Flex Spending Account (FSA)

This benefit can be used with Anthem - Option 1A only.

- DBS Plan Document
- FSA Help Guide
- Over-the-Counter Drug and Product Guide
- Claims Filing Options
- DBS Mobile App Guide

DBS Plan Document

S.C. SWIDERSKI LLC
BASIC PLAN DOCUMENT #125

S.C. SWIDERSKI LLC

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ARTICLE 1. INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to qualify as a cafeteria plan within the meaning of Code section 125. To the extent provided in the Adoption Agreement, the Plan provides for the pre-tax payment of premiums and contributions to spending accounts that are excludable from gross income under Code section 125, reimbursement of certain medical expenses that are excludable from gross income under Code section 105(b), reimbursement of certain dependent care expenses that are excludable from gross income under Code section 129, reimbursement of certain adoption expenses that are excludable from gross income under Code section 137, and/or for such other benefits as set forth herein.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Employer on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Employer whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2. DEFINITIONS

Account means
the bookkeeping balance of an account established for each Participant as of the applicable date. "Account" or "Accounts" shall include, to the extent provided in the Adoption Agreement, a Premium Conversion Account, a General Purpose Health Flexible Spending Account, an HSA-Compatible Health Flexible Spending Account, a Dependent Care Assistance Plan Account, an Adoption Assistance Flexible Spending Account and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

Adoption Agreement means
the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

Adoption Assistance Flexible Spending Account or Adoption Assistance FSA means
the Account established with respect to the Participant's election to have Adoption Expenses reimbursed by the Plan pursuant to Article 10.

Adoption Expenses means
the expenses described in Section 10.05(b)(2).

Affiliate means
the Plan Sponsor or any other employer required to be aggregated with the Plan Sponsor under Code sections 414(b), (c), (m) or (o); provided, however, that "Affiliate" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

Benefits means
the benefit options available to Eligible Employees under the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means
the Internal Revenue Code of 1986, as amended from time to time.

Compensation means
the cash wages or salary paid to a Participant. If the Adoption Agreement indicates that the Plan is a simple cafeteria plan as defined in Code section 125(j), "Compensation" shall mean Section 414(s) Compensation (defined below).

Contract means

an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. "Contract" shall not include any product which is advertised, marketed, or offered as long-term care insurance. "Contract" shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

Dependent means

an individual who qualifies as a dependent of a Participant under Code section 152 (as modified by Code section 105(b)). For purposes of the Premium Conversion Account, "Dependent" does not include any individual who is not a dependent under the underlying Contract. A child who is determined to be a Participant's alternate recipient under a qualified medical child support order under ERISA section 609 shall be considered a Dependent under this Plan, as applicable.

Dependent Care Assistance Plan Account or DCAP Account means

the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan pursuant to Article 8.

Effective Date shall have the meaning

set forth in Part A of the Adoption Agreement, provided that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.

Eligible Employee means

any Employee employed by an Employer, subject to the modifications and exclusions described in the Adoption Agreement. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Employer is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Employer in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by an Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the other entity shall not become eligible to participate in the Plan until the Employer or Plan Sponsor specifically authorizes such participation.

Employee means

any individual who is a common-law employee of an Employer, a leased employee as described in Code section 414(n), or full-time life insurance salesman as defined in Code section 7701(a)(20). The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock or combined voting power of an S corporation.

Employer means

the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

ERISA means

the Employee Retirement Income Security Act of 1974, as amended from time to time.

Flex Credits means

the Employer contributions described in Section 11.01 of the Plan.

FMLA means

the Family and Medical Leave Act of 1993 as amended from time to time.

Grace Period means

the designated period following a Plan Year during which a Participant who has unused benefits or contributions relating to a Benefit (for example, a Health FSA or DCAP Account) from the immediately preceding Plan Year and who incurs expenses for that same Benefit during the period, may be paid or reimbursed for those expenses as if the expenses had been incurred in the immediately preceding Plan Year.

General Purpose Health Flexible Spending Account or General Purpose Health FSA means
the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Article 6.

Health Flexible Spending Account or Health FSA means
the General Purpose Health FSA and/or HSA-Compatible Health FSA established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Article 6 and Article 7.

Health Savings Account or HSA means
a health savings account established pursuant to Article 9.

Highly Compensated Employee means
an Employee described in Code section 414(q).

Highly Compensated Individual means
an individual within the meaning of Code section 105(h)(5).

HIPAA means
the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

HRA means
a health reimbursement arrangement subject to Code section 105.

HSA-Compatible Health Flexible Spending Account or HSA-Compatible Health FSA means
a Limited Purpose Health Flexible Spending Account and/or a Post-Deductible Health Flexible Spending Account.

Key Employee means
an Employee described in Code section 416(i).

Leased Employee means
an Employee described in Code section 414(n)(2).

Limited Purpose Health Flexible Spending Account or Limited Purpose Health FSA means
the Account established with respect to the Participant's election to have medical expenses, as described in Section 7.05(b)(1), reimbursed by the Plan pursuant to Article 7.

Qualified Plan means
the retirement plan sponsored by an Employer and identified in the Adoption Agreement.

Participant means
an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

Plan means
the plan as identified in Part A.2 of the Adoption Agreement and as described in this Basic Plan Document and Adoption Agreement.

Plan Administrator means
the person(s) designated pursuant to the Adoption Agreement and Section 14.01.

Plan Sponsor means
the entity described in the Adoption Agreement that maintains the Plan.

Plan Year means
the 12-consecutive month period described in Part A of the Adoption Agreement.

Post-Deductible Health Flexible Spending Account or Post-Deductible Health FSA means

the Account established with respect to the Participant's election to have medical expenses, as described in Section 7.05(b)(2), reimbursed by the Plan pursuant to Article 7.

Premium Conversion Account means
the Account established with respect to the Participant's election to have premiums reimbursed by the Plan pursuant to Article 5.

PTO means
elective paid time off that must be used or forfeited by the last day of the Plan Year in which it was awarded.

Salary Reduction Agreement means
the agreement pursuant to which an Eligible Employee elects to reduce his or her Compensation and instead receive a Benefit provided under the Plan.

Section 414(s) Compensation means
compensation as defined in Code section 414(s) and Treas. Reg. section 1.414(s)-1. The period used to determine an Employee's compensation for a Plan Year must be either the Plan Year or the calendar year ending within the Plan Year. Whichever period is selected by the Plan Administrator must be applied uniformly to determine the compensation of every Eligible Employee under the Plan for that Plan Year. The Plan Administrator may, however, limit the period taken into account under either method to that portion of the Plan Year or calendar year in which the Employee was an Eligible Employee, provided that this limit is applied uniformly to all Eligible Employees.

Termination and Termination of Employment means
any absence from service that ends the employment of an Employee with the Employer.

ARTICLE 3. ELIGIBILITY

An Eligible Employee is an Employee who meets the age and service requirements set forth in the Adoption Agreement and who is not excluded pursuant to (a) Section 3.02, (b) the provisions governing the applicable Benefit below, or (c) the Adoption Agreement. An Eligible Employee may elect to participate in the Plan in accordance with Article 4.

Eligible Employees who were eligible to participate in the Plan immediately prior to the Effective Date shall be eligible to participate in the Plan on the Effective Date. Notwithstanding the foregoing, an Eligible Employee shall be eligible to make elections only for the Accounts as are specifically authorized in the Adoption Agreement.

Section 3.02 INELIGIBLE EMPLOYEES

Notwithstanding anything herein to the contrary, the Employees identified in the Adoption Agreement as such are not Eligible Employees and may not participate in any Benefit under the Plan.

Section 3.03 LEAVE OF ABSENCE

(a) FMLA Leave of Absence.
   (1) *Health Benefits.* If a Participant takes a leave of absence under FMLA, the Participant shall be entitled to continue to participate in those Benefits under the Plan that provide health care, including the Premium Conversion Account for payment of premiums applicable to health care, the Health FSA, and Flex Credits. A Participant may also elect to revoke coverage during an unpaid FMLA leave of absence or continue coverage but discontinue contributions for the period of the FMLA leave of absence, as set forth in the Adoption Agreement. If a Participant elects to revoke coverage during the unpaid FMLA leave of absence, the coverage will be reinstated under the same terms upon the Participant's return from the FMLA leave of absence.
   (2) *Non-Health Benefits.* A Participant shall not be entitled to continue to participate in Benefits under the Plan that do not provide health care except to the extent provided in the Adoption Agreement or in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave. Participant contributions for Benefits during a leave of absence under FMLA shall be determined by the Plan Administrator in accordance with Code section 125.
   (3) *Non-FMLA Leave of Absence.* If a Participant takes an unpaid leave of absence other than under FMLA, the Participant shall not be entitled to continue to participate in Benefits under the Plan except to the extent provided in the Adoption Agreement or in

accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave.

(4) *USERRA.* If a Participant is on a leave of absence in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the Participant shall be entitled to elect to continue participation in the Premium Conversion Account and Health FSA for the lesser of (i) 24 months, beginning on the date the Participant's absence began and (ii) the date the Participant fails to apply for or return to employment with the Employer, as determined under USERRA.

(5) *Applicable State Law.* The Plan Administrator shall permit a Participant to continue Benefits under the Plan as required under any applicable state law to the extent that such law is not pre-empted by federal law.

(6) *Paid Leave of Absence.* A Participant shall not be entitled to revoke participation in any Benefits during a paid leave of absence except in accordance with Article 4.

Section 3.04 TERMINATION OF PARTICIPATION

If a Participant remains an Employee but is no longer an Eligible Employee (e.g., due to a change in job classification), his or her participation in the Plan shall terminate on the date on which the Participant ceases to be an Eligible Employee, unless provided otherwise herein or in the Adoption Agreement. Should such Employee again qualify as an Eligible Employee, he or she shall be eligible to participate in the Plan as of the first day of the subsequent Plan Year, unless earlier participation is required by applicable law or permitted pursuant to Section 4.03.

Section 3.05 TERMINATION OF EMPLOYMENT

If a Participant has a Termination of Employment, his or her participation in the Plan shall be governed in accordance with the terms of the applicable Benefit as provided herein.

