the Election and

Salary Reduction Agreement then in effect, less any reimbursements already provided. Cards will be configured as follows:

- (a) "Restricted Card" - Restricted to purchases for RX prescriptions, and/or eligible over-the-counter items only. The SABCFlex Card may be used at participating merchants/pharmacies, mail-order pharmacies, and supermarkets that utilizes the inventory information approval system (IIAS). Eligible expenses are deducted from the account balance at the point of sale. Transactions are fully substantiated, no paper follow-up is needed. If the pharmacies cannot identify the eligible items at the point of sale, Participants must substantiate the expense(s), (as defined by Section 7.10).
- (b) "Open Card" - Card may be used for all eligible Section 213(d) expenses. Participants may use the Card to pay Medical Care Expenses, such as: a hospital, doctor, dentist, or vision provider provided the merchant accepts debit/credit cards. For Open Cards, Electronic Payment Card, "Auto-Adjudication" technology does not have the "inventory information approval system" (IIAS) to electronically verify the transaction's eligibility. Therefore, paper follow-up "validation" is required, (as defined in Section 7.10).

ARTICLE V

BENEFIT FUNDING AND CREDITS AND DEBITS TO ACCOUNTS

5.01 SOURCE OF BENEFIT FUNDING

The cost of coverage under the component Benefit Plans or Policies shall be funded by Participants Salary Reduction/Deduction. The component Benefit Plans or Policies, and required contributions thereunder, shall be made known to Employees in enrollment materials and set forth in Article I.

Participant Salary Reduction. The Employer shall withhold from a Participant's Compensation on a Pre-tax or After-tax basis (as elected by the Employee) an amount equal to the contributions required from the participant for coverage of the Participant or the Participant's spouse or dependents, under the Benefit Plans or Policies elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pre-tax Contributions or After-tax Contributions, shall be applied to fund benefits, as soon as administratively feasible. The amount of Pre-tax Contributions, made available by the Employer for the benefit of each Plan Participant, shall not exceed the aggregate cost of the benefits elected.

5.02 ALLOCATIONS IRREVOCABLE DURING PLAN YEAR

Except as provided in Section 3.04, 4.04, 5.03 and 5.04, neither (a) the coverage(s), nor amounts withheld, therefore elected under Section 6.01(a), nor (b) the amount to be credited to a Participant's Account during the Plan Year, pursuant to Section 5.05, 5.06 and 5.07 nor (c) the allocation of such amounts to the appropriate Account(s) or the Participant, can be changed during the Plan Year.

5.03 REDUCTION OF CERTAIN ELECTIONS TO PREVENT NONDISCRIMINATION

If the Plan Administrator determines, by nondiscrimination testing, before or during any Plan Year, that the Plan fails to satisfy, for such Plan Year, any requirements imposed by the Code or any limitation on Pre-tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as required under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

5.04 MODIFICATION OF AMOUNTS WITHHELD DUE TO PREMIUM INCREASES OR DECREASES

If the cost of a health plan provided by an independent, third party provider increases or decreases during a Plan Year, then the Pre-tax Contributions or After-tax Contributions (as applicable) under each affected Participant's election, shall be increased or decreased to reflect such change, except as provided in Section 4.04(b).

5.05 UNREIMBURSED MEDICAL SPENDING ACCOUNT

- (a) **Debiting and Crediting of Accounts.** Each Participant's Unreimbursed Medical Spending Account ("URM" or "Account") shall be credited with amounts withheld from the Participant's compensation for URM, pursuant to the Election and Salary Reduction Agreement. The Account shall be debited for reimbursement amounts disbursed to the Participant in accordance with Article VI of this document. The entire amount elected by the Participant on the Election and Salary Reduction Agreement, as an annual amount for the Plan Year for URM, less any reimbursements already disbursed, shall be available to the Participant at any time during the Plan Year, without regard to the balance in the Account (provided that the periodic premiums have been paid). Thus, the maximum amount of URM at any particular time during the Plan Year, shall not relate to the amount which a Participant has had withheld up to that time. In no event shall the amount of URM Account Reimbursement benefits, in any Plan Year, exceed the annual amount specified for the Plan Year in the Election and Salary Reduction Agreement for the URM. Any amounts allocated to the Account, shall be forfeited by the Participant and restored to the Employer, to defray administrative cost, if it has not been applied to provide URM benefit, following the end of the URM Plan Year benefit period, and submitted during Run-out Period, (defined by Section 1.08), for which the election was in effect.
- (b) **Source of Payments.** All URM reimbursements derived hereunder shall be paid exclusively from the amounts in each Employee's URM Account funded by amounts withheld from the Employee's wages pursuant to the Election and Salary Reduction Agreement for URM. In the event that an Employee's claim for URM exceeds the amount currently available in the Employee's URM, the Employer shall pay the excess amount, up to the amount elected by the Participant on his/her Election and Salary Reduction Agreement for URM, less any reimbursements already disbursed. Future premium payments by the Employee shall then go to the Employer, as reimbursement for the money so advanced on behalf of the Employee.
- (c) **Excepted Benefits.** All URM benefits herein, are intended to qualify as "excepted benefits" as defined by Code §106(d)(2)(c), as amended by Notice 2013-54. The URM benefit provided under the Plan "are excepted benefits" and satisfies two conditions:
- (1) **Maximum Benefit Condition.** Maximum Benefit Conditions are also determined by funding; however, benefits provided during any Grace Period, from a previous year's contributions are attributed to the previous year. The maximum benefit payable under the URM Plan to any Participant in the any class for a year, cannot exceed two times the Participant's salary reduction election under the URM Plan for the year (or, if greater, the amount of the Participant's salary reduction election for the URM Plan for the year, plus \$500). Maximum annual benefit refers to the entire available URM Plan benefit that the Participant may elect to receive for the Plan Year—i.e. the Participant's salary reduction plus any Employer contribution.
 - (2) **Availability Condition.** Other non-excepted group health plan coverage (e.g., major medical coverage) must be made available for the Plan Year to the class of participants being offered the URM Plan, by reason of their employment, to be eligible, and the other coverage cannot be limited to benefits that are excepted benefits—(e.g., the other coverage cannot consist solely of Limited Purpose Flexible Spending dental or vision coverage, as maybe defined in Section 1.10 D (4) if selected.

5.06 DEPENDENT CARE SPENDING ACCOUNT

- (a) **Debiting and Crediting of Accounts.** Each Participant's Dependent Care Spending Account ("DC" or "Account") shall be credited with amounts withheld from the Participant's compensation for DC pursuant to the Election and Salary Reduction Agreement. The Account shall be debited for reimbursement amounts disbursed to the Participant, in accordance with Article VI of this document. In the event that the amount in the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim shall be carried over into following months (within the same Plan Year), to be paid out as the Account balance becomes adequate. In no event shall the amount of DC, exceed the amount withheld, pursuant to the Election and Salary Reduction Agreement for any Plan Year. Any amounts allocated to the Account shall be forfeited by the Participant and restored to the Employer, to defray administrative cost, if it has not been applied to provide DC benefits for the Plan Year benefit period, and submitted during the Run-out Period, (defined by Section 1.08), for which the election was in effect.

- (b) **Source of Payments.** All DC derived hereunder, shall be paid exclusively from the amounts in each Employee's DC Reimbursement Account, funded by amounts withheld from the Employee's wages, pursuant to the Election and Salary Reduction Agreement for the DC.

5.07 HEALTH SAVINGS ACCOUNT

- (a) **Debiting and Crediting of Accounts.** Each Participant's Health Savings Account ("HSA") will be credited with amounts withheld from the Participant's Compensation for HSAs, pursuant to the Election and Salary Reduction Agreement, and the monthly maximums defined in Section 1.10 G).

The Employer may contribute a portion of contributions, to a Participant's HSA, if the option is defined in Section 1.10 G (3). Amount(s) of the contributions, are as provided in the open enrollment materials furnished to Employees, (determined annually), however, not to exceed maximum annual limits, (as defined by Code §223; indexed annually), and pro-rated based upon the number of whole months an employee is covered under the qualified HDHP plan; 1/12 for every month worked, for Participants meeting Eligibility Requirements (defined in Article I, Section 1.06).

The Participant is responsible for making sure that distributions never exceed the HSA account balance. Failure to comply may result in penalties as defined by Code §223, and per the employee signed custodial agreement.

- 1) Employees may have additional HSA contributions, into the same HSA, so long as the total contributions made by the Employee and/or on the Employees behalf; do not exceed the maximum annual contribution limits, as defined by Code §223. An additional annual "catch-up" amount (also determined on a monthly basis), can be contributed for eligible individuals who are age fifty-five (55) or older, and younger than sixty-five (65), as defined by Code §223. An excise tax as indexed, for each taxable year, is imposed on the HSA beneficiary for excess individual and Employer Contributions.
- (b) **Source of Payments.** All HSA funds derived hereunder; shall be paid exclusively from the funds in each Employee's HSA.
- (c) **Funds are non-forfeitable and automatically carry forward** (rollover) from year to year for future medical expenses. Rollovers are not subject to annual contribution limits (as defined by Code §223(f)(5)). Rollovers are limited to once every twelve (12) months. However, the trustee may not accept annual contributions to any HSA that exceed the sum of; (1) the dollar amount in effect under Code §223(b)(2)(B)(i), (i.e., the maximum family coverage deductible); plus (2) the dollar amount in effect under Code §223(b)(3)(B), (i.e., the catch-up contribution amount). Employees, who wish to transfer their HSA funds to another custodian/trustee, may do so as defined by Code §223 and the employee signed custodial agreement.

