Flexible Spending Account (FSA)

Employer Salary Reduction Plan

SECTION I. Introduction

1.1 Establishment of Plan

Employer hereby establishes the Employer Salary Reduction Plan effective as of the date shown below in section 1.1.

This Plan is designed to permit an Eligible Employee to elect between cash and benefits. An Eligible Employee can use the Plan to pay, on a pre-tax basis, the employee's share of Contributions under the Insurance Plans and to contribute on a pre-tax basis to an Employee's Benefits as defined below.

SECTION A: Plan Information

Employer / Plan Sponsor	● Entity Name: Texas Wesleyan University ● Address: 1201 Wesleyan St, Texas Wesleyan University, Fort Worth, TX 76105 If a plan is being presented by a group of employers, it may be the organization, association, or committee responsible for the plan.
Plan Administrator	● Entity Name: Texas Wesleyan University ● Address: 1201 Wesleyan St, Texas Wesleyan University, Fort Worth, TX 76105 ● Attention: Genaro Martinez ● Telephone Number: 817-531-5853 The Employer is the Administrator and the named fiduciary for the group health plan and FSA for purposes of ERISA §402(a).
The Named Fiduciary for the Plan	● Kim Stergio/Genaro Martinez The named fiduciary is the individual person or persons with the authority to control and manage the operation of the plan. *(Usually someone in Benefits).*
Agent for Service of Process	● Megan Cooley The *agent for service of legal process* is the person designated by a business entity, such as a corporation, to receive legal correspondence on behalf of the business entity within the state which the agent's address is located. The person may be an officer of the corporation or a third party, such as the corporation's lawyer. If a company has not designated such a person or entity, it is the person or people with the authority to accept legal process on behalf of the company. *(Usually someone very Senior that can speak on behalf of the company).*

EIN	75-0800691
Governing State	TX
Plan Number	502
The Plan Name	Employer Salary Reduction Plan Welfare plan providing some or all of: ● Medical, Dental, and/or Vision Insurance ● Health FSA: General Purpose FSA benefits ● Health FSA: Limited Purpose FSA benefits ● Dependent Care FSA benefits
Open Enrollment Period	The period during which you have an opportunity to elect participation in the Plan by signing and returning an individual Election Record. You will be notified of the timing and duration of the Open Enrollment Period, which for a Plan Year generally will be the month before the Plan Year Begins. Please check your open enrollment materials.
Effective Date	04/01/2026
Plan Year	04/01-03/31

SECTION B: Medical, Dental, and/or Vision Insurance, Health Flexible Spending Account and Dependent Care Flexible Spending Account

This **Premium Only Plan ("POP")** is adopted for the purpose of providing employees with the opportunity to pay their medical, dental, and/or vision insurance premiums with pre-tax dollars, in accordance with the requirements of Section 125 of the Internal Revenue Code (IRC), thereby reducing their taxable income and resulting in potential tax savings.	
Election	Elections may be made for the following Premium Payment Component and you can pay premiums for the following insurance plans with pre-tax dollars: ● Medical Insurance ● Dental Insurance ● Vision Insurance
Description	The Premium Only Plan allows eligible employees to pay premiums for their group health, dental, and/or vision insurance premiums before taxes are applied. This means the amount you pay for your premiums will be deducted from your paycheck on a pre-tax basis, reducing your overall taxable income.

Eligibility	You are eligible to participate in the POP if: ● You satisfy the eligibility requirements of the Employer's group health/medical plan, thereby becoming an Eligible Employee, and thus becoming eligible to participate in the Plan.
Employee Contributions & Salary Reductions	When you enroll in the Employer's group medical, dental, and/or vision insurance plan, your share of the plan(s) premiums, if any, will be automatically deducted from your paycheck before taxes are calculated. This means the money for your premiums will be taken out before your federal income tax, Social Security, and Medicare taxes are applied, which reduces your taxable income. The amount you contribute to the POP will be based on the premiums for the medical, dental, and/or vision insurance plans and will be deducted from your pay before federal income taxes, Social Security taxes, and Medicare taxes are calculated, reducing the employee's taxable income. These deductions will not reduce the employee's wages for purposes of state and local taxes, unless required by applicable state law. Your contribution amounts will depend on the benefits you select during open enrollment or your initial eligibility period.
Tax Information	These contributions will **not** reduce your state income tax (unless required by state law). Your pre-tax contributions may also affect your eligibility for other tax benefits, such as Social Security benefits or tax deductions, so please consult with a tax advisor if you have specific questions.
Claims	The applicable insurer will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurer for a review of the denied claim. For more information about how to file a claim and for details regarding the medical, dental, and/or vision insurers' claims procedures, consult the claims procedures applicable under that plan or policy, as described in the plan document or summary plan description for the Medical, Dental and/or Vision Insurance Plan.
Legal & Compliance	Medical, Dental and/or Vision insurance are group health plans governed by ERISA.

More Information	For more information about the Premium Only Plan, including how to enroll, modify your elections, or general questions about your insurance premiums, please contact the **Human Resources** department.