Section 3.06 REEMPLOYMENT

(a) Except as otherwise provided in the Adoption Agreement, the Plan Administrator shall automatically reinstate Benefit elections for Eligible Employees who are rehired by an Employer within 30 days of a Termination. If an Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee more than 30 days following the date of Termination, the Plan Administrator may allow the Eligible Employee to elect to reinstate the Benefit election in effect at the time of Termination or to make a new election under the Plan, unless otherwise provided herein or in the Adoption Agreement.

(b) *Ineligible Employees.* An Employee who has a Termination of Employment and who is subsequently reemployed by the Employer but is not an Eligible Employee shall be eligible to participate on the date the individual becomes an Eligible Employee and, at that time, may elect to participate in the Plan in accordance with Article 4.

ARTICLE 4. BENEFITS AND PARTICIPATION

Section 4.01 BENEFIT OPTIONS

Each Participant may elect to participate in the following Benefits to the extent selected in the Adoption Agreement, pursuant to the applicable Article herein:

(a) Premium Conversion Account
(b) General Purpose Health Flexible Spending Account
(c) HSA-Compatible Health Flexible Spending Account
(d) Dependent Care Assistance Plan Account
(e) Adoption Assistance Flexible Spending Account
(f) Health Savings Account
(g) PTO Purchase/Sale
(h) 401(k) Plan Contributions
(i) Flexible Benefit Credits

Section 4.02 ELECTION TO PARTICIPATE

(a) *Elections to Participate.* The Plan Administrator shall prescribe such forms and may require such data from an Eligible Employee as are reasonably required and permitted under applicable law to enroll the Eligible Employee in the Plan or to effectuate any elections made

pursuant to this Article 4. The Plan Administrator may adopt procedures governing the elections described in this Article 4, including, without limitation, a minimum annual and per pay-period contribution amount, a maximum contribution per pay-period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

(b) *New Employees.* An Eligible Employee may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 30 days after the date the Eligible Employee becomes an Employee. The election will be effective as of the Employee's hire date; provided, however, that amounts used to pay for such election must be made from Compensation not yet currently available on the date of the election.

(c) *Newly Eligible Employees.* An Employee who becomes an Eligible Employee (for example, after satisfying the Plan's age and/or service requirements, if any) may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 31 days after the date the Employee becomes an Eligible Employee. The election will be effective on a prospective basis.

(d) *Continuing Eligible Employees.* An Eligible Employee may elect to enroll in the Plan or to modify or revoke his or her election during the period established by the Plan Administrator that precedes the Plan Year for which the election will be effective, except as provided in Article 9 and Article 10.

(e) *Failure to Elect.* If an Eligible Employee does not make an election in accordance with the required enrollment procedures with respect to any or all Benefits under the Plan, the Eligible Employee will be deemed to have elected not to participate in such Benefit for the applicable Plan Year, except as otherwise provided herein or specified in the Adoption Agreement.

Section 4.03 MID-YEAR ELECTION CHANGES

An Eligible Employee's election to participate in a Benefit, other than an HSA, hereunder is irrevocable during the Plan Year, except that an Eligible Employee may change his or her election during the Plan Year no later than the end of the 31-day period beginning on the date of a Change in Status, unless provided otherwise in the Adoption Agreement. The election change must be on account of and correspond with a Change in Status that affects eligibility for coverage under the Plan.

A "Change in Status" means events described in Treasury Regulation section 1.125-4. Change in Status includes, but is not limited to, the following, to the extent provided in the Adoption Agreement:

(a) *Legal Marital Status.* Events that change an Eligible Employee's legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.

(b) *Number of Dependents.* Events that change an Eligible Employee's number of Dependents, including birth, death, adoption, and placement for adoption.

(c) *Employment Status.* Any of the following events that change the employment status of the Eligible Employee, the Eligible Employee's spouse, or the Eligible Employee's Dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer of the Eligible Employee or the Eligible Employee's Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the applicable plan, then that change constitutes a change in employment under this paragraph (c).

(d) *Dependent satisfies or ceases to satisfy eligibility requirements.* Events that cause an Eligible Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(e) *Residence.* A change in the place of residence of the Eligible Employee or the Eligible Employee's spouse or Dependent.

(f) *Adoption Assistance.* For purposes of adoption assistance provided through the Plan, the commencement or termination of an adoption proceeding.

(g) *COBRA.* If the Eligible Employee or the Eligible Employee's spouse or Dependent becomes eligible for continuation coverage under an Employer's group health plan as provided in Code section 4980B or any similar state law, the Eligible Employee may elect to increase contributions to his or her Premium Conversion Account under the Plan in order to pay for the continuation coverage.

(h) *Court Order.* A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for an Eligible Employee's child or for a foster child who is a Dependent of the employee. The Eligible Employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the Eligible Employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

(i) *Entitlement to Medicare or Medicaid.* If an Eligible Employee or an Eligible Employee's spouse or Dependent who is enrolled in an Employer's accident or health plan becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Eligible Employee may make a prospective election change to cancel or reduce

coverage of that Employee, spouse, or Dependent under the Employer-sponsored accident or health plan. In addition, if an Eligible Employee or an Eligible Employee's spouse or Dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the Eligible Employee may make a prospective election to commence or increase his or her coverage or the coverage of his or her spouse or Dependent, as applicable, under the Employer-sponsored accident or health plan.

(j) *Significant Cost or Coverage Changes.*

(1) *Automatic Changes.* If the cost of an Employer-sponsored Contract premium increases (or decreases) during a period of coverage and, under the terms of the Contract, Eligible Employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Eligible Employees' elective contributions for the Plan.

(2) *Significant Cost Changes.* If the cost charged to an Eligible Employee for a Contract benefit package option significantly increases or significantly decreases during a period of coverage, the Plan may permit the Eligible Employee to make a corresponding change in an election under the Plan. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available. For example, if the cost of an indemnity option under an accident or health plan significantly increases during a period of coverage, Eligible Employees who are covered by the indemnity option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the indemnity option and, in lieu thereof, elect coverage under another benefit package option including an HMO option (or drop coverage under the accident or health plan if no other benefit package option is offered).

A cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the Plan, whether that increase or decrease results from an action taken by the Eligible Employee (such as switching between full-time and part-time status) or from an action taken by an Employer (such as reducing the amount of Employer contributions for a class of Eligible Employees).

This paragraph (j) applies in the case of the Dependent Care Assistance Plan Account only if the cost change is imposed by a Dependent care provider who is not a relative of the Eligible Employee as described in Code section 152(a)(1) through (8), incorporating the rules of Code section 152(b)(1) and (2). This paragraph (j) does not apply to Health FSAs.

(k) *Significant Curtailment Without Loss of Coverage.* If an Eligible Employee or an Eligible Employee's spouse and/or Dependent has a significant curtailment of coverage under a Contract during a period of coverage that is not a loss of coverage as described in paragraph (l) of this section (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under the Contract), the Eligible Employee may revoke his or her election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing similar coverage. This paragraph (k) does not apply to Health FSAs.

(l) *Significant Curtailment With Loss of Coverage.* If an Eligible Employee (or an Eligible Employee's spouse or Dependent) has a significant curtailment that is a loss of coverage, the Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. For purposes of this paragraph (l), a loss of coverage means:

(1) a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation);

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

(3) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Eligible Employee or the Eligible Employee's spouse or Dependent is currently in a course of treatment; or

(4) any other similar fundamental loss of coverage as determined by the Plan Administrator's in its sole discretion.

This paragraph (l) does not apply to Health FSAs.

(m) *Addition or Improvement of a Benefit Package Option.* If the Plan or a Contract adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a period of coverage, an Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved benefit package option. This paragraph (m) does not apply to Health FSAs.

(n) *Change in Coverage Under Another Employer Plan.* An Eligible Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including another plan of the Employer or of another employer) if -

(1) The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under paragraphs (a) through (o) of this section (disregarding this paragraph (n)(1)); or

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

This paragraph (n) does not apply to Health FSAs.

(o) *FMLA.* If a Participant contributes to the cost of such Benefit, he or she may revoke coverage or continue coverage but discontinue payment of his or her share of the cost of a Benefit that provides group health plan coverage (including a Health FSA) during the period of a leave of absence under FMLA. An Eligible Employee who revokes coverage shall be entitled to reinstate coverage upon returning from a leave of absence under FMLA.

(p) *Loss of Coverage Under Other Group Health Coverage.* An Eligible Employee may make an election on a prospective basis to add coverage under the Plan for the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent if the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a Foreign government group health plan. This paragraph (p) does not apply to Health FSAs.

(q) *Revocation due to Reduction in Hours of Service.* A Participant may prospectively elect to cancel contribution for and payment of the Employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Employer-sponsored group health plan and (2) the revocation of the election of coverage under the Employer-sponsored group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(r) *Enrollment in a Qualified Health Plan.* A Participant may prospectively elect to cancel contribution for and payment of the employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant is eligible for a special enrollment period to enroll in a "qualified health plan" through a competitive marketplace established under Section 1311 of the Patient Protection and Affordable Care Act ("Marketplace") or the Employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.

The Plan Administrator reserves the right to determine whether an Eligible Employee has experienced a Change in Status and whether the Eligible Employee's requested election is consistent with such Change in Status.

ARTICLE 5. PREMIUM CONVERSION ACCOUNT

Section 5.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Premium Conversion Accounts, an Employee may elect to have a portion of his or her Compensation applied by the Employer toward the Premium Conversion Account. The Account established under this Article 5 is intended to qualify under Code sections 79 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 5.02 ELIGIBLE EMPLOYEES

All Employees are eligible to participate in the Premium Conversion Account, except as otherwise specified in the Adoption Agreement.

Section 5.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the Premium Conversion Account in accordance with Article 4. Except as otherwise provided in the Adoption Agreement, all Employees will automatically be enrolled in the Premium Conversion Account and will be deemed to have elected to contribute the entire amount of any premiums payable by the Employee for participation in Employer-sponsored Contract(s) unless he or she affirmatively elects otherwise in accordance with Section 4.02.

