BASIC PLAN DOCUMENT #125

UNIVERSITY OF SOUTHERN INDIANA CAFETERIA PLAN

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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

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

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) Heath 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

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

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.

(s) Enrollment of related individual(s) in a Qualified Health Plan. If the Adoption Agreement permits Participants to revoke an election of coverage under a group health plan due to enrollment of a family member in a qualified health plan offered through a Marketplace established under section 1311 of the Patient Protection and Affordable Care Act, the following conditions must be met:

(1) One or more related individuals to the Participant are eligible for a special enrollment period to enroll in a qualified health plan through the Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or one or more already-covered related individuals to the Participant seeks to enroll in a qualified health plan through a marketplace during the Marketplace's open enrollment period; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the related individual or related individuals of the Participant in a qualified health plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked. If the Participant does not enroll in a qualified health plan through the Marketplace, the Participant must elect self-only

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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 (as indexed) 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 as indexed (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 CARRYOVER 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 for the subsequent Plan Year, he or she may elect (or may be deemed by the Plan Administrator to have elected) as of the last day of the Plan Year (the "Conversion Date") to carryover the balance in his or her General Purpose Health FSA to an available HSA-Compatible Health FSA for the subsequent Plan Year if so elected in the Adoption Agreement. An HSA-Compatible Health FSA cannot 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

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.

(b) Contributions. A Participant's HSA-Compatible Health FSA will be 4 361.97 Tm0 G Pu03.

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), (iv) incurred for dental or vision care or for preventive care (as defined under Code section 223(c)(2)(C), and (v) incurred for telehealth services as defined in Code section 223(c)(2)(E); provided that BT/F1 11.16 Tf1 0 0 1 12

(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

Section 8.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Dependent Care

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 th

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

(a) Period for Reimbursement.The Plan Administrator shall direct the reimbursement from a

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 Nonelective 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.

(h) Carryover of Unused PTOTo 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.

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

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"

(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.

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

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

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:-6(o)00000912 0 612 5c300000s she Cla

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

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 I

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 transm