	General Purpose Flexible Spending Account (GPFSA)	**Limited Purpose Flexible Spending Account (LPFSA)**
Election	The Health FSA election may be for General Purpose Health FSA Coverage.	The Health FSA election may be for Limited (Vision/Dental/Preventive Care) Health FSA Coverage.
Description	Health Flexible Spending Arrangement (Health FSA) — permits Employees to pay for their qualifying Medical Care Expenses that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called Health FSA Benefits. A Health FSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere. If you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Record with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA taxes. Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. The Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan. If you elect Health FSA Benefits, a Health FSA Account will be set up in your name to keep a record of the reimbursements that you are entitled to and the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is a recordkeeping account; it is not funded, all reimbursements are paid from the general assets of the Employer, and it does not bear interest. Note: If you elect Health FSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect an Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. If you elect a General Purpose Health FSA Coverage Option, your Spouse and your Dependents will also be ineligible to make HSA contributions. NOTE: The HRA plan pays before the Health FSA plan.	
Eligible Expenses	For purposes of the General Purpose Health FSA Coverage	You may not make/receive tax-favored contributions to your HSA if you

	Option, “Medical Care Expense” means expenses incurred by you, your Spouse, or your Dependents for “medical care” as defined in Code §213(d). For more information about what items are—and are not—Medical Care Expenses, you may refer to IRS Publication 502 (Medical and Dental Expenses). In general, you should consult legal and tax specialists to better understand your compliance obligations. You may not make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses Medical Care Expenses as described under the General-Purpose Health FSA Option.	participate in a Health FSA that reimburses Medical Care Expenses as described under the General-Purpose Health FSA Option. You may, however, be eligible to make/receive tax-favored contributions to an HSA and participate in a Health FSA if the Health FSA reimbursement is limited to Medical Care Expenses for: Services or treatments for dental care (excluding premiums); Services or treatments for vision care (excluding premiums); or Services or treatments for “preventive care.” Preventive care is defined in accordance with applicable rules and regulations under Code §223(c)(2)(C). Preventive care does not include services or treatments that treat an existing condition.
Funding Medium	The Health FSA is a group health plan governed by ERISA. Each FSA is self-funded. A third-party administrator processes claims for these Components based on direction from the Employer, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration of the FSA. There is no trust for any part of the Plan.	
Funds Availability	The full amount of Health FSA coverage that you have elected, reduced by prior reimbursements made during the same Plan Year, will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim so long as you have continued to pay the contributions. In future years, the amount of Health FSA coverage that is available to you will be increased by the amount of your carryovers, if any. Note that only reasonable quantities of prescribed over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month, even if the drugs otherwise meet the requirements for reimbursement, including that they are for medical care under Code §213(d) and have been prescribed.	
Maximum FSA Benefits for Plan Year	● $3,400 or the maximum amount per Plan Year as adjusted for any increases announced by the IRS prior to the effective date of the plan year. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen. You must pay a contribution for such	

	coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).
Minimum Election	There is no minimum election for the plan.
Employer Contributions	If you select one or more of the above benefits, you will pay all or some of the contributions; The Employer may contribute the following amount to your Health FSA per plan year: ● The Employer makes *no* contributions
Carryover	● $680 or the maximum carryover amount allowed per Plan Year as adjusted for any increases announced by the IRS prior to the effective date of the plan year. You may carry over up to the amount specified of unused funds remaining in the FSA at the end of the Plan Year to be used for eligible expenses incurred during the next Plan Year. Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and they will not count toward the maximum dollar limit on annual salary reductions under the FSA. If you are otherwise eligible for the Health FSA for a Plan Year but you do not make a Health FSA election for that Plan Year, you may still use any carryovers from the preceding Plan Year for current or preceding Plan Year Medical Care Expenses (in accordance with Plan terms). However, you must be a participant in the Health FSA as of the last day of the Plan Year to benefit from the carryover and elect the FSA in the next plan year. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless a COBRA election is made.
Grace Period	No Grace period permitted
Runout	● 90-day runout for end of plan year and terminated employees The number of days you will have after the end of the Plan Year or after you cease to be eligible as a participant in which to submit a claim for reimbursement incurred during the Plan Year. Grace periods run concurrent to runout, if both are applicable.
Claim Procedures	When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses. Typically, this requires including an Explanation of Benefits (EOB) Form from