(b) *Contributions.* A Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation. The amount of a Participant's contribution to the Premium Conversion Account shall be equal to the amount of the Participant's portion of the premium on the applicable Contract. Except as elected in the Adoption Agreement, if the amount of the Participant's portion of the applicable premium on the Contract increases or decreases, the Participant's contribution to the Premium Conversion Account will automatically be adjusted to reflect the increase or decrease.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction

Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a Premium Conversion Account for the Plan Year with respect to non-Employer sponsored Contracts, regardless of the election he or she had in effect for the prior Plan Year. In addition, an Eligible Employee who affirmatively elected not to participate in the Premium Conversion Account for the Plan Year with respect to Employer-sponsored Contracts will not be enrolled in the Premium Conversion Account for any Plan Year until he or she affirmatively elects to participate in the Premium Conversion Account with respect to Employer-sponsored Contracts in accordance with Article 4.

Section 5.04 ELIGIBLE EXPENSES

A Participant's Premium Conversion Account will be debited for amounts applied to the Employee-paid portion of the applicable Contract premiums. The Plan Administrator will not direct the Employer to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

Contributions to the Premium Conversion Account for Code section 79 coverage (group term life insurance) shall be made on an after-tax basis to the extent that the premiums relate to coverage in excess of the limit described in Code section 79(a).

Section 5.05 TERMINATION OF EMPLOYMENT

Upon a Participant's Termination of Employment, the Participant's contributions to the Premium Conversion Account will cease, except with respect to contributions for COBRA continuation coverage under the Employer-sponsored Contract, if applicable. Coverage under the applicable Contract may continue in accordance with the terms of the Contract for the remainder of the period of coverage with respect to which the required Contract premium has been paid.

ARTICLE 6. HEALTH FLEXIBLE SPENDING ACCOUNT

Section 6.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Health Flexible Spending Accounts, an Eligible Employee may elect to participate in a General Purpose Health Flexible Spending Account in accordance with this Article 6. The Account established under this Article 6 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 6.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the General Purpose Health Flexible Spending Account, except as otherwise specified in the Adoption Agreement. An Employee who is not eligible to participate in an Employer-sponsored group health plan is not eligible to participate in the General Purpose Health Flexible Savings Account. An Eligible Employee who has elected to participate in the HSA Benefit and/or the HSA-Compatible Health FSA Benefit is not eligible to participate in the General Purpose Health FSA Benefit under this Article 6.

Section 6.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the General Purpose Health FSA and elect to have a portion of his or her Compensation contributed to a General Purpose Health FSA in accordance with Article 4. A Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03. An Eligible Employee's election to enroll in the Health FSA will not become effective until the Employee is enrolled in an Employer-sponsored group health plan.

(b) *Contributions.* A Participant's General Purpose Health FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a General Purpose Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 6.04 LIMITS

(a) The amount of an Eligible Employee's contribution to a Health Flexible Spending Account shall not exceed the maximum annual limit

described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 125(i), as adjusted. The Code section 125(i) limit is reduced by the amount of Flex Credits, if any, that a Participant may elect to receive in cash as set forth in the Adoption Agreement or as a taxable benefit.

(b) Employer contributions to a Participant's Health FSA will not exceed the greater of (a) two times the amount elected in the Participant's Salary Reduction Agreement to be contributed to the Health FSA for the Plan Year, including Flex Credits the Participant elects to contribute to the Health FSA, if applicable or, (b) $500 plus the amount elected in the Participant's Salary Reduction Agreement and any Flex Credits contributed to the Health FSA. If the Plan provides for Flex Credits but does not allow the cash out of the Flex Credits, the maximum amount of Flex Credits that a Participant can elect contribute to the Health FSA shall be treated as an Employer contribution for purposes of this Section 6.04(b).

Section 6.05 ELIGIBLE EXPENSES

(a) *Debits from the Health FSA.* A Participant's Health FSA will be debited for expenses described in this Section 6.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the Health FSA, less any reimbursements already disbursed from the General Purpose Health FSA, shall be available to the Participant at any time during the Plan Year without regard to the balance in the General Purpose Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.

(b) *Eligible Expenses.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her General Purpose Health FSA for expenses that are: (i) incurred in the Plan Year (or Grace Period, if applicable), (ii) incurred while he or she is a Participant in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses are not covered, paid or reimbursed from any other source. For purposes of determining whether an expense is excludable under Code section 105(b), the following applies:

(1) *Michelle's Law.* "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

(2) *Coverage of Adult Children.* Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.

(3) *Prescription Drug Expenses.* Reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is prescribed (determined without regard to whether such drug is available without a prescription) or is insulin, as provided by IRS Notice 2010-59, as amended.

Section 6.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's General Purpose Health FSA for eligible expenses incurred during the Plan Year. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's General Purpose Health FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a Grace Period beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with Prop. Treas. Reg. section 1.125-1(e), as amended or superseded. No claims incurred during a Grace Period shall be reimbursed from a General Purpose Health FSA if the Plan permits carry over of General Purpose Health FSA balances under Section 6.07(b).

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her General Purpose Health FSA during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant or, (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from General Purpose Health FSA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. Notwithstanding the foregoing payment schedule, the Plan Administrator may provide that payments/reimbursements from the General Purpose Health FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(d) *Coordination with HRA.* A Participant who is also eligible to participate in an HRA sponsored by the Employer shall not be entitled to payment/reimbursement under the General Purpose Health FSA for expenses that are reimbursable under both the General Purpose Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the General Purpose Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in

the General Purpose Health FSA have been paid.

(e) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who elects to receive coverage under a Contract that is offered in conjunction with an Employer-sponsored benefit plan may elect that any eligible expenses that are not covered under the applicable Contract, such as co-payments, co-insurance or deductibles, be automatically paid through his or her General Purpose Health FSA.

(f) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible General Purpose Health FSA expenses.

Section 6.07 FORFEITURES

(a) *Forfeitures.* Any balance remaining in a Participant's General Purpose Health FSA at the end of any Plan Year subject to the carryover amount limit in subsection (b) below, if applicable (or after the Grace Period described in Section 6.06(a), if applicable), shall be forfeited and shall be used to (1) pay administrative expenses, (2) offset losses to the Health FSA due to reimbursements exceeding contributions for the Plan Year, (3) reduce the required salary reduction amounts for the next Plan Year, (4) reduce the required employer contributions for the next Plan Year, (4) reallocate to participants on a uniform basis, and/or (5) any other use allowed under all applicable laws and regulations. If the General Purpose Health FSA is not subject to ERISA, the forfeited amount can be returned to the Employer.

(b) *Carryovers.* Notwithstanding subsection (a), and to the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year up to $500 of any amount remaining unused as of the end of the Plan Year in a Participant's General Purpose Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the General Purpose Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the Plan Year to which it is carried over. Any unused amount remaining in the General Purpose Health FSA in excess of $500 (or a lower amount specified in the Adoption Agreement) will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the rollover in the following Plan Year, provided that any such procedure is non-discriminatory.

Section 6.08 CONVERSION TO AN HSA-COMPATIBLE HEALTH FSA

If a Participant who has elected a General Purpose Health FSA for a given Plan Year establishes a Health Savings Account under the Plan or otherwise, and if an HSA-Compatible Health FSA is available under the Plan, he or she may irrevocably elect (or may be deemed by the Plan Administrator to have elected) effective as of the date he or she establishes the Health Savings Account (the "Conversion Date") to convert his or her election of a General Purpose Health FSA for such Plan Year to an election of an HSA-Compatible Health FSA for the balance of such Plan Year (and any applicable Grace Period). A General Purpose Health FSA cannot be converted to an HSA-Compatible Health FSA during the Grace Period following any Plan Year. An HSA-Compatible Health FSA may not be converted into a General Purpose Health FSA.

Section 6.09 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 6.10 QUALIFIED RESERVIST DISTRIBUTIONS

(a) If the Adoption Agreement provides for Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his General Purpose Health FSA specified in the Adoption Agreement. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(b) A Participant may submit General Purpose Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 6.11 SEPARATE PLAN

Although described within this document, the General Purpose Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The General Purpose Health FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 7. HSA-COMPATIBLE HEALTH FLEXIBLE SPENDING ACCOUNT

Section 7.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Limited Purpose Health Flexible Spending Accounts and/or Post-Deductible Health Flexible Spending Accounts (collectively, "HSA-Compatible Health FSAs"), an Eligible Employee may elect to have a portion of his or her Compensation contributed to an HSA-Compatible Health FSA. The Account established under this Article 7 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 7.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the HSA-Compatible Health FSA Benefit except as specified in the Adoption Agreement. An Employee who is not eligible to participate in Employer-sponsored group health plan is not eligible to participate in the HSA-Compatible Health FSA. A Participant who has elected the Health FSA under Article 6 is not eligible to elect an HSA-Compatible Health FSA except as otherwise provided in Section 6.08.

Section 7.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in an HSA-Compatible Health FSA in accordance with Article 4. An HSA-Compatible Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03. An Eligible Employee's election to enroll in an HSA-Compatible Health FSA will not become effective until the Employee is enrolled in an Employer-sponsored group health plan.

(b) *Contributions.* A Participant's HSA-Compatible Health FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an HSA-Compatible Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 7.04 LIMITS

The amount of contribution to a Participant's HSA-Compatible Health FSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 125(i), as adjusted.

Section 7.05 ELIGIBLE EXPENSES

(a) *Debits from the HSA-Compatible Health FSA.* A Participant's HSA-Compatible Health FSA will be debited for expenses described in this Section 7.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the HSA-Compatible Health FSA, less any reimbursements already disbursed for the Plan, shall be available to the Participant at any time during the Plan Year without regard to the balance in the HSA-Compatible Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.

(b) *Eligible Expenses.*

(1) *Limited Purpose Health FSA.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Limited Purpose Health FSA for expenses that are: (i) incurred in the Plan Year (except as provided in Section 7.05(c)), (ii) incurred while the Participant participates in the Plan, (iii) excludable under Code section 105(b), and (iv) incurred for dental or vision care or for preventive care (as defined under Code section 223(c)(2)(C)); provided that such expenses that are not covered, paid or reimbursed from any other source.