ARTICLE VI BENEFITS

6.01 QUALIFIED BENEFITS

The maximum benefit a Participant may elect under a Plan shall not exceed the sum of: 1) the aggregate premium for all Pre-tax Employee Contributions under Section 6.01(a); 2) the maximum Unreimbursed Medical Spending Account expense under 1.10 D and 6.01(b); 3) the maximum Dependent Care Spending Account Reimbursement under 6.01(c); and 4) the maximum amount for Health Savings Accounts (as defined by Code §223). The Qualified Benefits may be available (as defined by Section 1.10) for election for one or more of the following:

- (a) **Pre-tax Employee Contributions.** The Employer shall withhold from a Participant's Compensation, an amount equal to contributions required from the Participant for coverage of the Participant, or the Participant's Spouse or Dependents, under the Benefit Plans or Policies elected by the Participant and maintained by the Employer. The benefits are subject to the terms and conditions of the applicable Benefit Plans or Policies which are incorporated herein.
- (b) **Unreimbursed Medical Spending Account.** To the extent described in Article I, this benefit shall be made

available to Participants. Payment shall be made to the Participant in cash (except when the Electronic Payment Card is utilized) as reimbursement for Eligible Medical Expenses, incurred by the Participant or Participant's Dependents while he/she is eligible to Participate, during the Plan Year for which the Participant's election is effective.

The eligible Code §213(d) expense must also be expenses which C

- (1) are not covered, paid or reimbursed from any other source;
- (2) meet the criteria of tax-deductibility as a medical or dental expense under Section §213(d) of the Code, as amended and the regulations thereunder;
- (3) are not over-the-counter ("OTC") drugs/medicine purchases, disallowed by the ACA Act;
- (4) will not be taken as a deduction from income on the Participant's federal income tax return in a tax year;
- (5) do not exceed the amount the Employee has elected to have withheld for Unreimbursed Medical Spending Accounts for the Plan Year (or maximum reimbursement amount specified in Article I) less previous Unreimbursed Medical Reimbursements made during the Unreimbursed Medical Benefit Period;
- (6) are verified in writing to the satisfaction of the Administrator that a covered expense has occurred and the claim meets the substantiation requirements of Section 7.10;
- (7) are for an individual, and/or spouse and/or legal dependent(s) expenses; and
- (8) are not limited due to Participation in a HSA, (as defined by Section 2.35).

- (c) **Dependent Care Spending Account.** To the extent described in Article I, this benefit shall be made available to Participants. Payment shall be made to the Participant in cash as reimbursement for the Eligible Employment Related Expenses incurred by him/her while an Employee, during the Plan Year for which the Participant's election is effective, provided that the substantiation requirements of Section 7.10 have been complied with. No payment otherwise due a Participant hereunder, shall exceed the smallest of:

- (1) the Participant's Earned Income for the applicable month;
- (2) the Earned Income of the Participant's Spouse for such month (Note: a Spouse of a Participant, who is not employed during a month in which the Participant incurs Eligible Employment Related Expenses and, who is either incapacitated or a Student, shall be deemed to have Earned Income in the amount of \$200 per month per "Qualifying Individual" (as defined by Section 2.49), for whom the Participant incurs Eligible Employment Related Expenses(s), up to a maximum amount of \$400 per month);
- (3) the amount the Participant elected to have withheld from his/her Compensation for Dependent Care Spending Account Reimbursement during the plan year; or
- (4) Five Thousand Dollars (\$5,000) if the Participant is single or married and files a joint return, or Two Thousand, Five Hundred Dollars (\$2,500), if the Participant is married and files a separate tax returns, (or any future aggregate limitations promulgated under Code §129) less any prior reimbursements during the Plan Year.

- (d) **Health Savings Account:** Employees may participate in an HSAs provided they are an eligible, "eligible individual" means, with respect to any month, an employee/individual who: 1) is covered under a qualified High Deductible Health Plan (HDHP) on the first day of such month; 2) is not also covered by any other health plan that is not a HDHP, including any unrestricted Unreimbursed Medical Spending Account during its Grace Period; or is not a Limited Purpose Medical Spending Accounts (certain exceptions for plans providing limited or certain restricted types of coverage); 3) is not enrolled under Medicare; and 4) may not be claimed as a dependent on another person's tax return. A HDHP is a qualifying health plan as defined by Code § 223(g), as indexed.

HSA-eligible individuals not hired at the beginning of the Plan Year, and become HSA-eligible in any month other than January, may elect maximum HSA contributions for the year, based on their health coverage level in the last month of the year. If the Employee does not remain HSA-eligible for twelve (12) months following the last month of the year of the first year of eligibility, the amount which could not have been contributed except for this provision will be included as income and subject to an additional tax penalty.

To the extent described in Article I, this benefit shall be made available to individual employee(s) who are covered by a HDHP (for "Self Coverage"), or Employee, Spouse and/or Dependents (for "Family Coverage"), and are either not a Participants in Unreimbursed Medical Spending Accounts "URM" Plan, or their elections are based on

a Limited Purpose Plan for restricted coverage dental/vision.

To the extent described in Article I, this benefit shall be made available to individual employee(s); who are covered by a HDHP (for Self Coverage), or Employee, Spouse and/or Dependents (for Family Coverage), and only Participate in Unreimbursed Medical Spending Account election, based on Restricted Coverage or Limited Purpose coverage dental/vision, (as defined in Section 2.54 and Section 1.10 D (4)).

The Employer shall withhold from a Participant's Compensation, an amount equal to contributions requested by the Participant, pursuant to the Election and Salary Reduction Agreement, for coverage of the Participant, or the Participant's Spouse or Dependents, under the HSA benefit elected by the Participant and maintained by the trustee/custodian.

HSAs are subject to the terms and conditions (as defined by Code §223) and applicable rules which are incorporated herein. Employer's and/or Plan Administrator's involvement shall be limited to education, origination, and salary reductions. Benefits are subject to the terms and conditions of the applicable HSA Code § 223 and their trustee/custodial agreement, and Article III, Section 3.01.

A custodian/trustee account is designed and set up to pay HSA routine medical expenses and/or provide savings for the future. Funds deposited into the account can be used during the year, or accumulated in the account, to pay future qualified medical expenses. Individuals, who receive tax free distributions, are responsible for paying medical providers. In order to receive tax free distributions, it is the individual account holder's (employee) responsibility to prove that deductions for the account were from qualified medical expenses. Distributions for non-qualified medical expenses will be added to gross income and subject to additional tax penalties. There is not an independent third party that approves claims and releases funds from the account. Funds are non-forfeitable and automatically carry forward (rollover) from year to year for future medical expenses. Rollovers are not subject to annual contribution limits and are limited to once every twelve (12) months. The Employee may be assessed service charges and/or penalties for account distribution and/or balance requirements, etc., as defined by their custodial agreement.

Qualified Medical Expenses incurred by the Participant or Participant's Dependents, are expenses which are "qualified medical expense" paid by the Employee, spouse, beneficiary, or dependents for medical care (as defined in Section 213(d)); (including nonprescription drugs as described in Revenue Rule 2003-102, 2003-38 I.R.B. 559), but only to the extent that the expenses are not covered by insurance or otherwise. The qualified medical expense must be incurred only after the HSA has been established.

6.02 CASH BENEFIT

To the extent that a Participant does not elect to have the maximum amount of his/her Compensation contributed as a Pre-tax Contribution or After-tax Contribution hereunder, such amounts not elected shall be paid to the Participant in the form cash.

6.03 REPAYMENT OF EXCESS REIMBURSEMENTS

If it is determined that a Participant has received payments under this Plan that exceeds the amount of Eligible Reimbursement Expenses that have been substantiated by such Participant during the Plan Year, the Plan Administrator shall give the Participant prompt written notice of the excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

Resolving an Electronic Payment, due to improper payment, or in the event that a claim that qualifies for after-the-fact-substantiation for which an Electronic Payment Card (SABCFlex Card) used. The following procedures will be required:

- 1) **Required Repayment.** The Participant will be required to repay the improper payment and/or non-substantiated claim. A letter will be emailed to the Participant at email address as provided by the Participant or Plan Sponsor, requiring that the improper claim be repaid to the Plan listing the following; 1) identifying the reason for the improper payment; 2) the amount of the improper payment; 3) the timeframe in which the repayment must be made; and 4) requirements to resolve the improper payment;

- 2) **Deny Access to the SABCFlex Card.** The Participant will be notified of the improper payment and/or non-substantiated claim. During this time, the Participant will be required to submit valid documentation to substantiate the expense. Unresolved improper payments will result in deactivation of the Card;
- 3) **Withhold From Pay.** If a required repayment request is unsuccessful, the amount equal to the improper payment will be withheld from the participant's pay or other compensation;
- 4) **Offset.** If the improper payment is still outstanding and amounts are not available to be withheld, then the Plan Sponsor is to apply a substitution or offset approach against subsequent valid claims, up to the amount of the improper payment; and
- 5) All repayment requirements must be resolved by the deadline date, as provided on each Participant's emailed/written notification.