	the medical insurance carrier (or a bill from a doctor's office) indicating the amounts that you are obligated to pay. For medicines or drugs, you must provide an EOB, prescription, or receipt with an Rx number and the name of the purchaser or patient. If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Record for a valid claim. Claims will be paid in the order in which they are approved, up to the amount you have elected for the Plan Year. You will be notified in writing if any claim for benefits is denied. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense—only for you to have incurred the expense and that it is not being paid for or reimbursed from any other source. Some expenses may be validated at the time the expense is incurred if an electronic card payment method is utilized. For other expenses, the card payment is only conditional and you will still have to submit supporting documents. You will receive more information from the Employer about what you must do to obtain reimbursement if such a system is implemented. If a participant has both an HRA and an FSA with the employer, then the FSA balance should be depleted prior to accessing the HRA funds. When using the Benefit Access Card, the same pay order will be used. If HSA also exists on the Benefit Access stacked card, then the FSA balance will be depleted first, followed by the Standard HRA balance, and lastly followed by the HSA balance. Approved claims will be reimbursed directly to the eligible employee via direct deposit to the linked bank account. No cash, check, or other forms of reimbursement are supported.
Continuation Coverage	For purposes of pre-taxing COBRA (if this applies to you) coverage for Health FSA Benefits, certain Employees may be able to continue eligibility in the Plan for a certain period. *COBRA*. COBRA coverage is a continuation of health coverage that would otherwise end because of a life event known as a “qualifying event.” See Attachment 2 (found at the end of this Summary) regarding COBRA coverage under the Health FSA Component, including when it may become available to you and your family and what you need to do to protect the right to receive it. See the booklets for the Medical, Dental, and/or Vision Insurance Plans for information about COBRA continuation coverage under those plans. Note also that for purposes of pre-taxing COBRA coverage, certain Employees may be able to continue eligibility in the Plan for certain periods—see Attachment 1 (found at the end of this Summary). *USERRA*. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the federal Uniformed Services Employment and Reemployment Rights Act (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

COBRA	COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the HDHC Plan and the HRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the HDHC Plan and the HRA Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events: • Your termination from employment or reduction of hours; • Your divorce or legal separation from your Spouse; • Your becoming eligible to receive Medicare benefits; • Your Dependent child ceasing to qualify as a Dependent. If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.
Other	*Qualified Medical Child Support Order* - The Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA §609(a). The Health FSA has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator *HEART Act Distributions for Qualified Reservists* - Certain participants meeting legal eligibility requirements may take Qualified Reservist Distributions from their Health FSA under the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act). The Plan will be administered pursuant to the HEART Act (as amended) and will permit reservists called or ordered to active duty for a period of at least 180 days (or indefinitely) to take certain distributions after the call/order and before the last day that reimbursements could be made during the plan year of the call/order. The Plan must receive a copy of the qualifying call/order prior to the distribution being made. The amount available will be the participant's elected Health FSA amount minus reimbursements made to participant, including qualifying claims incurred prior

	to the distribution, but requested after the distribution has been requested and before it has been made.
HSA Eligibility	If you elect General-Purpose Health FSA Benefits, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you elect a Limited Health FSA Coverage Option. In the event that an expense is eligible for reimbursement under both a Limited Purpose FSA and an HSA, you may seek reimbursement from either a Limited Purpose FSA or an HSA, but not both.

Dependent Care Flexible Spending Account (DCFSA)	
Description	*Dependent Care Flexible Spending Account (DCFSA)*— also sometimes called dependent care assistance program (DCAP)—permits Employees to pay for thei qualifying Dependent Care Expenses with pre-tax dollars. A DCFSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere. If you elect DCFSA Benefits, then you will be able to provide a source of pre- tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into an ElectionRecord with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA taxes. If you elect DCFSA Benefits, a “DCFSA Account” will be set up in your name to keep a record of the reimbursements that you are entitled to, and the contributions for such benefits that you have paid during the Plan Year. Your DCFSA Account is a recordkeeping account; it is not funded, all reimbursements are paid from the general assets of the Employer, and it does not bear interest.
Eligible Expenses	Dependent Care Expenses means employment-related expenses incurred on behalf of a person who meets the requirements to be a Qualifying Individual, as defined below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement: Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be: — a person under age 13 who is your qualifying child under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild, foster child, sibling or step siblings, or a descendant of one of them; and (3) not provide more than half of their own support for the year); — your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or

	— a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition). Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the child as a dependent. The expenses are incurred for services rendered after the date of your election to receive DCFSA Benefits and during the Plan Year to which the election applies. The expenses are incurred to enable you to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expenses can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day. The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual. If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least 8 hours per day in your household. If the expenses are incurred for services provided by a dependent care center—that is, a facility (including a day camp) that receives payment for providing care to more than 6 nonresident individuals on a regular basis—the center must comply with all applicable state and local laws. The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent), or a person whom you (or your Spouse) can claim as a dependent for federal income tax purposes. If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred. The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight. The expenses can be for any of the following (assuming that the other requirements for reimbursement are met): — expenses for a day camp or a similar program to care for a Qualifying Individual, even if the camp specializes in a particular activity (e.g., soccer or computers), but excluding any separate equipment or similar charges (note that summer school and tutoring program expenses don't qualify because they are considered to be primarily for education rather than for care);

	— the cost of a Qualifying Individual's transportation to or from a place where care is provided, if furnished by a dependent care provider; and — expenses such as application fees, agency fees, and deposits that relate to but are not directly for a Qualifying Individual's care, if you must pay the expenses in order to obtain the related care (expenses of this type cannot be reimbursed unless and until the related care is provided—e.g., a deposit that is forfeited because you decide to send your child to a different dependent care provider is not eligible for reimbursement). Ask the Plan Administrator if you need further information about which expenses are—and are not —likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.
Funding Medium	DCFSA is not an ERISA welfare benefit plan under ERISA. Each FSA is self-funded. A third-party administrator processes claims for these Components based on direction from the Employer, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration of the FSA. There is no trust for any part of the Plan.
Funds Availability	You specify the amount of DCFSA Benefits that you wish to pay with your salary reduction during open enrollment. That portion is deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). These portions will be credited as of each pay period. The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCFSA Account at the time of the claim, reduced by the amount of any prior reimbursements paid to you during the Plan Year.
Maximum FSA Benefits for Plan Year	• $7,500 per Plan Year if filing taxes as married filing jointly/filing individually or $3,750 if filing taxes as married filing separately (or the maximum amount as adjusted for any increases announced by the IRS prior to the effective date of the plan year)
Minimum Election	There is no minimum election for the plan
Note on Dependent Care FSA Limit	Your statutory limit is the smallest of the following amounts: - Your earned income for the calendar year (after your salary reductions under the Plan); - The earned income of your Spouse for the calendar year (your Spouse is deemed to have earned income of at least $250 ($500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care (provided that you and your Spouse have the same principal place of abode for