(2) *Post-Deductible Health FSA.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Post-Deductible Health FSA for expenses that are: (i) incurred in the Plan Year (except as provided in Section 7.05(c)), (ii) incurred while the Participant participates in the Plan, (iii) excludable under Code section 105(b), and (iv) incurred after the Participant has satisfied the minimum annual deductible under Code section 223(c)(2)(A)(i), provided that such expenses that are not covered, paid or reimbursed from any other source.

(c) For purposes of determining whether an expense is excludable under Code section 105(b), the following applies:

(1) *Michelle's Law.* Unless otherwise provided in the Adoption Agreement, "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a Dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

(2) *Coverage of Adult Children.* Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.

(3) *Prescription Drug Expenses.* Reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses under Code section 105(b) only if such medicine or drug is prescribed (determined without regard to whether such drug is available without a prescription) or is insulin, as provided by IRS Notice 2010-59, as amended.

Section 7.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's HSA-Compatible Health FSA for eligible expenses incurred during the Plan Year or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in an HSA-Compatible Health FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a "Grace Period" beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with Prop. Treas. Reg. section 1.125-1(e), as amended or superseded.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her HSA-Compatible Health FSA during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Substantiation of Claims.* A Participant's claim for reimbursement from a Post-Deductible Health FSA must include information from an independent third party that the deductible for his or her high-deductible health plan has been satisfied. A Participant's claims for reimbursement from a Limited-Purpose Health FSA must include information from an independent third-party that the medical expenses to be reimbursed are for vision care, dental care or preventive care.

(d) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the HSA-Compatible Health FSA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements from the HSA-Compatible Health FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(e) *Coordination with HRA.* A Participant who is also eligible to participate in ("an HRA") sponsored by the Employer shall not be entitled to payment/reimbursement under the HSA-Compatible Health FSA for expenses that are reimbursable under both the HSA-Compatible Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the HSA-Compatible Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the HSA-Compatible Health FSA have been paid.

(f) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who elects to receive coverage under a Contract that is offered in conjunction with an Employer-sponsored benefit plan may elect that any eligible expenses that are not covered under the applicable Contract, such as co-payments, co-insurance or deductibles, be automatically paid through his or her HSA-Compatible Health FSA.

(g) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible HSA-Compatible Health FSA expenses.

Section 7.07 FORFEITURES

(a) *Forfeitures.* Any balance remaining in a Participant's HSA-Compatible Health FSA at the end of any Plan Year, subject to the carryover amount limit in subsection (b) below, if applicable (or after the Grace Period described in Section 6.06(a), if applicable), shall be forfeited and shall be used to (1) pay administrative expenses, (2) offset losses to the Health FSA due to reimbursements exceeding contributions

for the Plan Year, (3) reduce the required salary reduction amounts for the next Plan Year, (4) reduce the required employer contributions for the next Plan Year, (4) reallocate to participants on a uniform basis, and/or (5) any other use allowed under all applicable laws and regulations. If the HSA-Compatible Health FSA is not subject to ERISA, the forfeited amount can be returned to the Employer. Subject to Section 7.06(a) allowing for reimbursement of eligible expenses incurred during the Grace Period and subject to subsection (b) below, unused contributions to an HSA-Compatible Health FSA remaining at the end of a Plan Year may not be cashed-out or converted to any other taxable or nontaxable benefit.

(b) *Carryovers.* Notwithstanding subsection (a) and to the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year up to $500 of any amount remaining unused as of the end of the Plan Year in a Participant's HSA-Compatible Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the HSA-Compatible Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the entire Plan Year to which it is carried over. Any unused amount remaining in the HSA-Compatible Health FSA in excess of $500 (or a lower amount specified in the Adoption Agreement) will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the carryover in the following Plan Year, provided that any such procedure is non-discriminatory.

Section 7.08 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's HSA-Compatible Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's HSA-Compatible Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 7.09 QUALIFIED RESERVIST DISTRIBUTIONS

(a) If the Adoption Agreement provides for Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his HSA-Compatible Health FSA specified in the Adoption Agreement. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(b) A Participant may submit HSA-Compatible Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 7.10 SEPARATE PLAN

Although described within this document, the HSA-Compatible Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The Health FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 8. DEPENDENT CARE ASSISTANCE PLAN ACCOUNT

Section 8.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Dependent Care Assistance Plan Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to a DCAP Account. The Account established under this Article 8 is intended to qualify as a dependent care assistance program under Code section 129 and shall be interpreted in a manner consistent with such Code section.

Section 8.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the Dependent Care Assistance Plan Account, except as specified in the Adoption Agreement.

Section 8.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the DCAP Account in accordance with Article 4.
(b) *Contributions.* A Participant's DCAP Account will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.
(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a DCAP Account for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 8.04 LIMITS

The amount of all contributions to a Participant's DCAP Account shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 129(a)(2), as adjusted.

Section 8.05 ELIGIBLE EXPENSES

(a) *Debits from the DCAP Account.* A Participant's DCAP Account will be debited for expenses described in this Section 8.05. However, the Plan Administrator will not direct the Employer to reimburse such expenses to the extent the reimbursement exceeds the balance of the Participant's DCAP Account, except as otherwise provided in the Adoption Agreement.
(b) *Eligible Expenses.*
    (1) Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her DCAP Account for Dependent Care Expenses that are: (i) incurred in the Plan Year, (ii) are incurred while the Participant participates in the Plan, and (iii) qualify as eligible Dependent Care Expenses (as defined in Section 8.05(b)(2) below), provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the such expenses.
    (2) "Dependent Care Expenses" are expenses incurred for the care of a Qualifying Individual, as defined in Code section 21(b)(1) and generally includes either: (i) a Dependent who is under age 13, or (ii) the Participant's spouse or Dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are Dependent Care Expenses only if they allow the Participant to be gainfully employed. Dependent Care Expenses include expenses for household services and expenses for the care of a Qualifying Individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the Qualifying Individual stays overnight. Expenses described in this subsection (2) that are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or Dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least eight hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

Section 8.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's DCAP Account for eligible expenses incurred during the Plan Year or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's DCAP Account at the end of a Plan Year may be used to reimburse expenses that are incurred during a Grace Period beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with IRS Notice 2005-42, as amended or superseded. If the Adoption Agreement so provides, an individual who ceases to be a Participant in the Plan (due to Termination or any other reason) may spend down his or her unused DCAP Account expenses, and such individuals may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of Participation occurs (or end of the Grace Period if applicable) to the extent the claims do not exceed the balance of the DCAP Account.
(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her DCAP Account during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.
(c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii)

at the option of the Plan Administrator, pay the service provider directly for any amounts payable from DCAP Account. The Plan Administrator may provide that payments/reimbursements from the DCAP Account of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(d) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible DCAP Account expenses.

Section 8.07 FORFEITURES

Any balance remaining in a Participant's DCAP Account at the end of any Plan Year (or after the Grace Period described in Section 8.06(a), if applicable) shall be forfeited and shall remain the property of the Employer. Unused contributions to a DCAP Account may not be cashed-out or converted to any other taxable or nontaxable benefit.

Section 8.08 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's DCAP Account shall cease upon Termination of Employment. Any balance remaining in a Participant's DCAP Account on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 8.09 SEPARATE PLAN

Although described within this document, the DCAP Account is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 129. The DCAP Account is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 9. HEALTH SAVINGS ACCOUNT

Section 9.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Health Savings Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to a Health Savings Account. The Account established under this Article 9 is intended to qualify as a health savings account under Code section 223 and shall be interpreted in a manner consistent with such Code section.

Section 9.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 who, as of the first day of the month, are enrolled in a high deductible health plan as defined in Code section 223(c)(2) are eligible to participate in the Health Savings Account for the month, except as specified in the Adoption Agreement. An Eligible Employee who has elected to participate in a General Purpose Health FSA is not eligible to participate in the HSA Benefit under this Article 9. A Participant who has elected the General Purpose Health FSA Benefit that is in effect on the last day of a Plan Year cannot elect the HSA Benefit under this Article 9 for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's General Purpose Health FSA is $0 as of the last day of such Plan Year. An Eligible Employee who is not enrolled in a high deductible health plan as defined in Code section 223(c)(2) is not eligible to elect the HSA Benefit.

Section 9.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the HSA in accordance with Article 4. An HSA election may be modified as determined by the Plan Administrator, but no less frequently than monthly, provided, however, that any modification of an election during the Plan Year shall apply on a prospective basis only. A participant who becomes ineligible to make HSA contributions may prospectively revoke his or her HSA contribution election.

(b) *Contributions.* A Participant's HSA will be credited with amounts withheld from the Participant's Compensation and any amounts

contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an HSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 9.04 LIMITS

The amount of contributions to a Participant's HSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 223(b), as adjusted.

Section 9.05 ADMINISTRATION

The HSA Benefit is not an employer-sponsored employee benefit plan - it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the Employer does not establish or maintain the HSA. The Plan Administrator will maintain records to keep track of HSA contributions by the Employer and by the Participant, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

Section 9.06 TERMINATION OF EMPLOYMENT

Except as expressly provided herein, all contributions to a Participant's HSA will terminate upon a Termination of Employment. The Participant will continue to be eligible to receive a distribution from his or her HSA in accordance with the terms of the documents governing the HSA.

ARTICLE 10. ADOPTION ASSISTANCE FLEXIBLE SPENDING ACCOUNT

Section 10.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Adoption Assistance Flexible Spending Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to an Adoption Assistance FSA. The Account established under this Article 10 is intended to qualify as an adoption assistance program under Code section 137 and shall be interpreted in a manner consistent with such Code section.

Section 10.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the Adoption Assistance FSA, except as specified in the Adoption Agreement.

Section 10.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the Adoption Assistance FSA in accordance with Article 4.

(b) *Contributions.* A Participant's Adoption Assistance FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an Adoption Assistance FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 10.04 LIMITS

The amount of contributions to a Participant's Adoption Assistance FSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 137(b)(1).