6.04 TERMINATION OF REIMBURSEMENT BENEFITS

- (a) **Dependent Care Spending Account and Termination:** Coverage under Dependent Care Spending shall cease as of the date the Participant is no longer employed by the Employer or when a Participant's Contribution for the respective Plan has been missed for any reason. Provided however, Participants may submit claims for reimbursement for eligible employment-related Expenses arising during the Plan Year at any time until the close of the Run-out Period (as defined in Article I, Section 1.08), for which the election had been in effect, and receive reimbursement hereunder.

If the Participant terminates employment and any monies due, are not claimed by the expiration of the Run-out Period, (as defined in Article I, Section 1.08), shall be deemed to be an "administrative expense" to be refunded to the Employer by any unused Account balance(s), (if any) as provided in Section 5.05(a), and Section 11.16.

- (b) **Unreimbursed Medical Spending Account Plan and Termination: (Voluntary Plan Year Coverage):** In the event a Participant in an Unreimbursed Medical Spending Account terminates employment during the Plan Year, (as defined in Section 1.11), final reduction of the Participant's Plan Year election will be deducted from the Participant's final paycheck, (or any monies due the Participant upon employment termination). A Participant, in the Unreimbursed Medical Spending Accounts, ceases to be a Participant at the close of the Unreimbursed Medical Benefit Period, (as defined in Section 1.10 D (3)). Participants that terminate may continue to submit claims for reimbursement for Eligible Medical Expenses arising during the Unreimbursed Medical Benefit Period, and receive reimbursement hereunder. Participants shall not be entitled to receive reimbursement for Medical Expenses incurred after the end of Unreimbursed Medical Benefit Period, and any unused reimbursement benefits not claimed by the expiration of the Run-out Period, (as defined in Article I, Section 1.10 D (3)), be treated in accordance with Section 5.05 and Section 11.16.

If the Employee terminates employment and any monies due, do not cover the remaining Plan Year election, any reimbursements advanced or claimed during the remainder of the Plan Year shall be deemed to be an "administrative expense" to be refunded to the Employer by any unused Account balance(s), (if any) as provided in Section 5.05(a), and Section 11.16.

- (c) **Unreimbursed Medical Spending Account and Termination (COBRA):** When a Participant ceases to be a Participant under Section 3.02, the Participant's Salary Reductions will terminate. As defined in Section 1.11, the Participant will not be able to receive reimbursements for Unreimbursed Medical Spending Expenses incurred after his/her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursements for any Unreimbursed Medical Spending Expense incurred during the Unreimbursed Medical Benefit Period, (prior to termination), provided that the Participant (or the Participant's estate) files a claim by the expiration of the Run-out Period, (as defined in Article I, Section 1.10 D (3)), following the end of the Unreimbursed Medical Benefit Period in which the Unreimbursed Medical Spending Expense arose.

Notwithstanding any provision to the contrary in this Plan, (to the extent required by special limited COBRA), a Participant and his/her Spouse and Dependents, whose coverage terminates under the Unreimbursed Medical Spending Account because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis for the same coverage that he/she had under the Unreimbursed

Medical Spending Account for the day before the qualifying event occurred, for the periods prescribed by COBRA (subject to special limited conditions and limitations under COBRA), with premiums for such coverage to be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator), on a uniform and consistent basis, but not beyond the current Plan Year. Specifically, such individuals will be eligible for COBRA continuation coverage, only if, they have a positive or underspent Unreimbursed Medical Spending Account balance at the time of a COBRA qualifying event (taking into account all reimbursement claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Unreimbursed Medical Spending Account component would cease at the end of the Plan Year, a qualified beneficiary receiving COBRA coverage at that time, would also be entitled to any Grace Period (if provided for under Section 1.10 D (3)), or cannot be continued for the next Plan Year. Claims incurred after an employee's coverage terminates, can only be reimbursed if a COBRA Continuation coverage election is both applicable and properly made.

Unreimbursed Medical Participants with the Electronic Payment Card, (SABCFlex Card) will have their card deactivated or suspended at the point the Participant ceases to be a participant in the Unreimbursed Medical Spending Account Plan. However, such Participant (or the Participant's estate) may claim reimbursements for expenses incurred after the SABCFlex Card has been suspended/deactivated, by filing a manual claim for any Unreimbursed Medical Spending Expense incurred, provided the Participant (or the Participant's estate) files a claim by the expiration of the Run-out Period, (as defined in Article I, Section 1.10 D (3)), following the end of the Unreimbursed Medical Benefit Period in which the Unreimbursed Medical Spending Expense arose.

- (d) **HSA Account Plan and Termination:** In the event a Participant, who participates in an HSA, terminates during the Plan Year, the benefit does not terminate, as the account is owned by the individual Participant. The Participant's right to continue Employee contributions to the account on a pre-tax basis are terminated, however his/her right to contribute on an after-tax basis are based on *Code §223, the employee eligibility requirements to participate in an HSA*, (as defined Section 1.10 G), and its limitations. Funds are non-forfeitable and automatically carry forward, (rollover from year to year), for future medical expenses. Employees, who wish to transfer their HSA funds to another custodian/trustee, may do so (as defined by Code §223) and the Employee signed custodial agreement.

HSA Employer contributions (as defined Section 1.10 G (3), terminate on the earliest of: 1) the date an Employee ceases to be an Employee; 2) when an Employee ceases to meet the eligibility requirements of Section 3.01 of this Plan; 3) the date this Plan is amended to exclude the Employee or is terminated; or 4) the effective date of the Employee's election not to participate, pursuant to Section 4.03 or 4.04.

Eligible individuals hired in any month other than January, but do not remain HSA-eligible for twelve (12) months following the last month of the year, of the first year of eligibility, the amount which could not have been contributed except for this provision, will be included as income and subject to an additional tax penalty.

6.05 NAMED FIDUCIARY; COMPLIANCE WITH ERISA, COBRA, HIPAA, etc.

- a) **Named Fiduciary.** Employer, (as defined in Section 1.01(a)), is the named fiduciary for the Unreimbursed Medical Spending Account Plan for the purposes of ERISA § 402(a).
- b) **Laws Applicable to Group Health Plans.** Unreimbursed Medical Spending Account Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, etc.
- c) **Coordination of Benefits.** Unreimbursed Medical Spending Accounts are intended to pay benefits solely for Medical Care Expenses, not previously reimbursed or reimbursable elsewhere. Accordingly, the Unreimbursed Medical Spending Accounts shall not be considered a group health plan for coordination of benefits purposes, and Unreimbursed Medical Spending Account Benefits shall not be taken into account when determining benefits payable under any other plan.

6.06 COBRA COVERAGE

Each Benefit Plan or Policy made available under Article VI, that is considered to be a "group health plan" under Code §4980B, may be subject to COBRA and include Unreimbursed Medical Spending Accounts for special limited COBRA (as defined in Section 3.02 and Article XII, except for Unreimbursed Medical Spending Account Plans with Voluntary Plan Coverage provisions, as defined in Section 1.11 and 6.04 (b) of this Plan), as Employees and their families are provided with health care benefits within the meaning of Code §213(d) (1), and shall contain the necessary provisions required by Code §4980B and ERISA § 601, to ensure that such benefits may be continued on, or after the occurrence of the qualifying events defined in Code §4980B)f(3).

ARTICLE VII PLAN ADMINISTRATION

7.01 ALLOCATION OF AUTHORITY

The Board of Directors, (or authorized officer of the Employer, or authorized representative of a government entity), shall appoint a Plan Administrator, which keeps the records for the Plan, as well as controls and manages the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder; including the right to question and determine facts construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the Summary Plan Description issued in connection with the Plan. All determinations of the Plan Administrator, with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

- (a) To require any person to furnish such reasonable information as he may request, for the purpose of the proper administration of the Plan, as a condition to receiving any benefits under the Plan;
- (b) To make and enforce such rules and regulations, and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;
- (c) To decide on questions concerning the Plan, and the eligibility of any Employee to participate in the Plan, and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;
- (d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer or insurer, as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant, whose claim for benefits has been denied in whole or in part;
- (e) To designate other persons to carry out any duty or power which may, or may not, otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan;
- (f) To keep records of all acts and determinations, and to keep all such records, books of accounts, data and documents, as may be necessary, for the proper administration of the Plan;
- (g) To prepare and distribute to all Employees, information concerning the Plan and their rights under the Plan;
- (h) To do all things necessary to operate and administer the Plan in accordance with its provisions.

