AMAZON.COM

SECTION 125 PLAN

As Amended and Restated Effective April 1, 2016
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ARTICLE I. INTRODUCTION

1.1 Restatement of the Plan

Amazon Corporate LLC hereby amends and restates the Amazon.com Section 125 Plan (the “Plan”) as set forth herein, effective as of April 1, 2016 (“Effective Date”). The Plan was originally effective September 15, 1997 and was sponsored by Amazon.com, Inc. This sponsorship subsequently transferred to Amazon Corporate LLC effective as of January 1, 2001.

The Plan is designed to permit an eligible Employee to pay on a pre-tax Salary Reduction basis for his or her share of Contributions under the Qualified Benefit Plan, and to contribute on a pre-tax Salary Reduction basis to an Employee's health savings account (HSA), to an account for reimbursement of certain Health Care Expenses (Health FSA Account), and to an account for reimbursement of certain Dependent Care Expenses (DCAP Account).

1.2 Legal Status

The Plan is intended to qualify as a “cafeteria plan” under Section 125 of the Internal Revenue Code of 1986, as amended (the “Code”), and regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA Component of the Plan is intended to qualify as a “self-insured medical reimbursement plan” under Code Section 105, and the Health Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b). The DCAP Component is intended to qualify under Code Section 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 129(a).

Although reprinted within this document, the Health FSA Component and the DCAP Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of ERISA and COBRA. The HSA funding feature described in the HSA Component is not intended to establish an ERISA plan or to otherwise be part of an ERISA benefit plan. In the event that the Health FSA Component is determined not to be a separate plan, the Plan shall be designated as a hybrid entity for purposes of HIPAA, such that it shall be a covered entity only with respect to the Health FSA Component.
ARTICLE II. DEFINITIONS

2.1 Definitions

“Account(s)” means the Health FSA Account and the DCAP Account, described in Section 6.5 for Health FSAs and Section 7.5 for DCAPs. In some contexts, the term Account(s) may also include the record of HSA Contributions described in Section 8.3.

“Benefits” means the Premium Payment, the Health FSA, the DCAP, and the HSA Benefits offered under the Plan.

“Benefit Package Option” means a qualified benefit under Code Section 125(f) that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan (such as an indemnity option, an EPO option or a PPO option under an accident or health plan).

“Board” means the Board of Directors of Amazon Corporate LLC.

“Change in Status” has the meaning described in Section 9.3.

“Claims Administrator” shall be the Plan Administrator or its designee.

“COBRA” means the health care continuation provision of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.


“Compensation” means the wages, salary and other cash compensation paid to an Employee by the Employer, determined before (a) any amount withheld from the Employee's pay pursuant to a Salary Reduction election under this Plan, (b) any amounts withheld from the Employee's pay pursuant to a compensation reduction election under any other Code Section 125 cafeteria plan, and (c) any amounts withheld from an Employee's pay pursuant to a Code Section 132(f)(4) plan (qualified transportation fringe benefits); but determined after (d) any salary deferral elections under Code Sections 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” means the Premium Payment Component, the Health FSA Component, the DCAP Component or the HSA Component.

“Contributions” means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 5.2 for Premium Payment Benefits, Section 6.2 for Health FSA Benefits, Section 7.2 for DCAP Benefits and Section 8.2 for HSA Benefits.

“DCAP” means dependent care assistance program.
“DCAP Account” means the account described in Section 7.5.

“DCAP Benefits” has the meaning described in Section 7.1.

“DCAP Component” means the Component of the Plan described in Article VII.

“Dependent” means (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component and for purposes of the Health FSA Component), (1) a dependent is defined as in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; (2) any child (as defined in Code Section 152(f)(1) of the Participant who has not attained age 26; and (3) any child to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCAP Component, a dependent means a Qualifying Individual as defined in Section 7.3. Notwithstanding the foregoing, the Health FSA Component of the Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of “Dependent.”

“Dependent Care Expenses” has the meaning described in Section 7.3.

“Earned Income” means all income derived from wages, salaries, tips, self-employment and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned Income does not include (a) any amounts received pursuant to any dependent care assistance program under Code Section 129, or (b) any amounts excluded from earned income under Code Section 32(c)(2), such as any amounts received as a pension or annuity and any amounts received pursuant to workers' compensation.

“Effective Date” of the Plan has the meaning described in Section 1.1.

“Employee” means an individual classified by the Employer as its common-law employee and on the Employer's W-2 payroll, excluding: (a) any such employee regularly scheduled to work less than 20 hours per week; (b) any such employee classified by the Employer as “in-house temporary staffing,” “regular part-time Class Q,” “temporary” or “seasonal” except that such an employee shall be an Employee for purposes of the Premium Payment Component of the Plan; (c) any employee of a Related Company not participating in the Plan (as listed in Appendix B); (d) any individual who is not treated by the Employer as an employee for payroll tax purposes at the time he or she performs services for the Employer (including those individuals paid by a temporary or other staffing agency or classified as independent contractors), whether or not such individual is subsequently determined by a government agency, by the conclusion or settlement of threatened or pending litigation, or otherwise to be or have been a common-law employee of the Employer during such period; (e) any leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)); (f) an employee not on the U.S. payroll of the Employer; (g) any such employee who is a nonresident alien with no U.S.-source income (within the
meaning of Code Section 911(d)(2)); and (h) any employee who is included in a unit of employees covered by a collective bargaining agreement.

“Employer” means Amazon Corporate LLC and any Related Employer not identified in Appendix B. However, for purposes of Articles VII and XII and Section 13.3, and elsewhere based on the context, “Employer” means only Amazon Corporate LLC.

“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.


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

“Grace Period” means the period that begins immediately following the close of a Plan Year and ends on the day that is two months following the close of that Plan Year.