Section 10.05 ELIGIBLE EXPENSES

(a) *Debits from the Adoption Assistance FSA.* A Participant's Adoption Assistance FSA will be debited for expenses described in this Section 10.05. However, the Plan Administrator will not direct the Employer to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Adoption Assistance FSA, except as otherwise provided in the Adoption Agreement.

(b) *Eligible Expenses.*

(1) Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Adoption Assistance FSA for expenses that: (i) are incurred in the Plan Year, (ii) are incurred while the Participant participates in the Plan, and (iii) qualify as eligible Adoption Expenses, (as defined in Section 10.05(b)(2) below) provided that such expenses are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the such expenses.

(2) "Adoption Expenses" are the reasonable and necessary adoption fees, court costs, attorney fees and other expenses that are (i) directly related to the legal adoption of an Eligible Child by the Participant and (ii) not incurred in violation of state or federal law or in carrying out any surrogate parenting arrangement. For purposes of this paragraph, an "Eligible Child" is a child under age 18 or a child who is physically or mentally incapable of caring for himself/herself. An Eligible Child does not include a child of the Participant's spouse. In the case of an adoption of a child who is not a citizen or resident of the United States, any Adoption Expense with respect to such adoption is not reimbursable until such adoption becomes final.

Section 10.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's Adoption Assistance FSA for eligible expenses incurred during the Plan Year or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's Adoption Assistance FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a "Grace Period" beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with Prop. Treas. Reg. section 1.125-1(e), as amended or superseded.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her Adoption Assistance FSA during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Substantiation of Claims.* A Participant's claim for reimbursement from an Adoption Assistance FSA must include reasonable substantiation that the claim constitutes an Adoption Expense eligible for reimbursement under the Plan.

(d) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall reimburse the Participant. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements from the Adoption Assistance FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

Section 10.07 FORFEITURES

Any balance remaining in a Participant's Adoption Assistance FSA at the end of any Plan Year (or after the Grace Period described in Section 10.06(a), if applicable), shall be forfeited and shall remain the property of the Employer.

Section 10.08 TERMINATION OF EMPLOYMENT

Except as expressly provided herein, any balance remaining in a Participant's Adoption Assistance FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 10.09 SEPARATE PLAN

Although described within this document, the Adoption Assistance FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 137. The Adoption Assistance FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 11. OTHER BENEFITS

Section 11.01 FLEX CREDITS

(a) *In General.* To the extent the Adoption Agreement authorizes Flex Credits, an Employer may make a non-elective contribution to the Plan that may be used at each Participant's election for one or more Benefits under the Plan.

(b) *401(k) Contributions.* To the extent provided in the Adoption Agreement, an Eligible Employee may elect to contribute all or a portion of his or her Flex Credits to a Qualified Plan in accordance with the terms of the Qualified Plan, the applicable provisions of which are incorporated herein by reference. All claims for benefits that are provided under the Qualified Plan shall be governed by the terms of the Qualified Plan.

Section 11.02 PURCHASE/SALE OF PTO

(a) *In General.* To the extent that the Adoption Agreement authorizes the purchase and/or sale of PTO, an Eligible Employee may elect to purchase PTO days and/or sell PTO days.

(b) *Eligible Employees.* The Employees identified in Article 3 are eligible to purchase/sell PTO days, except as specified in the Adoption Agreement.

(c) *Enrollment.* An Eligible Employee may elect to purchase PTO days at such time as an Eligible Employee may enroll in the Plan in accordance with Article 4 and to the extent the Adoption Agreement provides. A Participant's PTO Account will be credited with amounts withheld from the Participant's Compensation in accordance with the Participant's Salary Reduction Agreement and any amounts contributed by the Employer pursuant to the Adoption Agreement. The Participant may use these amounts to purchase PTO days.

(d) *Failure to Elect.* An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a PTO Account for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

(e) *Forfeiture.* A Participant must use PTO during the Plan Year in which it was purchased. Any unused elective PTO (determined as of the last day of the Plan Year) shall either be paid in cash or be forfeited as of the end of the Plan Year, pursuant to the Adoption Agreement. The Participant must receive the cash on or before the last day of the Plan Year to which the amounts contributed and used to purchase the unused PTO relate.

(f) *Ordering of Elective and Non-elective PTO.* Participants are deemed to use PTO in the following order:
   (1) Non-elective PTO (that is, paid time off with respect to which the employee has no election to buy/sell) is used first; then
   (2) Elective PTO is used after all non-elective PTO is used.

(g) *Sale of PTO.* An Eligible Employee may elect to sell PTO days at such time as an Eligible Employee may enroll in the Plan in accordance with Article 4 and to the extent the Adoption Agreement provides. A Participant's PTO Account will be credited with the value of the PTO sold in accordance with the Eligible Employee's election. The Participant may use the amounts in the PTO Account to purchase other Benefits under the Plan or may cash out the amounts in the PTO Account in accordance with Section 11.03.

(h) *Carryover of Unused PTO.* To the extend provided in the Adoption Agreement, unused elective PTO (determined as of the last day of the Plan Year) may be carried over to a subsequent Plan Year at the Participant's election, subject to the Employer's PTO policies.

Section 11.03 CASH OUT

(a) *In General.* To the extent provided in the Adoption Agreement, a Participant may elect to receive a cash distribution of Flex Credits and PTO from the Plan.

(b) *Eligible Employees.* The Employees identified in Article 3 are eligible to receive a cash distribution from the Plan under this Section 11.03.

ARTICLE 12. SIMPLE CAFETERIA PLAN

Section 12.01 IN GENERAL

If the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the nondiscrimination requirements of Code sections 125(b), 79(d), 105(h) and 129(d)(2), (3), (4), and (8) shall be treated as met during such year.

Section 12.02 ELIGIBLE EMPLOYERS

(a) The Plan shall not be a simple cafeteria plan if the Employer employed more than 100 Employees on business days during either of the

two years preceding the date of the election. If the Employer was not in existence throughout the preceding year, the number of Employees shall be based on the average number of Employees that it is reasonably expect to employ on business days in the current year.

(b) If an Employer maintains the Plan as a simple cafeteria plan for its Employees then, if the Employer fails to meet the requirements of subparagraph (a) for any subsequent year, the Plan will continue to be a simple cafeteria plan for such subsequent year with respect to its Employees, unless and until the Employer employs an average of 200 or more Employees on business days during any year preceding any such subsequent year.

Section 12.03 EMPLOYER CONTRIBUTIONS

(a) *Required Employer Contributions.* The Employer shall make a contribution to provide Qualified Benefits under the Plan on behalf of each Eligible Employee who is not a Highly Compensated Employee or Key Employee (without regard to whether the Eligible Employee makes any salary reduction contribution) in an amount equal to:
   (1) a uniform percentage (not less than two percent) of the Employee's Compensation for the Plan Year, or
   (2) an amount which is not less than the lesser of:
      (A) six percent of the Employee's Compensation for the Plan Year, or
      (B) twice the amount of the salary reduction contributions of each Eligible Employee who is not a Highly Compensated Employee or Key Employee.

(b) *Additional Employer Contributions.* An Employer may elect to make additional contributions to the Plan, subject to the terms set forth herein; provided, however, that the rate of contributions with respect to any Participant contribution by a Highly Compensated Employee or Key Employee at any rate of contribution is not greater than the rate of contributions with respect to an employee who is not a Highly Compensated Employee or Key Employee.

Section 12.04 ELIGIBLE EMPLOYEES

To the extent that the Plan is intended to qualify as a simple cafeteria plan under Code section 125, all Employees who had at least 1,000 hours of service for the immediately preceding Plan Year are eligible to participate in the Plan, and each Employee eligible to participate in the Plan may, subject to terms and conditions applicable to all Participants, elect any Benefit available under the Plan.

ARTICLE 13. NONDISCRIMINATION

Section 13.01 NONDISCRIMINATION REQUIREMENTS

Unless the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the following nondiscrimination requirements shall apply:

(a) *Cafeteria Plan.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate.

(b) *Group Term Life.* The Plan may not discriminate in favor of Key Employees as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 4.01.

(c) *Health Flexible Spending Account.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate with respect to the Health FSA.

(d) *Dependent Care Assistance Plan Accounts.* The Plan may not discriminate in favor of Highly Compensated Employees as to benefits provided or eligibility to participate with respect to DCAP Accounts.

(e) *Adoption Assistance FSAs.* The Plan may not discriminate in favor of Highly Compensated Employees as to benefits provided or eligibility to participate with respect to Adoption Assistance FSAs.

Section 13.02 ADJUSTMENTS

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Section 13.02 shall be carried out in a uniform and non-discriminatory manner.

ARTICLE 14. PLAN ADMINISTRATION

Section 14.01 PLAN ADMINISTRATOR

(a) *Designation.* The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor. The Committee shall elect a chair and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents on its behalf. The Plan Administrator shall also be the Plan "administrator" as such term is defined in section 3(16) of ERISA and the "named fiduciary" of the Plan (only to the extent that the Plan is subject to ERISA).

(b) *Authority and Responsibility of the Plan Administrator.* The Plan Administration shall have total and complete discretionary power and authority:

(1) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(2) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits under the Plan;

(3) to determine the amount and manner of any allocations hereunder;

(4) to maintain and preserve records relating to the Plan;

(5) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(6) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(7) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(8) to determine all questions of the eligibility and of the status of rights of Participants;

(9) to adjust Accounts in order to correct errors or omissions;

(10) to determine the validity of any judicial order;

(11) to retain records on elections and waivers by Participants;

(12) to supply such information to any person as may be required; and

(13) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) *Procedures.* The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) *Allocation of Duties and Responsibilities.* The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) *Compensation.* The Plan Administrator shall serve without compensation for its services.

(f) *Expenses.* All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Plan Sponsor.

Section 14.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Plan Sponsor shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegates) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA to the extent that the Plan is subject to ERISA.

ARTICLE 15. AMENDMENT AND TERMINATION

Section 15.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor or its delegate.