7.02 PROVISION FOR THIRD-PARTY SERVICE PROVIDERS

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary, or desirable, in connection with the operation of the Plan and to rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

7.03 FIDUCIARY LIABILITY

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act, except for their own willful misconduct or willful breach of this Plan.

7.04 COMPENSATION OF PLAN ADMINISTRATOR

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator, who is also an Employee of the Employer, shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties, shall be paid by the Employer.

7.05 BONDING

Unless otherwise determined by the Employer, or unless required by any Federal or State Law, the Plan Administrator shall not be required to give any bond or other security, in any jurisdiction, in connection with the administration of the Plan.

7.06 PAYMENT OF ADMINISTRATIVE EXPENSES

All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

7.07 FUNDING POLICY

The Employer shall have the right to enter into a contract with one or more insurance companies for the purpose of providing any benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type which may become payable under any such insurance contract, shall not be assets of the Plan, but shall be the property of, and retained by the Employer.

7.08 DISBURSEMENT REPORTS

The Plan Administrator shall issue directions to the Employer concerning all benefits, which are to be paid from the Employer's general assets, pursuant to the provisions of the Plan.

7.09 INDEMNIFICATION

The Plan Administrator shall be indemnified by the Employer against claims, and the expense of defending against such claims, resulting from any action or conduct relating to the administration of the Plan, except claims arising from gross negligence, willful neglect, or willful misconduct.

7.10 SUBSTANTIATION OF EXPENSES

Participant must submit a Claim Form to the Plan Administrator to receive reimbursements from his/her Unreimbursed Medical, and/or Dependent Care Spending Account Plan. Participants must include a written statement/bill or electronic document from an "independent third party" (individual or entity who provided the expense service), stating that the expense has been incurred, and the amount thereof. The forms shall contain such evidence as the Plan Administrator shall deem necessary as to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed, (as defined by IRS Notice 2006-69), and by such other information as the Plan may deem necessary to validate the expense. If payment was made in kind, such fact shall be so reflected. Participants may have restricted coverage or a Limited Purpose (dental/vision) Unreimbursed Medical Spending Account Plan, for those who participate or have dependents that participate in other tax favored programs (i.e. Health Savings Accounts "HSA" or Health Reimbursement Arrangements "HRA").

Use of the SABCFlex Card is limited to eligible Code §213(d) expenses. Participants, who receive an improper payment, (an expense that may not qualify as an eligible expenditure, as defined under section 6.01(b)), will be required to provide, when requested, substantiation and/or repayment of the expense, (as defined in Section 6.03).

7.11 REIMBURSEMENT

Reimbursements may be in the form of a manual reimbursement check, direct deposit or Electronic Payment Card, (SABCFlex Card). Reimbursements shall be made, as soon as administratively feasible after the required forms have been received by the Plan Administrator. Manual check reimbursements require a minimum reimbursement limit of \$15. For manual checks, claims received for less than \$15 will be carried forward and aggregated with future claims until the reimbursable amount is greater than \$15, provided, however, that the entire amount of each reimbursable claim by manual check, outstanding at the end of Plan Year (and such other times determined by the Plan Administrator) shall be reimbursed without regard to the \$15 threshold limit. Manual check reimbursements will not be issued for any sum less than \$1.00. There are no minimum reimbursement limits on direct deposit or Electronic Payment Cards, (SABCFlex Card).

Although the Plan will make every effort to reimburse expenses on a timely basis, the Participant is responsible for ensuring funds are properly credited to their financial institution before utilizing funds. The Plan or the Plan service provider is not responsible for any NSF fee(s), (defined as "Insufficient Funds Service Fee"), as may be charged by the Participant's financial institution.

SABCFlex Card debits the Participants Unreimbursed Medical Spending Accounts at the point of sale, and payment is based exclusively on the annual amount for the Unreimbursed Medical Spending Plan Year, pursuant to the Election and Salary Reduction Agreement for Unreimbursed Medical Spending Account, less any reimbursements already disbursed.

7.12 STATEMENTS

The Plan Administrator may periodically furnish each Participant with a statement, showing the amounts reimbursed, expenses incurred by the Employer in providing Unreimbursed Medical and/or Dependent Care Spending Account Reimbursement and the respective Reimbursement Account balances(s).

ARTICLE VIII FUNDING AGENT

The Plan shall be funded with amounts withheld from Compensation, pursuant to Election and Salary Reduction Agreements. The Employer will apply all such amounts without regard to their source, to pay for the welfare benefits provided herein, as soon as, administratively feasible and shall comply with all applicable regulations promulgated by the Department of Labor ("DOL"), taking into consideration any enforcement procedures adopted by the DOL.

ARTICLE IX CLAIMS PROCEDURES

9.01 APPLICATION TO PLAN BENEFITS

This Article shall not apply to benefits under the component Benefit Plans or Policies, but shall only apply to issues germane to the pre-tax benefits available under this Plan (i.e., such as a determination of: a Change in Status; significant change in premiums charged; or eligibility and participation matters under this Plan Document). This Article shall be the claims procedure applicable to the Unreimbursed Medical and/or Dependent Care Spending Account Plan(s).

9.02 PROCEDURES IF BENEFIT(S) IS DENIED UNDER THE PLAN

~~Any Employee, beneficiary, or his/her duly authorized representative, who may file a claim for a benefit to which the claimant believes that he is entitled, but that has been previously denied by the Plan; such a claim must be in writing and delivered to the Plan in person, email, faxed, or by mail, postage paid. Not later than thirty (30) days after receipt of such claim, the Plan shall send to the claimant, by email, or mail, postage prepaid, notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. Plan may extend~~

this time for one (1), fifteen (15) days extension from the end of the initial period for "matters beyond the control of the Plan," including cases where a claim is incomplete. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial thirty (30) day period and claimant will be allowed forty-five (45) days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided. The Plan Administrator shall have full discretion to deny or grant a claim, in whole or in part, based on information received. If notice of the denial of a claim is not furnished in accordance with this Section 9.02, the claim shall be deemed denied and the claimant shall be permitted to exercise his/her right to review pursuant to Sections 9.04 and 9.05.

9.03 REQUIREMENT FOR WRITTEN NOTICE OF CLAIM DENIAL

The Plan Administrator shall contact every claimant who is denied a claim for benefits under this Article. Such notice shall be set forth in a manner calculated to be understood by the claimant (verbal or in writing), the following information:

- (a) The specific reason, or reasons, for the denial;
- (b) Specific reference pertinent to the Plan provision on which the denial is based;
- (c) A description of any additional material, or information necessary, for the claimant to perfect the claim and an explanation of why such material is necessary, and
- (d) If unresolved after initial claim, an explanation of the Plan's claims review "appeal" procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 5.02(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination or review.

9.04 RIGHT TO REQUEST A HEARING ON BENEFIT DENIAL

Within sixty (60) days after the receipt by the claimant of written notification of the denial, in whole or in part, of his/her claim, the claimant or his/her duly authorized representative, may make a written application to the Plan Administrator, in person, by email, fax, or by mail (postage prepaid or certified mail), to be afforded a review of such denial; may review pertinent documents; and may submit issues and comments in writing.

9.05 DISPOSITION OF DISPUTED CLAIMS

Upon receipt of a request for review, the Plan Administrator shall make a prompt decision on the review matter. The decision on such review shall be written in a manner calculated to be understood by the claimant, and shall include specific reason for the decision and specific references to the pertinent plan or insurance policy, or regulation provisions on which the decision was based. Claimant will have one hundred, eighty (180) days to file an appeal to the decision after receipt of denial notification. The decision, upon review, shall be made by the "named fiduciary", who will provide for the disclosure to the claimant of information and documents "relevant" to the appealed claim; and allow the submission of written comments and documents by the claimant, decided on in a "reasonable period" not later than sixty (60) days after an appeal is filed, with no extensions; If the appeal is adverse, a written notification of "adverse benefit determination on review" will be provided by the Plan setting forth the reason for the plan provisions on which the determination is based; and that the claimant may obtain relevant documents and information; with the claimant's right to bring a civil action under ERISA. The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. The review will take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. If notice of the decision on the review is not furnished in accordance with this Section 9.05, the claim shall be deemed denied, and the Claimant shall be permitted to exercise his/her right to a legal remedy.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.01 PERMANENCY

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Section 10.02 and 10.03 below. Nothing in this Plan is intended to be, or shall be, construed to entitle any Participant, (retired or otherwise), to vested or non-terminable benefits.

10.02 EMPLOYER'S RIGHT TO AMEND

The Employer reserves the right to amend, at any time, any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Plan Administrator in accordance with its normal procedures for transacting business. Such amendment may apply retroactively or prospectively. Each Benefit Plan or Policy shall be amended in accordance with the terms specified therein, or if no amendment procedure is prescribed, in accordance with this Article. Any amendment made by the Employer, shall be deemed to be approved and adopted by any Affiliated Employer.