	more than one-half of such year), or (b) a full-time student); or - either $7,500 or $3,750 for the calendar year (or the maximum amount as adjusted for any increases announced by the IRS prior to the effective date of the plan year) , depending on your marital and tax filing status, as described further in “Maximum FSA Benefits for Plan Year”.
Employer Contributions	The Employer makes no contributions to your DCFSA.
Carryover	Carryovers are not permitted under the DCFSA.
Grace Period	No grace period permitted
Runout	● 90-day runout for end of plan year and terminated employees The number of days you will have after the end of the Plan Year or after you cease to be eligible as a participant in which to submit a claim for reimbursement incurred during the Plan Year. Grace periods run concurrent to runout, if both are applicable.
Claim Procedures	When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a DCFSA Reimbursement Request Form. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses. If there are enough credits to your DCFSA Account, you will be reimbursed for your eligible DCFSA Expenses within 30 days after the date you submitted the DCFSA Reimbursement Request Form. If a claim is for an amount larger than that remaining in your current DCFSA Account balance, then you will be reimbursed for the amount of contributions made and you will need to submit another claim as additional payroll contributions are made into the account. You cannot be reimbursed for any total expenses above your available annual credits to your DCFSA Account.
Other	You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCFSA, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit. Consult a tax advisor to determine the appropriate tax treatment of your specific circumstances. You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a DCFSA, the maximum amount that you and your Spouse together can exclude from income is $7,500

	(or the maximum amount as adjusted for any increases announced by the IRS prior to the effective date of the plan year) . No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCFSA Account.
COBRA	Not applicable
HSA Eligibility	You can elect a Dependent Care FSA and also elect HSA Benefits.

1.2 Legal Status

The Medical, Dental, and/or Vision Insurance, Health FSA Component, and the DCAP Component, if applicable as indicated in Section 1.1 above, are separate plans for purposes of administration, reporting requirements and for purposes of applicable provisions of ERISA, HIPAA, and COBRA.

This Plan is intended to qualify as a cafeteria plan under Code §125 of the Internal Revenue Code of 1986 (as amended) and the implementing and interpretive regulations issued thereunder.

- Medical, Dental, and/or Vision Insurance Benefits—permits Employees to use pre-tax funds for their share of contributions for the Medical, Dental, and/or Vision Insurance Plans.
- The Health FSA Component is intended to qualify as a self-insured medical reimbursement plan under Code §105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b).
- The DCAP Component is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

SECTION II. Definitions

2.1 Definitions

Account(s) means the benefits as defined in Section 1.1 above.

Benefits means the benefits as defined in Section 1.1 above that are offered under the Plan.

Benefit Package Option means a qualified benefit under Code §125(f) that is offered under a cafeteria plan. Benefits prohibited under Code §125(f) (such as long-term care insurance and certain Exchange- participating qualified health plans) are not permitted Benefit Package Options.

Carryover means unused amounts as defined in Section 1.1.

Change in Status means any of the events described below, as well as any other events included in subsequent changes to Code §125, or regulations or guidance issued thereunder that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under applicable law and under this Plan:

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

(b) *Number of Dependents.* Events that change a Participant'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 Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan;

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

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

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

Code means the Internal Revenue Code of 1986, as amended.

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code §132(f)(4) plan; but determined after (d) any salary deferral elections under any Code §401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, “Compensation” generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

Component(s) means one or more of the following: the medical, dental, and/or vision group health plan, the DCFSA Component or the Health FSA Components, as applicable and defined in Section 1.1.

Contributions means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured) as described in Section 1.1.

DCFSA means the component described in Section 1.1.

DCFSA Account means the account described in Section 1.1.

DCFSA Benefits has the meaning described in Section 9.1.

DCFSA Component means the component of this Plan described in Section 1.1.

Dependent means: (a) for purposes of the Health FSA Component, if applicable as defined in Section 1.1 (1) a dependent as defined in Code §105(b), (2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCFSA Component, if applicable as defined in Section 1.1, a Qualifying Individual. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order, even if the child does not meet the definition of Dependent.

Dependent Care Expenses has the meaning described in Section 1.1.

Earned Income shall have the meaning given such term in Code §129(e)(2).

Effective Date of this Plan is the date defined in Section 1.1.

Election Form means the actual or deemed paper or electronic form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following benefits as defined in Section 1.1. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions. If an interactive voice-response system or web-based program is used for enrollment, the Election Form may be maintained on an electronic database in accordance with applicable laws.