Section 15.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will continue indefinitely; however, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) A participating Employer may terminate its participation in this Plan upon (i) written notice to the Plan Sponsor of its intent to terminate participation in the Plan, (ii) the closing of a merger in which the participating Employer is not the surviving entity and the surviving entity is not an affiliate of the Plan Sponsor, or (iii) the sale of all or substantially all of the participating Employer's assets to an entity that is not an affiliate of the Plan Sponsor.

ARTICLE 16. CLAIMS PROCEDURES

Section 16.01 CONTRACT BENEFIT AND HSA CLAIMS

(a) *Benefits Provided by Contracts.* Claims and reimbursement for benefits provided under any Contract shall be administered in accordance with the claims procedures for the applicable Contract, as set forth in the Contract's plan documents, summary plan description, and/or similar documentation.

(b) *HSA Claims.* Claims relating to the HSA shall be administered by the HSA trustee/custodian in accordance with the HSA trust or custodial document between the Participant and such trustee/custodian.

Section 16.02 CLAIMS PROCEDURES FOR PLAN ACCOUNTS (OTHER THAN CONTRACT BENEFITS AND HSA)

(a) *Claims.* A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) *Documentation.* A Participant or any other person requesting benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(c) *Health Flexible Spending Account Claims.* This Section 16.02(c) shall apply for any claim for benefits under the Health Flexible Spending Account.

(1) *Timing of Notice of Denied Claim.* The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA after following the Plan's claims procedures, and (E): (1) if an internal rule, guideline, protocol, or

other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The Claimant shall lose the right to appeal if the appeal is not timely made. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

(4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (D) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Before a suit can be filed in federal court, claims must exhaust internal remedies. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Health Flexible Spending Account must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

(d) *Other Plan Account Claims.* This Section 16.02(d) shall apply for any claim for benefits under Accounts other than the Health Flexible Spending Account.

(1) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, ordinarily within 90 days after receipt of the claim, unless the Plan Administrator determines additional time is required to make a determination.

(2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying the reason or reasons for such denial and an explanation of the steps that the Claimant must take if he wishes to appeal the denial.

(3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall rule on an appeal within a reasonable period of time, ordinarily within 60 days of receipt of the appeal, unless the Plan Administrator determines additional time is required to make a determination.

(4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice

identifying the reason or reasons for such denial. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Unless otherwise prohibited under the Plan or pursuant to applicable law, before a suit can be filed in court, Claimants must exhaust the Plan's claim procedures. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Section 16.03 REFUNDS/INDEMNIFICATION

If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (a) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (b) offset other benefits payable hereunder.

ARTICLE 17. MISCELLANEOUS

Section 17.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he or she may expect to receive, contingently or otherwise, under the Plan.

Section 17.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and the Participant, or as a right of any Employee to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

Section 17.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made solely out of the general assets of the Employer.

(b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any Benefit or account other than as expressly authorized in the Plan.

Section 17.04 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

To the extent the Plan is not subject to ERISA, any applicable law related to qualified medical child support orders or National Medical Support Notices shall apply and the Plan Administrator shall follow any required procedures under such law.

Section 17.05 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth identified in the Adoption Agreement, to the extent not preempted by Federal law.
(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 17.06 TAX EFFECT

The Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan.

Section 17.07 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 17.08 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 17.09 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Section 17.10 TRANSFERS

Except as explicitly set forth herein, amounts may not be transferred between Accounts.

Section 17.11 COBRA

If the Plan or Benefit is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan or Benefit is subject to COBRA, a Participant shall be entitled to continuation coverage as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

Section 17.12 CONFLICTS

In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions that must be satisfied to become covered, if any, the benefits Participants are entitled to receive and the circumstances under which coverage terminates.

Section 17.13 DEATH

If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her Dependents or a representative of the Participant's estate. Such payment shall fully discharge the Plan Administrator and the Employer from further liability on account thereof.

ARTICLE 18. HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article 18 shall only apply in the event that the Health FSA(s) under the Plan constitutes a group health plan as defined in section 2791(a)(2) of

the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy and security rules. The Plan will comply with HIPAA as set forth below.

Section 18.01 DEFINITIONS

For purposes of this Article 18, the following terms have the following meanings:

(a) Business Associate means
any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) Group Health Benefits means
the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

(c) Individual means
the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.

(d) Notice of Privacy Practices means
a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) Plan Administration Functions means
the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) Protected Health Information ("PHI") means
information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan or the Plan Sponsor;
(2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and
(3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) Summary Health Information means
information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

(1) names;
(2) any geographic information which is more specific than a five digit zip code;
(3) all elements of dates relating to a covered Individual (*e.g.*, birth date) or any medical treatment (*e.g.*, admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);
(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;
(5) facial photographs or biometric identifiers (*e.g.*, finger prints); and
(6) any other unique identifying number, characteristic, or code.

Section 18.02 HIPAA PRIVACY COMPLIANCE The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:
(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;
(B) for auditing claims payments made by the Plan;
(C) to request proposals for services to be provided to or on behalf of the Plan; and
(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.

(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

(3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.

(3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.

(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

Section 18.03 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

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

(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;
(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
(d) Report to the Plan any security incident of which it becomes aware.

FSA Help Guide

DIVERSIFIED BENEFIT SERVICES, INC.

Excellence in Benefit Management Solutions

Health Care Flexible Spending Account (HCFSA)

What is a Health Care Flexible Spending Account?

A Health Care FSA (HCFSA) is a program that saves you money by allowing you to pay for eligible medical, dental and vision expenses for you, your spouse and your dependents (including children to age 26) using **pre-tax dollars**. That means the money you set aside for your HCFSA is not subject to federal income tax, Social Security, Medicare and, in most cases, state and local taxes. Using a HCFSA can save you approximately 20-30% in taxes on your expenses!

How does it work?

During your employer's open enrollment period, you calculate your annual expenses and determine an election amount that you are comfortable with. Your employer will take pre-tax deductions from your paychecks in equal amounts throughout the entire plan year. Ex: You elect $1,300 and you are paid 26 times per year. Your employer will deduct $50 pre-tax from each paycheck over the course of the plan year. The plan year is the timeframe in which services need to be rendered to qualify for reimbursement. Check your enrollment materials for the plan year your employer has chosen.

When you have an eligible expense to be reimbursed, you simply file a claim with DBS. Services must be incurred within the plan year to be eligible for reimbursement.

How am I reimbursed for expenses?

Filing a claim is **easy**! Once you have incurred an eligible expense, file a claim with DBS online at DBSbenefits.com on your mobile phone or via mail or fax. You need to provide documentation showing the date of service, description of the expense incurred, name of the service provider and the amount of the expense. Dates of service need to be within the HCFSA plan year.

A great benefit of the plan is that you have access to your entire election amount on the first day of the plan year. This means that if you have an expense at the beginning of the plan year, you can be reimbursed up to your entire election amount, even though you have not yet contributed that amount, easing the financial burden on you.

Why should I enroll?

- Improve your cash flow and increase your spendable income
- Save approximately 20-30% in taxes on your expenses

Need more information? Contact DBS at **(800) 234-1229** to speak with a representative. You can review plan balance, claims and reimbursement information online at **DBSbenefits.com**

What expenses qualify for Health Care FSA reimbursement?

- Medical deductibles
- Co-pays
- Glasses
- Contact lenses
- Vision exams
- Dental expenses
- Prescription drugs
- Over-the-counter (OTC) drugs
- Office visits
- Diabetic supplies
- Chiropractic expenses

... and much more

What if I don't use my entire election amount by the end of the plan year?

It is uncommon for participants to have money remaining in their account at the end of the plan year, but it is important to plan carefully. If you do have remaining funds, the unused funds may be forfeited and become the property of your employer, depending on the provisions of the plan. This is known as the use-or-lose provision.

Some employers offer a carryover provision, allowing you to carry over unused funds into the new plan year, while others offer a grace period that allows additional time to incur expenses. If you are unsure if your plan offers either option, please contact DBS at **(800) 234-1229**.

What is a run-out period?

The run-out period is the period of time that you have after the end of the plan year to submit claims for expenses incurred during the plan year. Please check your enrollment materials for the run-out period your employer has chosen.

Additional Health Care FSA Information

- If you are enrolled in a HCFSA, you are not able to contribute to a Health Savings Account (HSA) during the plan year. This applies to you and your spouse's HSA.
- Participation in a Health Care FSA may slightly affect your Social Security retirement benefit because you are lowering your annual gross income. For most people, the effect is minimal.
- If you are a highly compensated employee, an owner of the company or a family member of an owner, federal law may impose limits on your eligibility to participate in the plan.
- Expenses reimbursed from the HCFSA cannot be reimbursed through any other source. This includes any insurance company, insurance plan, other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or another reimbursement plan.

Can I change my Health Care FSA election during the plan year?

In certain situations, you may modify your election amount upon a "change in status" such as those listed below. There are several conditions and/or limitations that apply. Contact your employer if you believe that you may qualify for an election change.

- **Change in marital status (marriage, divorce, death of spouse)**
- **Change in number of dependents (birth, adoption, death of dependent)**
- **Change in employment status**
- **Change that causes your dependent to no longer meet dependent eligibility**
- **You take leave under FMLA**

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Excellence in Benefit Management Solutions

DBSbenefits.com

Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
(800) 234-1229

Over-the-Counter Drug and Product Guide

DIVERSIFIED BENEFIT SERVICES, INC.