10.03 EMPLOYER'S RIGHT TO TERMINATE

The Employer reserves the right to discontinue or terminate the Plan, without prejudice, at any time and for any reason without prior notice. Any such termination shall be in writing and shall be approved by the Employer, or Committee formed by the Employer, in accordance with its normal procedures for transacting business, or by written consent by committee or Employer. Each Benefit Plan or Policy shall be terminated in accordance with the terms specified therein, or if no amendment procedure is prescribed, in accordance with this Article. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

10.04 DETERMINATION OF EFFECTIVE DATE OF AMENDMENT OR TERMINATION

Any such amendment, discontinuance or termination shall be effective, as such date as the Employer shall determine. Subject to Section 5.05(a) and 5.06(a) (if applicable), no amendment, discontinuance or termination shall allow the return to any Employee any Reimbursement Account balance, nor can its use be for any purpose other than for the exclusive benefit of the Participant and their beneficiaries.

ARTICLES XI
GENERAL PROVISIONS

11.01 NOT AN EMPLOYMENT CONTRACT

Neither this Plan, nor any action taken with respect to it, shall confer upon any person the right to continue employment with the Employer.

11.02 APPLICABLE LAWS

The provisions of the Plan shall be construed, administered and enforced according to applicable Federal Law and the laws of the Employer's domicile state, to the extent not preempted.

11.03 POSTMORTEM PAYMENTS

Any benefit payable under the Plan after the death of a Participant, shall be paid to his/her surviving spouse (if any); otherwise, to his/her estate. If there is doubt as to the right of any beneficiary, to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

11.04 NON ALIENATION OF BENEFITS

Except as expressly provided by the Administrator, no benefit under the Plan shall be subject, in any manner, to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so, shall be void. No benefit under the Plan shall in any manner be liable for, or subject to, the debts, contract, liabilities, engagements or torts of any person.

11.05 MENTAL OR PHYSICAL INCOMPETENCY

Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age, until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent, or a minor, or a guardian, conservator or other person, legally vested with the care of his/her estate has been appointed.

11.06 INABILITY TO LOCATE PAYEE

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan, due to not being able to ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person, shall be forfeited after a reasonable time, after the date any such payment first became due, shall be refunded to the Employer to defray administrative cost, by any unused Account balance(s), (if any) as provided in Section 5.05(a) and 5.06(a).

11.07 REQUIREMENT FOR PROPER FORMS

All communication in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

11.08 SOURCE OF PAYMENTS

The Employer, and any insurance company contracts purchased or held by the Employer, or funded pursuant to this Plan, shall be the sole source of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan; and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

11.09 MULTIPLE FUNCTIONS

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

11.10 TAX EFFECTS

Neither the Employer nor the Plan Administrator, makes any warranty or other representation as to whether any Pre-tax Contribution made to, or on behalf of, any Participant hereunder, will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary is includible in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated as a "Cafeteria Plan" under Code §125.

11.11 GENDER AND NUMBER

Masculine pronouns include the feminine, as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the content.

11.12 HEADINGS

The Article and Section headings contained herein; are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

11.13 INCORPORATION BY REFERENCE

The actual terms and conditions of the separate component Benefit Plans or Policies offered under the Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

11.14 SEVERABILITY

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof, shall be given effect to the maximum extent possible.

11.15 EFFECT OF MISTAKE

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made, or to be made, to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated, or cause to be withheld or accelerated, or otherwise make adjustments of, such amounts as will in its judgment accord with such Participant, or other person the credits to the account, or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

11.16 FORFEITURE OF UNCLAIMED REIMBURSEMENT ACCOUNT BENEFITS

This plan has a "use-it-or-lose-it" rule, requiring all funds in any Flexible Spending Plan be used to reimburse qualified expenses incurred during the Plan Year benefit period, and be claimed before the Participants' Run-out Period closes. Any reimbursement account benefit payments (e.g., uncashed reimbursement checks), and any unused reimbursement benefits not claimed by the expiration of the Run-out Period, (as defined in Article I, Section 1.08), shall be forfeited to the Employer, to defray administrative cost, (as defined by Section 5.05(a) and 5.06(a)).

ARTICLE XII

CONTINUATION COVERAGE UNDER COBRA

The following provisions shall be applicable to the Unreimbursed Medical Spending Account Plan (except as otherwise limited under the provisions of Section 1.11 and 6.04 (b) of this Plan), and any other group health plan (as defined by Code §4980B and 5000(b)(1) and the regulations promulgated thereunder) subject to COBRA that does not otherwise contain COBRA provisions. The intent of this Article is to extend continuation rights required by COBRA. To the extent greater rights are provided for hereunder, this Article shall be void.

12.01 CONTINUATION COVERAGE AFTER TERMINATION OF NORMAL PARTICIPATION

During any Plan Year which the Employer is subject to Code §4980B, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under the Unreimbursed Medical Spending Plan (or other group health plan subject to COBRA), upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage hereunder. Such extended coverage under the Plan is known as "Continuation Coverage."

12.02 WHO IS A "QUALIFIED BENEFICIARY"?

A "Qualified Beneficiary" is any person who is, as of the day before a Qualifying Event: (a) an Employee of the Employer (including persons who are considered to be "Employees" within Code §401; (b), directors and independent contractors) covered under a health plan offered under the Plan as of such day (such persons are called "Covered Employees"); (c) the Spouse of the Covered Employee; or (d) a Dependent or a Qualified Individual, (as defined by Section 2.12 and Section 2.49) of the Covered Employee. A Covered Employee can be a Qualified Beneficiary, only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of the Covered Employee's employment. A child born to or placed for adoption with a Covered Employee during Continuation Coverage will be a Qualified Beneficiary. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will be treated as a "Qualified Beneficiary."

12.03 WHO IS NOT A "QUALIFIED BENEFICIARY"?

A person is not a Qualified Beneficiary if, as of such day, either the individual is covered under the Unreimbursed Medical Spending Account Plan (or other group health plan subject to COBRA) by virtue of the election of Continuation Coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event, or is entitled to Medicare coverage under Title XVIII of the Social Security Act. Furthermore, an individual who fails to elect Continuation Coverage within the election period, (provided in Section 12.07) shall not be considered to be a Qualified Beneficiary.

12.04 WHAT IS A "QUALIFYING EVENT"?

Any of the following shall be considered as a "Qualifying Event":

- (a) death of a "Covered Employee" (as defined in Section 12.02);
- (b) termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment;
- (c) divorce or legal separation of a Covered Employee from the Employee's spouse;
- (d) a Covered Employee's becoming eligible for benefits under Title XVII of the Social Security Act; and
- (e) a Qualified Individual (as defined by Section 2.49) of a Covered Employee ceasing to be a eligible.

In the case of any person treated as a Covered Employee, but who is not a Common-Law Employee, termination of "Employment" means termination of the relationship that originally gave rise to eligibility to participate in the Unreimbursed Medical Spending Account Plan (or other group health plan subject to COBRA). COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her coverage.

12.05 WHAT BENEFIT IS AVAILABLE UNDER CONTINUATION COVERAGE?

Each person, who is eligible to elect to continue coverage under Article XII, shall have the right to continue the level of coverage in effect for the Covered Employee on the day before the Qualifying Event (or a lesser level of coverage). If a Qualified Beneficiary of another group health plan maintained by the Employer is prevented from receiving a previous level of Benefit due to a change in plan benefits or plan termination, such individual will be entitled to elect any available level of coverage under the Unreimbursed Medical Spending Account Plan. A premium for Continuation Coverage shall

be charged to Employees and/or Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by applicable law.

12.06 NOTICE REQUIREMENTS

- (a) When an Employee becomes covered under the Unreimbursed Medical Spending Account Plan (or any other group health plan subject to COBRA), the Plan Administrator must inform the Participant (and the Spouse or Dependent, if any) in writing of the rights to continued coverage, as described in Article XII.
- (b) The Employee shall give the Plan Administrator (if different from the Employer) written notice of a Qualifying Event within thirty (30) days of the occurrence thereof.
- (c) Within fourteen (14) days of receipt of the Employee's notice, the Plan Administrator shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the Unreimbursed Medical Spending Account Plan (or any other group health plan subject to COBRA), as well as recital of the rights of any such Beneficiary to elect Continuation Coverage, as required by Code §4980B and ERISA §601, in accordance with the terms of this Plan.
- (d) In case of a Qualifying Event described in Section 12.04(c) or (e), a Covered Employee or a Qualified Beneficiary, of such Employee, must notify the Plan Administrator within sixty (60) days of the occurrence thereof. The Plan Administrator shall give written notification of Continuation Coverage rights to any other affected Qualified Beneficiaries within fourteen (14) days of receipt of the notice described in this Section 12.06(d).
- (e) The initial payment for COBRA coverage must be sent within forty-five (45) days of the election and must bring the Qualified Beneficiaries to a current paid status.
- (f) Subsequent payments must be sent within thirty (30) days of the due date.

Notwithstanding any of the foregoing, notification to a Qualified Beneficiary, (including Spouse or Dependent of a Covered Employee) is treated as notification to all other Qualified Beneficiaries of the Covered Employee, (either residing or not with the Covered Employee), at the time notification is made.