Eligible Employee means an Employee eligible to participate in this Plan, pursuant to Employer's eligibility requirements established under the Medical Insurance Plan.

Employee means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or individual classified by the Employer as an independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any self-employed individual; (d) any partner in a partnership; and (e) any more-than-2% shareholder in a

Subchapter S corporation. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

Employer means Employer, and any Related Employer that adopts this Plan with the approval of Employer.

Employment Commencement Date means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

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

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

General-Purpose Health FSA has the meaning described in Section 1.1.

Grace Period means the period as defined in Section 1.1.

Group Health Plan is a health insurance product offered by an employer, union or association to its members based on eligibility qualifications set by the employer, union, or association.

Health FSA means health flexible spending arrangement as defined in Section 1.1.

Health FSA Account means the account described in Section 1.1.

Health FSA Benefits has the meaning described in Section 1.1.

Health FSA Component means the component of this Plan described in Section 1.1.

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

High-Deductible Health Plan means the high-deductible health plan offered by the Employer as a Benefit Package. This offering, if applicable, is defined in separate documentation by your Employer.

HSA means a health savings account established under Code §223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian. Although funded by Salary Reduction under this Plan, the HSA is not part of or intended to be part of an ERISA-covered benefit plan. This offering, if applicable, is defined in separate documentation by your Employer.

HSA-Eligible Individual means an individual who is eligible to contribute to an HSA under Code §223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage

offered by the Employer.

Limited Purpose FSA has the meaning described in Section 1.1.

Medical Care Expenses has the meaning described in Section 1.1.

Medical Insurance Benefits means the Employee's Medical Insurance Plan coverage for purposes of this Plan. This offering, if applicable, is defined in separate documentation by your Employer.

Open Enrollment Period with respect to a Plan Year means the period defined in Section 1.1.

Medical, Dental, and/or Vision Insurance Plan means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents who may be eligible under the terms of such plan), providing major medical-type benefits through a group insurance policy or policies. This offering, if applicable, is defined in separate documentation by your Employer.

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Section III. Participants include (a) those who elect one or more of the Health FSA Benefits, DCAP Benefits, and Salary Reductions to pay for such Benefits (as applicable in Section 1.1).

Period of Coverage means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 1.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 1.1.

Plan means the Employer Salary Reduction Plan as set forth herein and as amended from time to time.

Plan Administrator means Employer The contact person is the Human Resources Manager for Employer, who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 1.1.

Plan Year means the calendar year (i.e., the 12-month period commencing on the date of the Establishment of the Plan in 1.1), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

The Initial Plan Year is a short plan year as defined in Section 1.1, if applicable.

Prior Plan Year DCFSA Amounts have the meaning described in Section 9.4.

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

Qualifying Dependent Care Services has the meaning described in Section 9.3.

Qualifying Individual means (a) a tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1); (b) a tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code §21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code §152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

Related Employer means any employer affiliated with Employer that, under Code §414(b), §414(c), or §414(m), is treated as a single employer with Employer for purposes of Code §125(g)(4).

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis). For clarification, Salary Reduction is calculated by dividing the Participant’s Election by the number of pay periods remaining in the plan year. The final pay period’s Salary Reduction will be adjusted up or down in cases where the exact election is not equally divisible by the number of pay periods.

Spouse means an individual who is treated as a spouse for federal tax purposes. Notwithstanding the above, for purposes of the DCFSA Component, if applicable, the term Spouse shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who is married to the Participant and files a separate federal income tax return, where (i) the Participant maintains a household that constitutes a Qualifying Individual’s principal place of abode for more than one-half of the taxable year, (ii) the Participant furnishes more than half of the cost of maintaining such household, and (iii) during the last 6 months of such taxable year, the individual is not a member of such household.

Student means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

SECTION III. Eligibility and Participation

3.1 Eligibility to Participate

When an Employee satisfies the eligibility requirements of the Employer's group health/medical plan, thereby becoming an Eligible Employee, she or he will become eligible to participate in the Plan.

3.2 Termination of Participation

An individual is no longer eligible to participate in the Plan as soon as any of the following conditions occur:

(a) the Participant ceases to be an Eligible Employee, (though that the Participant may be permitted continue to participate in those sections of this Plan subject to COBRA or similar continuation laws); or,

(b) the termination of this Plan; or,

(c) the Participant's death.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates employment and is subsequently rehired within 30 days after the date of the termination and otherwise satisfies eligibility requirements, such Participant shall be reinstated with the elections in effect at the time of the termination. If a former Participant is rehired more than 30 days following termination, the individual may make new elections upon satisfying the eligibility requirements herein.

3.4 FMLA Leaves of Absence or other Benefits Protective Leaves

(a) *Health Benefits.* Please see benefits described in the Summary Plan Document (SPD).

(b) *Non-Health Benefits.* Please see benefits described in the Summary Plan Document (SPD).**3.5 Non-FMLA Leaves of Absence**

Please see benefits described in the Summary Plan Document (SPD).