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Over-the-Counter (OTC) Drug and Product Guide

The following list includes examples of expenses that qualify for reimbursement through a Section 125 Flexible Benefit Plan

Acne treatments
Allergy medications
Antacids
Antibiotic ointments
Antihistamines
Anti-itch creams
Arthritis gloves
Aspirin
Bactine
Bandages and gauze pads
Birth control
Breast pump
Diagnostic Items (examples include: blood pressure monitoring devices, blood sugar test kits and test strips, pregnancy tests, and ovulation monitors)
Calamine lotion
Carpal tunnel wrist supports
Cold medicines
Cold/hot packs (for a medical condition)
Cold sore relievers
Contact lenses, saline solutions and enzyme cleaners
Cough suppressants
COVID-19 at home testing kits
Crutches
Decongestants
Denture adhesives
Diabetic supplies
Diaper rash ointments and creams
Diarrhea medicine
Ear wax removal products
Earplugs
Expectorants
Eye drops
Fever reducing medications
First aid creams
First aid kits
Hearing aid batteries
Heating Pads
Hemorrhoid treatments
Incontinence supplies
Insect bite creams and ointments
Insulin
Laxatives
Liniments (i.e. vaporizing rub)
Menstrual products (pads & tampons)
Motion sickness medications
Nasal strips and sprays
Pain relievers
Personal protective equipment (including masks, hand sanitizer, and sanitizing wipes)
Rubbing alcohol
Sinus medications
Smoking cessation products
Snoring Cessation aids
Sunburn creams and ointments
Thermometers for medical use
Throat lozenges
Toothache and teething pain relievers
Vaporizer
Walkers
Wart removal medications
Yeast infection medications

The following list includes OTC drugs and products that require a letter of medical necessity from a medical practitioner verifying the item's use is to treat a current and specific medical condition.

Air purifier
Anti-balding treatments
Chondroitin
Dietary supplements
Fiber Supplements
Fluoridation device or supplies
Glucosamine
Herbs
Humidifier
Mineral Supplements
Vitamins

The following list includes examples of OTC drugs and products that DO NOT qualify for reimbursement.

Cosmetic products
Cologne/perfume
Dental floss
Deodorant
Diapers
Diet Foods
Hand lotion/moisturizers
Mouthwash
Vitamins for general health
Safety glasses
Shampoo
Shaving cream
Soap
Teeth whitening kits
Tooth brushes/tooth paste

Note: For OTC drugs and products to qualify under the Section 125 Flexible Benefit Plan, the item's use must be to treat, heal, or cure a medical condition. This guide is intended to provide examples of OTC drugs and products that are reimbursable through a Section 125 Flexible Benefit Plan and is not all inclusive. If further verification is needed regarding whether an expense qualifies, please contact DBS at (800) 234-1229. Items will not qualify if purchased in bulk or used for resale. Consult your tax advisor for maximum benefit. It is understood DBS is not engaged in the practice of law or giving tax advice.

DBSbenefits.com

P.O. Box 260
Hartland, WI 53029
800-234-1229

Claims Filing Options

Why file online?

- **Fast**
  There's no quicker way to get reimbursed for your FSA or HRA claims.
- **Convenient**
  Day or night, on your favorite device, go online and get account information.
- **Safe**
  You have encrypted Internet access to the site, which is protected and Verisign secured.
- **Comprehensive**
  View account balance and activity.

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Hartland, WI 53029
(800) 234-1229

DIVERSIFIED BENEFIT SERVICES, INC.
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Claims Filing
Options that meet your needs.

File Online—it's fast, convenient and secure

Using your laptop or PC, you can submit your claims online 24/7. DBS's exclusive A.S.A.P.® (Advanced Strategic Administration Program) is a safe and quick way to see claim information and get reimbursed from your Health Care FSA (HCFSA), Dependent Care FSA (DCFSA), Limited Purpose FSA (LPFSA), or Health Reimbursement Arrangement (HRA).

1. Login to your online account at DBSbenefits.com
2. Select the Benefit Plan Type (FSA, HRA)
3. Select "Claims > Claims View/Submit > Submit"
4. Complete the required information
5. Attach an image with supporting documentation (.pdf or .jpg)
6. Submit

File on the go—use our Mobile Phone App

Filing using your smartphone or tablet is simple.

1. Login using your A.S.A.P.® name and password, click "File a Claim"
2. Take a picture or use an existing photo, click "Attach Image"
3. Select the Benefit Plan Type
4. Enter dollar amount, answer questions, click "Submit"

Visit your favorite app store to download.

ANDROID APP ON Google play Available on the App Store

File via mail or fax

More traditional filing is available, too.

1. Download a claim form at DBSbenefits.com
2. Select the "Participant Resources Tab > Forms"
3. Complete the form and attach copies of your documentation
4. Mail to Diversified Benefit Services, P.O. Box 260, Hartland, WI 53029
5. Or fax to 262-367-5938

For assistance, please call DBS at **(800) 234-1229**
or visit **DBSbenefits.com**

Important Information About Your PREPAID BENEFITS CARD

Frequently Asked Questions

General Questions on the Prepaid Benefits Card

1. **What is the Prepaid Benefits Card?**

   The Prepaid Benefits Card is a special-purpose MasterCard® Card or Visa® Card that gives participants an easy, automatic way to pay for eligible health care/benefit expenses. The Card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), and Health Savings Accounts (HSAs).

2. **How does the Prepaid Benefits Card work?**

   It works like a MasterCard® Card or Visa® Card, with the value of the participant's account(s) contribution stored on it. When participants have eligible expenses at a business that accepts MasterCard debit cards or Visa debit cards, they simply use their Card. The amount of the eligible purchases will be deducted – automatically – from their account and the pre-tax dollars will be electronically transferred to the provider/merchant for immediate payment.

3. **How does the Prepaid Benefits Card change how the participant is reimbursed for expenses?**

   Before the Prepaid Benefits Card became available, participants had to pay for their eligible expenses at the time of purchase, submit claim forms along with all receipts, and then wait for the reimbursement to be processed. Checks were issued and mailed to the participants, who then cashed the checks. In essence, participants "paid twice" – through payroll deduction and then at the point of sale – then they had to wait for reimbursement.

   However, with the Prepaid Benefits Card, participants simply swipe their Cards and the funds are automatically deducted from their respective benefit account(s) for payment. The Card eliminates most out-of-pocket cash outlays and paperwork, as well as the need to wait for reimbursement checks.

4. **Is the Prepaid Benefits Card just like other MasterCard® Cards or Visa® Cards?**

   No. The Prepaid Benefits Card is a special-purpose MasterCard Card or Visa Card that can be used only for eligible health care/benefits expenses. It cannot be used, for instance, at gas stations or restaurants. There are no monthly bills and no interest.

5. **How many Prepaid Benefits Cards will the participant receive?**

   The participant will receive two Cards. If participants would like additional Cards for other family members, they should contact Diversified Benefit Services, Inc. (DBS).

6. **Will participants receive a new Prepaid Benefits Card each year?**

   No, participants will not receive a new Card each year. If the participant will again have a benefit associated with the Card for the following plan year – and he/she used the Card in the current benefit year – the participant will simply keep using the same Card the following year. The Card will be loaded with the new annual election amount at the start of each plan year or incrementally with each pay period, based on the type of account(s) the participant has.

7. **What if the Prepaid Benefits Card is lost or stolen?**

   Participants should call DBS to report a Card lost or stolen as soon as they realize it is missing, so the card can be turned off and replacement cards can be issued. There may be a fee for replacement cards.

Getting Started and Activating Your Card

1. **How do participants activate the Card?**

   Participants should call the toll-free number on the activation sticker on the front of the Card.

   Participants can use both Cards once the first Card is activated – they do not need to activate both. They should wait one business day after activation to use their Cards. Each Card user should sign the Card with his or her own name.

2. **What dollar amount is on the Prepaid Benefits Card when it is activated?**

   For Health Care FSAs, the dollar value on the Card will be the annual amount that participants elected to contribute to their respective employee benefit account(s) during their annual benefits enrollment. It's from that total dollar amount that eligible expenses will be deducted as participants use their Cards or submit manual claims.

   Some other types of accounts, like Dependent Care FSAs, HRAs, and transportation accounts, are funded incrementally at each pay period, so it is especially important to be aware of account balances in order to avoid Card declines at the point of service.

Using the Card

1. **Where may participants use the Prepaid Benefits Card?**

   IRS regulations allow participants to use their Prepaid Benefits Cards in participating pharmacies, mail-order pharmacies, discount stores, department stores, and supermarkets that can identify FSA/HRA-eligible items at checkout and accept MasterCard® prepaid cards or Visa® prepaid cards. Eligible expenses are deducted from the account balance at the point of sale. Transactions are fully substantiated, and in most cases, no paper follow-up is needed. Participants can find out which merchants are participating by visiting the website on the back of the Card or consulting DBS.

   Some plan designs may also allow participants to use their Cards in pharmacies that have certified that 90% of the merchandise they sell is FSA/HRA-eligible. However, since these pharmacies cannot identify the eligible items at the point of sale, another form of auto substantiation or paper follow-up will be required.

   Participants may also use the Card to pay a hospital, doctor, dentist, or vision provider that accepts MasterCard® or Visa®. In this case, EB uses its auto-substantiation technology to electronically verify the transaction's eligibility according to IRS rules. If the transaction cannot be auto substantiated, paper follow-up will be required.

2. **Are there places the Prepaid Benefits Card won't be accepted?**

   Yes. The Card will not be accepted at locations that do not offer the eligible goods and services, such as hardware stores, restaurants, bookstores, gas stations and home improvement stores.

   Cards will not be accepted at pharmacies, mail-order pharmacies, discount stores, department stores, and supermarkets that **cannot** identify FSA/HRA-eligible items at checkout. The Card transaction may be declined. Participants can find out which merchants are participating by visiting the website on the back of the Card.

3. **If asked, should participants select "Debit" or "Credit"?**

   DBS's Prepaid Benefits Card is actually a prepaid card. But, since there is no "prepaid" selection available, participants should select "Credit." Participants do not need PIN and cannot get cash with the Prepaid Benefits Card.

4. **How does the Card work in participating pharmacies, discount stores, department stores, and supermarkets?**

   a. Bring prescriptions, vision products, eligible OTCs and other purchases to the register at checkout to let the clerk ring them up.

   b. Present the Card and swipe it for payment.

   c. If the Card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the products are FSA/HRA-eligible), the amount of the FSA/HRA-eligible purchases is deducted from the account balance and no receipt follow up is required. The clerk will then ask for another form of payment for the non-FSA/HRA-eligible items.

   d. If the Card swipe transaction is declined, the clerk will ask for another form of payment for the total amount of the purchase.

   e. The receipt will identify the FSA/HRA-eligible items and may also show a subtotal of the FSA/HRA-eligible purchases.

   f. In most cases, the participant will not receive requests for receipts for FSA/HRA-eligible purchases made in participating pharmacies, discount stores, department stores, or supermarkets.