12.07 ELECTION PERIOD

Any Qualified Beneficiary entitled to Continuation Coverage, shall have sixty (60) days from the date of the notice required by the Section 12.06, in the case of occurrence of a Qualifying Event, in which to return a signed election to the Plan Administrator indicating the choice to continue benefits under this Plan.

12.08 DURATION OF CONTINUATION COVERAGE

Except as otherwise provided in this Plan, Continuation Coverage shall extend for a period of eighteen (18) months after the date that regular coverage ceased, due to occurrence of the initial Qualifying Event described in Section 12.04(b), unless during such eighteen (18) months period, a subsequent Qualifying Event occurs, in which case, another election to extend coverage for eighteen (18) months shall be available to the Beneficiary. Except as otherwise provided for in this Section, in the case of a Qualifying Event not described in Section 12.04(b), Continuation Coverage shall extend for a period of thirty-six (36) months after the date that regular coverage ceased, due to the occurrence of the Qualifying Event. In the case of a Qualified Beneficiary who is determined, under title II or XVI of the Social Security Act to have been disabled within sixty (60) days of a Qualifying Event described in Section 12.04(b), Continuation Coverage, with respect to such event, shall extend for a period of twenty-nine (29) months after the date that regular coverage ceased, due to the occurrence of the Qualifying Event, if the Qualified Beneficiary has provided such determination within sixty (60) days after the date of such determination, and before the end of the initial eighteen (18) month Continuation Coverage period. In the event a Covered Employee becomes entitled to Medicare coverage, the period of Continuation Coverage for a Qualified Beneficiary, (other than the Covered Employee for such Qualifying Event or any subsequent Qualifying Event), shall not terminate for a period of thirty-six (36) months from the date the covered Employee becomes entitled to Medicare Benefits. In no event, however, shall Continuation Coverage extend more than thirty-six (36) months beyond the date of the original Qualifying Event.

12.09 AUTOMATIC TERMINATION OF CONTINUATION COVERAGE

Continuation Coverage shall automatically cease if:

- (a) the Employer no longer offers any group health coverage to any of its Employees;
- (b) the required premium for Continuation Coverage for any coverage, is not paid within thirty (30) days of the date due, or within forty-five (45) days after the initial election of Continuation Coverage made pursuant to Section 12.07 (whichever is later);
- (c) an electing Qualified Beneficiary becomes covered under another group health plan, other than a group health plan which may limit a Qualified Beneficiary's coverage because it involves a pre-existing condition; or
- (d) an electing Qualified Beneficiary becomes eligible to receive benefits under Medicare.

ARTICLE XIII HIPAA PRIVACY COMPLIANCE

13.01 HIPAA PRIVACY RULE

Pursuant to Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), Public Law 104-191, compliance April 14, 2003, (*April 14, 2004, for small health plans*), the Unreimbursed Medical Flexible Spending Accounts, (as a HIPAA health plan), shall comply with the standards for privacy of protected health information, as set forth in the Privacy Rule, (i.e. information about employees is protected by applicable provisions of 45 CFR Part §160, and Part §164, subparts A and E (the "Privacy Rules"), the security standards for the protection of Protected Health Information ("PHI"), as set forth in the Security Rule, subpart C of 45 CFR § Part 164, HIPAA Security Standards for the protection of Electronic Protected Health Information ("EPHI"), as set forth in 45 CFR Part §160 and Part §164, Subparts A and C, compliance date of April 20, 2005, (*April 20, 2006 for small health plans*), the American Recovery and Reinvestment Act ("ARRA") of 2009 ("the Act"), the notification requirements for any breach of unsecured PHI under the Breach Notification Rule for HIPAA, as set forth in subpart D of 45 CFR § Part 164, September 23, 2009, the Health Information Technology for Economic and Clinical Health, (the HITECH Act), enacted February 17, 2009, and final regulations March 26, 2013, as amended by the U.S. Department of Health and Human Services).

Protected Health Information, or "PHI," is any individually identifiable health information that: (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant, Spouse or Dependent; or (3) is information created or received by, or on behalf of, a health care provider, health plan, employer, health care clearinghouse or the Plan. PHI is information that identifies an employee, or may reasonably be used, to identify an employee. Therefore, the Plan hereby agrees to implement reasonable and appropriate security measures that shall ensure the adequate separation that is required by 45 CFR §164.504(f)(2)(iii) of the HIPAA Privacy Rule and HIPAA Security Standards.

The Plan is required by law to:

- (a) ensure all PHI that it creates, receives, obtains, produces or reproduces is protected;
- (b) provide employees with a HIPAA Privacy Notice of the Plan's legal duties and privacy practices, with respect to PHI that it creates, receives, obtains, produces or reproduces;
- (c) provide a Summary Plan Description, distributed to Plan Participants that is currently in effect;
- (d) provide all notices and/documents, in a culturally and linguistically appropriate manner;
- (e) implement appropriate administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of general and EPHI that it creates, receives, maintains or transmits, on behalf of the Plan, to prevent the use or disclosure of PHI or EPHI, other than as provided for in accordance with 45 CFR §164 (HIPAA Security Standards);
- (f) ensure that any Responsible Person, (as provided in Section 1.12), or Business Associate, (*i.e. agent or subcontractor*), that the Plan provides EPHI, agrees to implement reasonable and appropriate security measures (*i.e. firewalls and encrypted transmission software*), as required by the Privacy Rule; and report any security incident to the Plan, of which it becomes aware;
- (g) ensure all PHI that is received, obtained, produced or reproduced, or stored on any type media, is secure and protected, including, but not limited to, meeting all requirements for proper destroying; and

- (h) provide notification of any breach of unsecured PHI to individuals affected.

13.02 HIPAA PRIVACY WITH RESPECT TO UNREIMBURSED MEDICAL SPENDING ACCOUNT PLAN

(a) The Unreimbursed Medical Spending Account Plan (the "Plan") will use protected health information (PHI) to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations, as defined in the Employer's HIPAA Privacy Notice for Employees Cafeteria Plan, and the Summary Plan Description distributed to Plan Participants. Any of the terms not defined, should have the same meaning as they have in the HIPAA Privacy and/HIPAA Security Rules.

The Employer verifies by adoption of this Plan and any amendments, that the Plan's Plan Sponsor certifies the Plan has, or has been amended, to incorporate all HIPAA provisions for PHI in Subsection (b), and the Employer and Responsible Employees (*designated contractor, temporary or leased employee*), who by their duties to the Plan, shall adhere to all conditions listed below.

- (b) With Respect to PHI, and certain conditions, the Employer and Responsible Employees agree to:

- Not use or disclose PHI other than as permitted, or required by, the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- Report to the Plan any PHI use or disclosures provided, of which it becomes aware; Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures; Make internal practices, books and records relating to the use and disclosure of PHI received from Plan, available to the Department of Health & Human Services, ("HHS") Secretary for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);
- Maintain physical, technical, electronic, and procedural safeguards that, reasonably and appropriately, protect the confidentiality, integrity, and availability of the physical and electronic PHI that it creates, receives, maintains or transmits on behalf of the individual to comply with federal and state regulations 45 CFR 164 (HIPAA Security Rule);
- Ensuring Responsible Person or Employees are within the Employer's HIPAA firewall when they perform Plan functions and/or are utilizing encrypted software; and
- Comply with the Genetic Information Nondiscrimination Act ("GINA") that prohibits discrimination by group health plans and employers against an individual based on the individual's genetic information, and requires that such information be treated as PHI. The term "genetic information," includes information about an individual and/or their family members genetic tests, (including first through fourth-degree relatives), and the manifestation of a disease or disorder in a family member (including any request for a receipt of genetic services or participation by the individual or family member in clinical research that includes genetic services).

(c) Adequate separation between the Plan and the Employer must be maintained. Any disclosures to "Employer," (as defined in Section 1.01), or Responsible Persons (as defined by Section 1.12), shall be for purposes of administering the Plan. The Plan may also disclose enrollment/disenrollment information to "Employer," for enrollment or disenrollment purposes only, and may disclose "summary health information" (as defined under HIPAA Privacy Rules) for the purpose of obtaining premium bids, or modifying, or terminating the Plan. Any employee of the "Employer," agents or subcontractors

who are provided employee PHI must agree to be bound by the restrictions and conditions concerning a Participants PHI found herein.