SECTION IV. Method and Timing of Elections

4.1 Elections When First Eligible

Upon first meeting the requirements to become an Eligible Employee, such Employee may elect to commence participation in one or more Benefits after the eligibility requirements have been satisfied, by completing and returning to the Plan Administrator the Election Form. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that creates an exception to this irrevocability rule and so long as the conditions for eligibility do not cease to be met.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form to each Eligible Employee. The Election Form shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. An Eligible Employee's elections are made effective by completing and returning to the Plan Administrator the Election Form before the timeframe communicated by the Employer which is prior to when participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that creates an exception to this irrevocability rule.

4.3 Irrevocability of Elections

The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his elections as described herein.

SECTION V. Benefits and Contributions

5.1 Benefits Available for Election

Participants who qualify as Eligible Employees shall have the opportunity to elect from the following Benefits and plan configurations as defined in Section 1.1.

HSA Benefits cannot be elected with Health FSA Benefits unless a Limited Purpose FSA is selected, if available as defined in Section 1.1.

In addition, a Health FSA Participant who elects the High-Deductible Health Plan option for a Plan Year is treated as automatically enrolled in the Limited Purpose FSA for that Plan Year, and unused amounts remaining in the Participant's General-Purpose Health FSA at the end of the preceding Plan Year that are available for carryover, if any, will be automatically carried over to that Limited Purpose FSA if the participant elects an FSA of at least $0 for the next plan year.

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* Please see benefits described in the Summary Plan Document (SPD).

(b) *Participant Contributions.* Participants who elect Plan Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form.

(c) *Amount of Salary Reduction.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected: (1) the annual Contributions for such Benefits, divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator. If a Participant increases his or her election under the Health FSA Component or DCAP Component, as indicated in Section 1.1., the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 12.3, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the

Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

5.3 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. No trust fund is established under this Plan by either the Employer or the Plan Administrator.

SECTION VI. Premium Payment Plans

6.1 Benefits

Notwithstanding any other provision in this Plan, the Medical, Dental and/or Vision Insurance Benefits are subject to the terms and conditions in the Medical, Dental and/or Vision Insurance documents, and no changes can be made with respect to such Medical, Dental and/or Vision Insurance under this Plan (such as midyear changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under this Component by electing to pay for his or her share of the Contributions for Medical, Dental and/or Vision Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and pay for his or her share of the Contributions, if any, for Medical, Dental and/or Vision Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Article X), such election is irrevocable for the duration of the Period of Coverage to which it relates. A Participant's Salary Reductions during a Plan Year under the Premium Payment Component may be applied by the Employer to pay the Participant's share of the Contributions for Medical, Dental and/or Vision Insurance Benefits that are provided to the Participant during the period that begins immediately following the close of that Plan Year and ends on the day that is 2 months plus 15 days following the close of that Plan Year.

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Benefits Provided Under the Medical and Dental Insurance Plans

Medical, Dental and/or Vision Insurance Benefits will be provided by the Medical, Dental and/or Vision Insurance, not this Plan. The types and amounts of Medical, Dental and/or Vision Insurance Benefits, the requirements for participating in the Medical, Dental and/or Vision Insurance Plans, and the other terms and conditions of coverage and benefits of the Medical, Dental and/or Vision Insurance Plans are set forth in the Medical, Dental and/or Vision Insurance Plans. All claims to receive benefits under the Medical, Dental and Vision Insurance Plans shall be subject to and governed by the terms and conditions of the Medical, Dental and/or Vision Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical, Dental, and Vision Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical and/or Dental Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical, Dental and/or Vision Insurance Plans the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for COBRA coverage for Medical, Dental and/or Vision Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Medical, Dental and/or Vision Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

SECTION VII. Health FSA Component

7.1 Health FSA Benefits

See definition in Section 1.1.

7.2 Contributions for Cost of Coverage of Health FSA Benefits

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant.

7.3 Eligible Medical Care Expenses for Health FSA

Under the Health FSA Component, if applicable, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force, or for which Health FSA Benefits are otherwise available as a result of a carryover as provided in Section 7.4.

(a) *Incurred.* Please see description in the Summary Plan Description (SPD).

(b) *Medical Care Expenses.* “Medical Care Expenses” will vary depending on which Health FSA coverage option the Participant has elected.

General-Purpose Health FSA. See Section 1.1 Eligible Expenses.

Limited Purpose FSA. See Section 1.1 Eligible Expenses, if applicable

7.4 Maximum Benefits for Health FSA

(a) *Maximum Reimbursement Available; Uniform Coverage.* Please see Section 1.1.

(b) *Termination of Participation.* Please see benefits described in the Summary Plan Document (SPD).

(c) *Maximum Dollar Limits.* See Section 1.1.

(d) *Carryovers or Grace Periods.* See Section 1.1.

(e) *Grace Periods.* See Section 1.1.

(f) *Employer Contributions.* See Section 1.1

(g) *Minimum Election.* See Section 1.1

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations, but it will not create a separate fund or otherwise segregate assets for this purpose. Employer is the named fiduciary for the Health FSA Component for purposes of ERISA §402(a). As a HIPAA Health Plan, the Health FSA shall be operated in accordance with HIPAA and regulations thereunder.