5. **Why do participants need to save all of their itemized receipts?**

   Participants and their other eligible users should always save itemized receipts for FSA and HRA purchases made with the Prepaid Benefits Card. They may be asked to submit receipts to verify that their expenses comply with IRS guidelines. Each receipt must show: the merchant or provider name, the service received or the item purchased the date and the amount of the purchase. The IRS requires that every card transaction must be substantiated. This can occur through automated processing as outlined by the IRS (e.g. copay matching, etc.). If the automated processing is unable to substantiate a transaction, the IRS requires that itemized receipts must be submitted in order to validate expense eligibility.

6. **How long do participants need to save their itemized receipts?**

   Participants should save itemized receipts for FSA and HRA until the end of the benefit year and/or grace period (if applicable). HSA participants should save receipts for three years to comply with IRS document retention rules.

7. **What if participants lose their receipts or accidentally swipe the Card for something that's not eligible?**

   Usually the service provider can recreate an account history and provide a replacement receipt. In the event that a receipt cannot be located, recreated, or if the expense is ineligible for reimbursement, the participant can reimburse their employer the amount so it can be credited back to the participant's FSA/HRA account.

8. **May participants use the Prepaid Benefits Card for prescriptions ordered prior to activating the Card?**

   No. The Card must be activated prior to the order and/or purchase date of prescriptions. In some cases, participants need to wait 1 business day after activating the Card to purchase prescriptions at their pharmacy. For example, if the Card is activated on Tuesday, a prescription can be ordered and picked up on Wednesday.

9. **Sometimes the participant is asked for the CVV when paying the balance due or when placing an order by phone or online. What is this and where is it found?**

   CVV stands for "Card Verification Value." It is a 3-digit number that can be found on the back of the card to the right of the signature panel.

10. **How do participants know how much is in their account?**

    They can visit the DBS website or phone app and view their account activity and current balance. Or, they can call DBS at the phone number on the back of the Card to obtain their current balance. Participants should always know their account balance before making a purchase with the Card.

11. **What if participants have an expense that is more than the amount left in their account?**

    By checking their account balance often – either online, via the phone app or by calling DBS at the phone number shown on the back of the Card – participants will have a good idea of how much is available. When incurring an expense that is greater than the amount remaining in their account, participants may be able to split the cost at the register. (Check with the merchant.) For example, participants may tell the clerk to use the Prepaid Benefits Card for the exact amount left in the account, and then pay the remaining balance separately. Alternatively, participants may pay by another means and submit the eligible transaction manually via a claim form with the appropriate documentation to DBS.

12. **What are some reasons that the Prepaid Benefits Card might not work at point of sale?**

    The most common reasons why a Card may be declined at the point of sale are:

    a. The Card has not been activated.

    b. The Card has been used before the 24-hour period after activation is over.

    c. The participant has insufficient funds in his or her employee benefit account to cover the expense.

    d. Non-eligible expenses have been included at the point-of-sale. (Retry the transaction with the eligible expense only.)

    e. The merchant is encountering problems (e.g. coding or swipe box issues).

    f. The pharmacy, discount store, department store, or supermarket cannot identify FSA/HRA-eligible items at checkout according to IRS rules.

13. Is the participant responsible for charges on lost or stolen Prepaid Benefits Cards?

If DBS and the issuing bank are notified within 2 business days, the participant will not be responsible for any charges. If the notification is after 2 days, the participant may be responsible for the first $50 or more. Replacement Cards may be purchased.

14. Whom do participants call if they have questions about the Prepaid Benefits Card?

Call DBS at the phone number shown on the back of the Card.

15. Can a participant use the Prepaid Benefits Card to access last year's money left in the account this year?

Any funds eligible for carryover will be available on the card within the first week of the new plan year. The card can only be used to pay for dates of service within the new plan year. Services incurred during the prior plan year must be submitted online, via mobile phone app, by fax (262-367-5938) or by mail. Your card can not be used for prior plan year expenses.

16. How will a participant know to submit receipts to verify a charge?

The participant will receive a letter or notification from DBS if there is a need to submit a receipt. All receipts should be saved per the IRS regulations.

17. What if a participant fails to submit receipts to verify a charge?

If receipts are not submitted as requested to verify a charge made with Prepaid Benefits Card, then the Card may be suspended until receipts are received. The participant may be required to repay the amount charged. DBS will advise the participant that the Card has been suspended, if a receipt is not received. Submitting a receipt or repaying the amount in question will allow the Card to become active again.

DIVERSIFIED
BENEFIT SERVICES, INC.

Important Information About Prepaid Benefits Card Substantiation

Participants may have questions about the requirements for submitting receipts when the Prepaid Benefits Card is used to pay for a service. This handout provides an explanation of the receipt substantiation requirements.

IRS rules govern substantiation requirements
The IRS has established specific guidelines that require all Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA) transactions — even those made using a health care payment card — to be substantiated (verified that the purchase was an eligible medical expense).

The IRS requires that FSA/HRA administrators have the date of service, nature of the expense, provider name and the out-of-pocket cost on file for each expense paid for with a card.

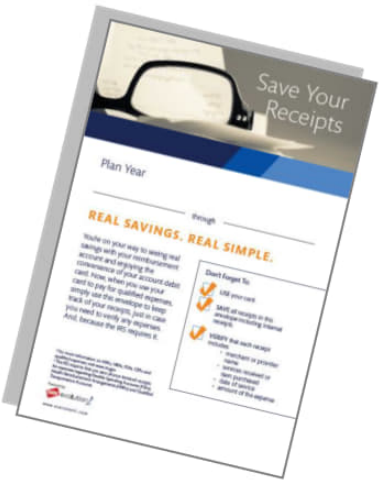
Common myths about receipt requirements
1. If the Prepaid Benefits Card is used for an eligible service, no further receipts or documentation are needed to support the expense.
2. All claims at a doctor, dentist or vision provider do not require receipts.

These are misconceptions since some services from medical, dental, vision or pharmacy providers are ineligible expenses. As an example, teeth whitening is an ineligible expense. In addition, the date of service must be within the FSA/HRA plan year. The payment date is not always the date of service.

IIAS and Auto Substantiation
Inventory Information Approval System (IIAS) is a Federal Government approved system used by many pharmacy merchants that identifies eligible prescription and over the counter products. This system limits FSA/HRA health care payment cards to only those eligible items.

This system makes it easier for account holders to manage eligible over-the-counter products and pharmacy expenses, since the merchants automatically substantiate purchases at the point of sale.

Always save itemized documentation of your expenses
Employees should save their itemized receipts from every health care payment card transaction and all of the Explanation Of Benefits (EOBs) they receive from health/pharmacy/dental plans.



An easy approach for keeping this information on hand is to designate one envelope or folder to store all itemized health care payment card receipts and EOBs. Using this process will help employees find documentation if requested.

Information required on documentation
All receipts or documentation must include the following information:

- Name of person who incurred the service or expense
- Name and address of the provider or merchant
- Date of service for the amount charged
- Detailed description of the service
- Amount due for the service provided

EOBs contain all of the required information and are excellent sources of documentation. *Credit card receipts and cancelled checks are not acceptable!*

Receipts for over-the-counter (OTC) products and prescription items do not need to include the person's name, but must display the name of the item (e.g. band aids).

IMPORTANT - Requests for additional information
If a debit card transaction is not auto-substantiated, DBS will send you a request for documentation via email or traditional mail.

It is important that you act upon the request. If you do not, the IRS requires DBS to suspend the use of your card. You are responsible for submitting proper documentation and may need to pay the plan back if you fail to do so. Contact DBS for assistance.

You can submit debit card substantiations utilizing our Mobile App. It's easy, convenient and secure!

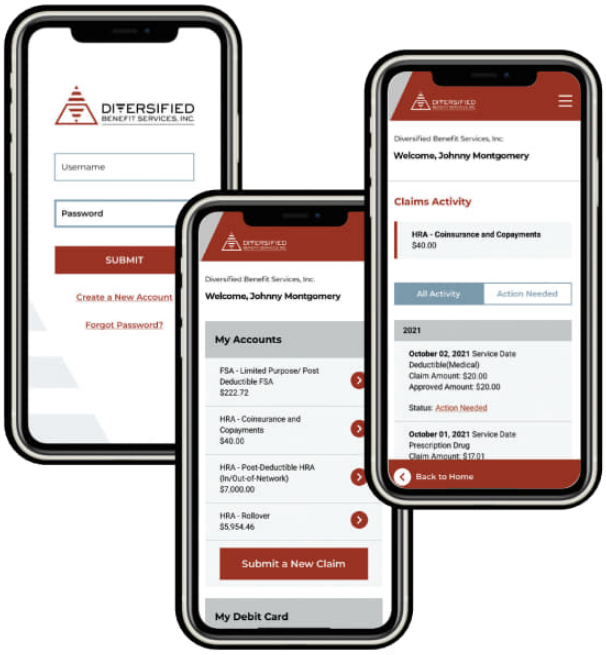
Submitting substantiation documents via our phone app is easy. When you login to our app, click the icon titled "Debit Card Substantiation". Take a picture of your document(s), click "OK" and then "Submit". You just submitted your supporting documents! In addition, you do not have to wait for DBS to send you a notice that substantiation is needed. If you would like to submit your documentation right away, follow the procedures above and your documents will be queued in our system.

For assistance please call our Customer Service Department at 1-800-234-1229.

DBS Mobile App Guide

ENHANCED DBS MOBILE APP

There's no easier way to submit claims and review account information than with the latest version of our mobile app. Day or night, you have convenient and secure access to account activity from your mobile phone.



NEW APP FEATURES:

- View account balances
- Submit new claims and view claim status
- Submit supporting documentation
- Manage debit card transactions
- Create a new account or reset your password

Download the updated app to begin using the new features today!

GET IT ON Google Play

Download on the App Store

P.O. Box 260 Hartland, WI 53029
Toll Free: (800) 234-1229
Phone: (262) 367-3300
DBSbenefits.com

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