The Responsible Person described, (as defined in Section 1.12), may only use and disclose PHI for Plan administration functions, including those described in the Employer's HIPAA Privacy Statement for the Cafeteria Plan, provided they do not violate the provisions set forth in 45 CFR §164.504(f)(2)(iii). If the persons described in Section 1.12, do not comply with provisions set forth in Section 1.12 and Article XIII, the "Employer" shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

13.03 PLAN SPONSORS "EMPLOYER" OBLIGATION AND RESPONSIBILITY

Where PHI or EPHI will be created, received, maintained, or transmitted to, by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the PHI as follows:

- A. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably, and appropriately, protect the confidentiality, integrity, and availability of the electronic and/or paper PHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- B. Plan Sponsor shall ensure that the adequate separation, that is required by 45 CFR §164.504(f)(2)(iii) of the HIPAA Privacy Rule, is supported by reasonable and appropriate security measures;
- C. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures (i.e. firewalls, encrypted transmission software), to protect such information;
- D. Plan Sponsor shall report to the Plan any Security Incidents, as defined under 45 CFR §164.304, of which it becomes aware; as described below:
 1. Plan sponsor shall report to the Plan, within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and
 2. Plan Sponsor shall report to the Plan any other Security Incident as it occurs, or upon the Plan's request.
- E. Plan Sponsor shall ensure employees, who perform the following functions on behalf of the Plan, are Responsible Employees: (1) claims determination and processing functions; (2) Plan spending account vendor functions; (3) benefits education and information functions; (4) Plan spending account administrative activities; (5) legal department activities; (6) Plan compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions; and
- F. In addition to those individuals described in subsection E, the Plan shall identify the HIPAA Privacy Officer, and/or Security Official and/or those to which they have designated (as defined in Article I, Section 1.12), any of the following responsibilities, and shall also be Responsible Persons: (1) implementation, interpretation, and amendment of the Privacy Policy; (2) Privacy Rule, Breach Notification Rule, or Security Rule training for Employer employees; (3) investigation of, and response to complaints by Participants, Spouses, or Dependents to inspect or copy PHI; (6) response to, request by Participants, Spouse, or Dependents; (9) response to requests by Participants, Spouses, or Dependents for an accounting of disclosures of their PHI; (10) response to requests for information by the Department of Health and Human Services; (11) approval of disclosures to law enforcement or to the military for government purposes; (12) maintenance of records and other documentation required by the Privacy Rule, Breach Notification Rule, and Security Rule; (13) negotiation of Privacy Rule, Breach Notification Rule, and Security Rule provisions, and/or reasonable security provisions, into contracts with third-party service providers; (14) maintenance of the spending account Plan PHI or EPHI surety documentation; or (15) approval of access to EPHI by Participants, Spouses or Dependents.

13.04 CERTIFICATION REQUIREMENTS

Plan shall disclose PHI, including EPHI, to responsible employees only upon receipt of a certification by the Employer that the Employer agrees:

- (a) not to use or further disclose PHI, other than as permitted or required, by this Article and the Privacy Policy, or as required by law;

- (b) to take reasonable steps to ensure that any agents to whom the Employer provides PHI, or EPHI received from the Plan agree: (1) to the same restrictions and conditions that apply to the Employer, with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such EPHI;
- (c) not to use or disclose PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Employer, other than another health plan;
- (d) to report to the Plan any use or disclosure of PHI, including EPHI, that is inconsistent with the uses or disclosures, (as described in Section 13.05), or any security incident, or which the Employer becomes aware;
- (e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;
- (f) to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;
- (g) to make available PHI required to provide an accounting of disclosure in accordance with 45 CFR § 164.528;
- (h) to make its internal practices, books and records relating to the use and disclosure of PHI and EPHI, received on behalf of the Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule, the Breach Notification Rule, or the Security Rule;
- (i) if feasible, to return or destroy all PHI and EPHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI and EPHI when no longer needed for the purposes for which disclosure was made, (except if such return or destruction is not feasible), limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible and EPHI;
- (j) to take reasonable steps to ensure that there is adequate separation between the Plan and the Employer's activities in its role as the Plan Sponsor and Employer, and that such adequate separation is supported by reasonable and appropriate security measures; and
- (k) to implement administrative, physical and technical safeguards that, reasonably and appropriately, protect the confidentiality, integrity, and availability of any EPHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

13.05 PERMITTED USES AND DISCLOSURES

Responsible Persons or Employees may access, request, receive, use, disclose, create, and/or transmit PHI, only to perform certain permitted and required functions on behalf of the Plan, consistent with the Privacy Policy. This includes, but is not limited to, uses and disclosures for the Plan's:

- (a) own payment and Plan operations functions;
- (b) another HIPAA Plan's payment and operations functions;
- (c) disclosures to the health care provider, (as defined under 45 CFR §160.103);
- (d) disclosures to the Employer, acting in its role as Plan Sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA health plans, or for making decisions to modify, amend, or terminate a HIPAA health plan; (2) enrollment or disenrollment information; and (3) premium payment for HIPAA health plans;
- (e) disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal or legal representative, (as defined under 45 CFR §164.502(g));
- (f) disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care, payment, or claim filing for the Participant's, Spouse's, or Dependent's Plan, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;
- (g) to comply with worker's compensation laws or request;
- (h) for legal and law enforcement purposes, such as to comply with court order;

- (i) disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule, Security Rule, and Breach Notification Rule;
- (j) for other governmental purposes, such as for national security purposes;
- (k) for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
- (l) to identify a decedent or cause of death, or for tissue donation purposes;
- (m) required by other applicable laws; and
- (n) pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508.

13.06 PROHIBITED USES AND DISCLOSURES

Notwithstanding anything in the Plan to the contrary, use or disclosure of PHI is prohibited in the following situations:

- (a) **Genetic Information.** Use or disclosure of PHI that is Genetic Information about an individual for "underwriting purposes" includes: determining eligibility or benefits, computation or premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.
- (b) **Employment-Related Actions.** Use or disclosure of PHI for the purposes of employment-related actions or decisions shall not be a permitted use or disclosure.
- (c) **Other Benefits.** Use or disclosure of PHI in connection with any other benefit or employee benefit plan or the Employer, except as expressly permitted in Section 13.05, shall not be permitted use or disclosure.

13.07 BUSINESS ASSOCIATE

Plan may disclose PHI to a Business Associate; the term "Business Associates" refers specifically to a person or organization that conducts business with the Plan, which involves the use or disclosure of individually identifiable Participant health information. This includes an organization that provides data transmission of PHI to the Plan or requires access to PHI routinely. The service must be on behalf of the Plan, and the Plan must have valid Business Associate agreement in place. The Plan requires Business Associate to protect the confidentiality of PHI (as provided in 45 CFR §164.504(f)(2)(iii)) and to use it solely for the purposes for which Plan disclosed the information, except as permitted by law. Otherwise, the Plan will not disclose PHI.

Examples of the Plans Business Associates are: claims processing, data analysis, utilization review, billing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, financial services (banks and/or debit card providers), data programmers, data storage services, the Plan cafeteria service provider, Plan enrollment agent(s) or insurance agent(s), (including any subcontracted personnel) approved by the Plan.

Plan requires Business Associate to implement administrative, physical and technical safeguards, consistent with, and required by, the HIPAA Security Standards, that reasonably protect the confidentiality, integrity, and availability of written or electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan, that it is used solely for the purposes for which Plan disclosed the information, (except as permitted by law), or as otherwise defined; the Plan does not disclose PHI. Business Associate agrees to fully implement the requirements of the HIPAA Privacy and Security Standards (45 CFR Parts §160, 162, and 164), as amended.

Business Associate shall report to the Plan any security incident that results in: (1) unauthorized access, use, disclosure, modification, or destruction of Plan's electronic PHI; (2) interference with Business Associate's system operations in Business Associate's information systems, of which Business Associate becomes aware, and (3) Business Associate shall report to Plan, upon occurrence of such non-permitted or violating use or disclosure, and the report must meet the format and content requirements imposed by the Plan. Business Associate agrees it will insure that any agent, including subcontractor to whom it provides such information, agrees to implement reasonable, and appropriate, safeguards to protect such information.

13:07 PROTECTED HEALTH INFORMATION BREACH AND NOTIFCATION REQUIREMENTS

The American Recovery and Reinvestment Act of 2009 ("the Act") requires notice to affected individuals of any *breach* of

unsecured protected health information; effective September 23, 2009. Summary of the Act requirements apply if all of the following are present:

- a) **There is a "breach."** The Rule defines "breach" to mean (subject to exceptions discussed below) the unauthorized acquisition, access, use, or disclosure of protected health information ("PHI").
- b) **The PHI is "unsecured."** The Rule defines "unsecured protected health information" to mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by HHS guidance.
- c) **The breach "compromises the security of the PHI."** Under the Rule, this occurs when there is a significant risk of financial, reputation, or other harm to the individual whose PHI has been compromised.
- d) **PHI that is "secure" Secured PHI.** PHI is considered Secured PHI, when technologies and methodologies that renders PHI unusable, unreadable, indecipherable or de-identified to unauthorized individuals, are in place. Plan Administrator, covered entities and Business Associates are not required to provide the breach notifications required by the Act for PHI meeting these standards. PHI is rendered unusable, unreadable, or indecipherable to unauthorized individuals only if one or more of the following methods are used:

(1) **Encryption.** EPHI is secured where it has been encrypted. Encryption means the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning, without use of a confidential process or key. Our encryption processes meets the standard requirements of not less than 128 bit encryption. Further, such confidential process or key, that enable decryption are kept in a separate location, and only eligible recipients of transmitted data are able to receive the confidential indecipherable or de-identified data, in accordance with 45 CFR § 164.514(b), and by use of password protection by HIPAA approved recipient.