(a) *Crediting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited during such period with an amount equal to the Participant's Salary Reductions elected periodically to be allocated to such Account, as well as any carryovers as provided in Section 7.4, as well as any applicable Employer contributions.

(b) *Debiting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period.

(c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage and increased by any carryovers, if applicable; it is not based on the amount credited to the Health FSA Account at a particular point in time except as provided in Section 7.4(f). Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Forfeitures

(a) *Use-or-Lose Rule.* Please see benefits described in the Summary Plan Document (SPD).

7.7 Reimbursement Claims Procedure for Health FSA

(a) *Timing.* Claims for reimbursement incurred in the Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within the "Runout Period" as noted in Section 1.1. , those claims shall not be considered for reimbursement. Claims are paid in the order they are received by the administrator and substantiated under the Plan.

(b) *Substantiation*. All claims shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the "Runout" period described in Section 1.1

See details on COBRA as described in the Summary Plan Description (SPD).

7.9 Electronic Payment Cards

Participants will be required to comply with substantiation procedures established by the Plan Administrator in accordance with applicable IRS guidance regarding electronic payment card programs when paying for expenses with electronic payment cards.

(a) *Utilization of Payment Card*. Each Participant issued a card shall certify that such card shall only be used for qualified Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) *Deactivation of Card.* A Participant's card will be deactivated when participation in the Health FSA ceases or for failure to comply with the Plan's rules relating to substantiation, participation, or qualifying expenses.

(c) *Merchants; Card Use.* Card use is limited to eligible merchants as provided in applicable IRS guidance and as further identified by the Plan Administrator or its designee. The card's debit available balance will be the amount of the Participant's available reimbursement in that current plan year plus any funds available from the previous year's grace period, if applicable. Funds from the previous year's grace period will be depleted before using the current plan year's funds. . Card use does not obviate the Substantiation requirements described above. Participants must obtain and retain a bill, invoice, or other statement from the merchant describing the service or product, the date of the service or sale, and the amount of the expense.

(d) *Correction of Improper Payments.* A Participant must repay the Plan for any improper payments that are made with their cards. Improper payments may be recouped in accordance with applicable IRS guidance.

7.10 HEART Act

See Section 1.1.

SECTION VIII. Health Savings Accounts

[RESERVED]

SECTION IX. DCAP Component

9.1 DCAP Benefits

See definition in Section 1.1.

9.2 Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 1.1.

9.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) *Incurred.* Please see description in the Summary Plan Description (SPD).

(b) *Dependent Care Expenses.* See Section 1.1 Eligible Expenses.

(c) *Qualifying Dependent Care Services.* See Section 1.1 Eligible Expenses.(d) *Exclusion.* Dependent Care Expenses do not include amounts paid to individuals as described in Section 1.1 Eligible Expenses.

9.4 Maximum Benefits for DCAP

(a) *Maximum Reimbursement Available*. Please see Section 1.1 in “Other”.

(b) *Maximum Dollar Limits.* Please see Section 1.1. “Maximum FSA Benefits”.

(d) *Grace Periods.* See Section 1.1.

(e) *Employer Contributions.* See Section 1.1..

(f) *Minimum Election.* See Section 1.1.

9.5 Establishment of DCAP Account

The DCAP Component is intended to qualify as a program under Code Section 129. The Plan Administrator will establish and maintain a DCAP Account, for the purpose of keeping track of contributions and determining forfeitures, with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose.

(a) *Crediting of Accounts*. A Participant's DCAP Account will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected.

(b) *Debiting of Accounts*. A Participant's DCAP Account will be debited for any reimbursement of Dependent Care Expenses incurred during such period.

(c) *Available Amount Is Based on Credited Amount.* The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's Account, less any prior reimbursements for Dependent Care Expenses incurred during the Plan Year.

9.6 Forfeitures

Please see benefits described in the Summary Plan Document (SPD)

9.7 Reimbursement Claims Procedure for DCAP

(a) *Timing.* Claims for reimbursement incurred in the Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within the “Runout Period” as noted in Section 1.1., those claims shall not be considered for reimbursement. Claims are paid in the order they are received by the administrator and substantiated under the Plan.

(b) *Substantiation*. All claims shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall follow established regulatory rules and review the nature and date of the Expenses, the amount, the name of the person, organization, or entity to whom the Expense was or is to be paid, and the Participant’s certification that the Expense has not been and will not be otherwise reimbursed. All charges shall be conditional pending confirmation and substantiation.

9.8 Report to DCAP Participants

On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the DCAP Component, as the Plan Administrator deems appropriate.

9.9 Electronic Payment Cards

Participants will be required to comply with substantiation procedures established by the Plan Administrator in accordance with applicable IRS guidance regarding electronic payment card programs when paying for expenses with electronic payment cards.

(a) *Utilization of Payment Card*. Each Participant issued a card shall certify that such card shall only be used for qualified expenses. The Participant shall also certify that any DCAP Expense paid with the card has not already been reimbursed by any other plan covering childcare reimbursement benefits and that the Participant will not seek reimbursement from any other such plan.

(b) *Deactivation of Card.* A Participant's card will be deactivated when participation in the DCAP ceases or for failure to comply with the Plan's rules relating to substantiation, participation, or qualifying expenses.

(c) *Merchants; Card Use.* Card use is limited to eligible merchants as provided in applicable IRS guidance and as further identified by the Plan Administrator or its designee. The card's debit available balance will be limited to the amount of the Participant's available reimbursement in that current plan year plus any funds available from the previous year's grace period, if applicable. Funds from the previous year's grace period will be depleted before using the current plan year's funds. Card use does not obviate the Substantiation requirements described above. Participants must obtain and retain a bill, invoice, or other statement from the merchant describing the service or product, the date of the service or sale, and the amount of the expense.

(d) *Correction of Improper Payments.* A Participant must repay the Plan for any improper payments that are made with their cards. Improper payments may be recouped in accordance with applicable IRS guidance.

SECTION X. Irrevocability of Elections; Exceptions

10.1 Irrevocability of Elections

A Participant's elections under the Plan are irrevocable for the duration of the Period of Coverage to which it relates unless an exception applies.

10.2 Procedure for Making New Elections If An Exception Applies

(a) *Timeframe for Making New Elections.* Except for changes where a different timeline is proscribed by statute, a Participant may make a new election within 30 days of a qualifying event if the new election is made consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury. A Change in Status that results in a beneficiary becoming ineligible for coverage under the Medical and/or Dental Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant.

(b) *Effective Date of New Election.* Elections made pursuant to this Section shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change.

(c) *Special Enrollment Rights.* Notwithstanding subsection (a), a Participant may make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

10.3 Qualifying Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable component(s) of this Plan:

Key:

E = Elect new, different, or no coverage	T= coverage will be terminated
U= update elections consistent with change	N = not eligible for changes

	Health FSA/LPFSA	**DCAP**
Open Enrollment	E	E
Termination of Employment	T	T
Leaves of Absence	U	U
Change in Status	U	U
Loss of Eligibility for Spouse or Dependent	U	U
New COBRA eligibility of Participant, Spouse, or Dependent	U	T
New coverage for Participant, Spouse, or Dependent	U	U
Court orders, including QMCSO, that specify requirements to add, change, or drop coverage	U	U
Medicare or Medicaid enrollment, other than coverage consisting solely of pediatric vaccine benefits	U	U
Significant reduction in coverage constituting a loss of coverage, as determined by the plan administrator	U	U
Significant reduction in coverage without a loss of coverage, as determined by the plan administrator	U	N
Addition or significant improvement to benefits offering, as determined by the plan administrator	U	N
Cessation of coverage under a different group health plan	U	N

for Participant, Spouse, or Dependent		
Significant cost change to Participant's coverage, as determined by the plan administrator	U	N
Insignificant cost change to Participant's coverage, as determined by the plan administrator	N	N

Notes:

- Health FSA Election Changes (if applicable as indicated in Section 1.1.) Election changes can be made to reduce Health FSA coverage, but it may not be made to reduce Health FSA coverage to less than the amount spent or already contributed to the Health FSA. Coverage can be reduced due to one of the following must occur to reduce coverage due to the occurrence of any of the following: death of a Spouse, legal change in marital status; death of a Dependent; Medicare or Medicaid enrollment (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act) or, Participant and/or Dependent becoming ineligible for Health FSA coverage. Such cancellations take effect only after total contributions for the Plan Year are made to cover costs reimbursed by the Plan for the Plan Year.

- Dependent Care FSA Election Changes (if applicable as indicated in Section 1.1.) With respect to the DCAP Benefits, a Participant may change or terminate an election, but not less than the amount spent or already contributed to the DCAP, if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129. A DCAP change in status may include the Participant replacing one dependent care service provider with a different provider at a different cost, which would allow a prospective change based on the adjusted cost.

- A "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, a network ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an annual or lifetime limitation). The Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat other occurrences as a Loss of Coverage.

- Participants are required to increase their elective contributions (by increasing Salary Reductions) to cover insignificant increases in their required contribution for their elections, and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

10.4 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of

Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

SECTION XI. Appeals Procedure

11.1 Procedure If Benefits Are Denied Under This Plan

If a claim for benefits under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the Summary Plan Description (SPD) for this Plan.

SECTION XII. Recordkeeping and Administration

12.1 Plan Administrator

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

12.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

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

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

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

(e) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

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

(g) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

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

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

12.3 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

12.4 Inability to Locate Payee

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

12.5 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code §125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

SECTION XIII. General Provisions

13.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 and Section 9.6 if applicable, and then by the Employer.

13.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time.

13.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan (including any Component) at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

13.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the state in Section 1.1., to the extent not superseded by the Code, ERISA, or any other federal law.

13.5 Compliance With Code, ERISA, and Other Applicable Laws

It is intended that this Plan meets all applicable requirements of the Code and ERISA and of all regulations issued thereunder. (ERISA applies to the Health FSA Component but not the DCAP Component as applicable.) This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

13.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

13.7 Indemnification of Employer

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

13.8 Non-Assignability of Rights

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

13.9 Severability

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

This document is executed this _____ day of _____, 2026.

Employer

By: Donna S. Nance Digitally signed by Donna S. Nance Date: 2026.07.21 12:02:40 -05'00'

Title:_____