(2) **Destruction.** Hard copy PHI, such as paper or film media, is only secured where it has been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. All hard copy PHI in paper format, which is received by mail, fax, written or created as a result of processing the paper PHI, is destroyed by a shredding all of all paper copies, including any media, and or computer hard drives housing any PHI.

The Plan, Plan Sponsor, Plan Administrator, HIPAA Privacy Officer, Security Officer, covered entities, Business Associates and/or any Business Associate subcontractor's associates will analyze the following in determining whether a breach to the Plan of unsecured PHI has occurred by:

- (1) **Determine whether the use or disclosure of PHI violates the HIPAA Privacy Rule.** For an acquisition, access, use, or disclosure of PHI to constitute a breach, it must constitute a violation of the HIPAA Privacy Rule. For example; if information is de-identified in accordance with 45 CFR §164.514(b), it is not PHI, and any inadvertent or unauthorized use or disclosure of such information, will not be considered a breach under the notification requirements of the Act and the Rule.
- (2) **Analyze whether there is a use or disclosure that compromises the security and privacy of PHI.** Use or disclosure that "compromises the security and privacy of PHI" means a use or disclosure that "poses a significant risk of financial, reputation or other harm to the individual." Thus, in order to determine whether a breach has occurred, Plan Administrator, covered entities and Business Associates will conduct a risk assessment to determine whether the potential breach presents a significant risk of harm to individuals as a result of an impermissible use or disclosure of PHI.
- (3) **Assess whether any exceptions to the Breach definition apply.** The following three situations are excluded from the definition of "breach" under the Act:
 - (i) The unintentional acquisition, access, or use of PHI, by any workforce member or person acting under the authority of a covered entity or Business Associate, if such acquisition, access or use was made in good faith, and within the scope of authority, and does not result in further use or disclosure in a manner not permitted by the Privacy Rule.
 - (ii) The inadvertent disclosure of PHI by an individual, otherwise authorized to access PHI at a facility operated by a covered entity or Business Associate, to another person at the same covered entity or Business Associate, or at a organized health care arrangement in which the covered entity participates, and the information received as

a result of such disclosure, is not further used or disclosed in a manner not permitted under the Privacy Rule.

(iii) An unauthorized disclosure where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom PHI is disclosed, would not reasonably have been able to retain the information.

The Plan, Plan Sponsor, Plan Administrator, HIPAA Privacy Officer, Security Officer, covered entities, Business Associates and/or any Business Associate subcontractor's associates has the burden of proving why a breach notification was not required and must document why the impermissible use or disclosure fell under one of the exceptions, and shall document the risk and other breach assessments accordingly.

Plan Requirements for Breach Notification:

Following the discovery of a breach of unsecured PHI, the Plan shall:

Provide individual Participants with a Notice of breach of PHI, triggered upon the "occurrence" or "discovery" of a qualifying breach of unsecured PHI. A breach is treated as "discovered" by the Plan, Plan Sponsor, Plan Administrator, HIPAA Privacy Officer, Security Officer, covered entity or Business Associate and/or any Business Associate subcontractors, as of the first day the breach is known, or reasonably should have been known to the Plan, Plan Sponsor, Plan Administrator, HIPAA Privacy Officer, Security Officer, covered entity or Business Associate and/or any Business Associate subcontractors. The Plan, Plan Sponsor, Plan Administrator, HIPAA Privacy Officer, Security Officer, covered entity or Business Associate and/or any Business Associate subcontractors shall implement reasonable breach discovery procedures required by:

- (a) **Notification to Individuals.** Plan Administrator, covered entity, or Business Associate shall send the required notification to each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed as a result of the breach, without unreasonable delay, and in no case later than sixty (60) calendar days after the date the breach was first discovered by the covered entity.

The Plan, Plan Sponsor, Plan Administrator, HIPAA Privacy Officer, Security Officer, covered entity or Business Associate, and/or any Business Associate subcontractor's associates will provide a substitute notice, as soon as reasonably possible. If entity does not have sufficient contact information on the breach individuals for ten (10) or more individuals, then substitute notice will be provided via a posting for a period of ninety (90) days on the home web page of its web site, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. In such instances, an active toll-free number will be provided for ninety (90) days, so that an individual can find out whether his or her unsecured PHI may be included in the breach.

- (b) **Notification to Media.** If a breach is discovered affecting more than five hundred (500) residents of a state or jurisdiction, notice will be provided to prominent media outlets serving the state or jurisdiction without unreasonable delay, and in no case later than sixty (60) calendar days, after the date the breach was discovered by the covered entity.
- (c) **Notification to HHS.** If more than five hundred (500) individuals are involved in the breach, regardless of whether the breach involved more than five hundred (500) residents of a particular State or jurisdiction, then the Secretary of Health and Human Services, ("HHS") will be notified concurrently with the individual notifications. For breaches involving fewer than 500 individuals, an internal log, or other documentation of such breaches, will be maintained and will be annually submitted to HHS.
- (d) **Notification by a Business Associate.** Following the discovery of a breach of unsecured PHI by a Business Associate, the Business Associate is required to notify the covered entity and/or Plan Administrator of the breach and Plan Administrator and/or covered entity can, in turn, notify the affected individuals. To the extent possible, Business Associate shall identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached. Such notice shall be given without unreasonable delay, and no later than sixty (60) days, following discovery of a breach.
- (e) **Delay Required by Law Enforcement.** The Act provides that a breach notification may be delayed if a law enforcement official determines that such notification would impede a criminal investigation or cause damage to national security.

13.08 EMPLOYEE PARTICIPANTS PRIVACY RIGHTS

As provided by 45 CFR §164.528 of the Privacy Rule, Employees, as a Participant (herein referred to as Participant), have a right to receive an accounting of disclosures, to amend, to confidential communications, to request restrictions, to file a complaint, to inspect and receive a copy of their PHI, and Participants have a right to a copy of the Employer's and the Plan's HIPAA Privacy Notice. Uses and disclosures of a Participant's PHI may be made only with Participant's written authorization or that of the Participant's legal representative, and Participant may revoke such authorization as provided in 45 CFR §164.508(b)(5) of the Privacy Rule. Any disclosures that are made, when a Participant authorization was in effect, may not be revoked. However, Participants may revoke any future disclosures. If any use or disclosure of required or permissible purposes, as defined the Plan and the Employer's HIPAA Privacy Notice for Employees Cafeteria Plan, or the Plans Summary Plan Description distributed to Participants, are prohibited, or materially limited, by other applicable laws, then the use or disclosure will reflect the more stringent law.

The Plan is required by law to maintain the privacy of Participant's PHI. The Plan's Plan Administrator, and the Employer are obligated to provide the Participant with a copy of this HIPAA Privacy Notice of the legal duties and of the Plan's and the Employer's privacy practices with respect to PHI, and shall abide by the terms of the notice. The Plan Administrator on behalf of the Plan, reserves the right to change the provisions of the Notice and make the new provisions effective for all PHI that the Plan maintains. Plan Administrator will notify Participants of any changes to the Notice by emailing the revised notice to Plan Participants at the last known email address.

13.09 MITIGATION

In the event of noncompliance with any of the provisions set forth in this Article XIII;

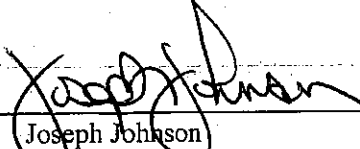
- (a) The HIPAA Privacy Officer and/or Security Official, (as defined by Section 1.12), as appropriate, shall address any complaint promptly and confidentially, and shall first investigate the complaint; document the investigation efforts and findings;
- (b) If PHI, including EPHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA Privacy Officer and/or Security Official, (as defined by Section 1.12), as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur; and
- (c) If a Responsible Person, (as defined by Section 1.12), or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule; such personnel shall be subject to disciplinary actions up to, and including, termination.

These rules will apply from the time our relationship begins, during the course of our relationship, as well as after the relationship ends.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption and amendment of the foregoing instrument comprising the Flexible Benefit Cafeteria Plan, so defined in Section 1.02, the Plan Sponsor certifies the Plan has incorporated all HIPAA provision for PHI, and has caused this Plan to be executed on this 1st day of January, 2014

LAFAYETTE COUNTY, MISSISSIPPI

By: _____


Joseph Johnson
Plan Administrator

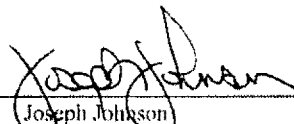
Title: County Administrator

Date: _____

5-20-14

IN WITNESS WHEREOF, and as conclusive evidence of the adoption and amendment of the foregoing instrument comprising the Flexible Benefit Cafeteria Plan, so defined in Section 1.02, the Plan Sponsor certifies the Plan has incorporated all HIPAA provision for PHI, and has caused this Plan to be executed on this 1st day of January, 2014

LAFAYETTE COUNTY, MISSISSIPPI

By: 
Joseph Johnson
Plan Administrator

Title: County Administrator

Date: 5-20-14