“Health Care Expenses” has the meaning defined in Section 6.3.

“Health FSA Account” means the account described in Section 6.5.

“Health FSA Benefits” means the benefits described in Section 6.1.

“Health FSA Component” means the component of the Plan providing the Health FSA Benefits, as described in Article VI. The Health FSA Component is also known as the “Health FSA Plan.”

“High Deductible Health Plan” means the high deductible health plan offered by the Employer as a Benefit Package Option that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials provided separately by the Employer.

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

“HRA” means a health reimbursement arrangement as defined in IRS Notice 2002-45.

“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. Even though funded by Salary Reduction under this Plan, the HSA is not part of or intended to be part of an ERISA-covered benefit plan.

“HSA Benefits” has the meaning described in Section 8.1.

“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.
“Medical Benefit Plan” means the major medical plan or other group health plan components listed in Appendix A that the Employer maintains for its Employees (and for their eligible Spouses and Dependents) through a group insurance policy or policies (including EPOs, PPOs and other arrangements) or on a self-insured basis.

“Open Enrollment Period” with respect to a Plan Year means the period preceding such Plan Year prescribed by the Plan Administrator (which period must end prior to the beginning of the relevant Plan Year).

“Participant” means an eligible Employee who is participating in the Plan in accordance with the provisions of Article III. Participants include eligible Employees who elect one or more of the Qualified Benefits, Health FSA Benefits, DCAP Benefits, HSA Benefits, and Salary Reductions to pay for such Benefits.

“Period of Coverage” means the Plan Year, except that: (a) for Employees who first become eligible to participate, it means the portion of the Plan Year following the date participation commences as described in Section 3.2; and (b) for Employees who terminate participation, it means the portion of the Plan Year preceding the date participation terminates as described in Section 3.3.

“Plan” means the Amazon.com Section 125 Plan set forth herein and as amended from time to time.

“Plan Administrator” means Amazon Corporate LLC.

“Plan Year” means the period from April 1 to March 31, and each 12-consecutive-month period beginning with April 1 thereafter. Records of the Plan shall be established and maintained on the basis of the Plan Year.

“Premium Payment Benefits” means the benefits described in Section 5.1.

“Premium Payment Component” means the component providing the Premium Payment Benefits, as described in Article V.

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

“Qualified Benefit” means any benefit set forth in Appendix A and excluded from the Employee’s taxable income under Chapter 1 of the Code (other than Code Sections 106(b), 117, 124, 127 or 132) and any other benefit permitted by IRS Regulations (i.e., any group term life insurance coverage that is includible in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Section 79). Long-term care insurance shall not be a Qualified Benefit hereunder.

“Qualified Benefit Plan” means the major medical, dental, or vision plan or other plans listed in Appendix A that the Employer maintains for its Employees (and for their eligible Spouses and Dependents) and includes plans providing major medical type benefits through a
group insurance policy or policies (including EPOs, PPOs and other arrangements) or on a self-insured basis, which plan or plans qualify as an accident or health plan under Code Section 106. The Employer may substitute, add, subtract or revise at any time the menu of such plans and/or the benefits, and the terms and conditions of any such plans or policies. Any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference under the Plan.

“Qualifying Dependent Care Services” has the meaning described in Section 7.3.

“Qualifying Individual” has the meaning described in Section 7.3.

“Related Employer” means any employer affiliated with Amazon Corporate LLC that, under Code Sections 414(b), 414(c), or 414(m), is treated as a single employer with Amazon Corporate LLC for purposes of Code Section 125(g)(4).

“Salary Reduction” means the amount by which a Participant's Compensation is reduced and applied by the Employer under the 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).

“Salary Reduction Agreement” means the form provided by the Plan Administrator for the purpose of allowing an eligible Employee to participate in the Plan by electing Salary Reductions to pay for Premium Payment Benefits, Health FSA Benefits, DCAP Benefits, and/or HSA Benefits. It includes an agreement pursuant to which an eligible Employee or Participant authorizes the Employer to make Salary Reductions. For purposes of this definition, an online election will constitute an agreement.

“Spouse” means an individual who is legally married to a Participant as determined by applicable state law (and who is treated as a spouse under the Code). Notwithstanding the foregoing, for purposes of the DCAP Component, the term “Spouse” shall not include (a) an individual who is legally separated from the Participant under a divorce or separate maintenance decree, or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate principal residence from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant. For purposes of the Plan, “Spouse” does not include a domestic partner.

“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 a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.
ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

Only Employees are eligible to participate in the Plan. An Employee shall become eligible to participate in the Plan as of the first day he or she becomes eligible under any component under the Qualified Benefit Plan to the extent contributions may be made on a pre-tax basis for such component. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the Qualified Benefit Plan. To participate in the HSA Component, the individual must be an HSA-Eligible Individual and shall also be subject to the additional requirements, if any, specified in the High Deductible Health Plan.

3.2 Election to Participate; Commencement of Participation

(a) Election When First Eligible. A new eligible Employee who first becomes eligible to participate in the Plan in the middle of a Plan Year pursuant to Section 3.1 may commence participation by submitting a Salary Reduction Agreement to the Plan Administrator within 30 calendar days of becoming eligible to participate. If a Salary Reduction Agreement is timely filed, participation will commence as of the first day the individual became an Employee. An Employee who first becomes eligible to participate under the look-back measurement method may commence participation by submitting a Salary Reduction Agreement to the Plan Administrator before the end of the applicable administrative period. If timely filed, participation will commence as of the first day of the applicable stability period.

(b) Elections During Open Enrollment Period. During the Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide a Salary Reduction Agreement to each Employee who is eligible to participate in the Plan. The Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of the Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the benefits elected. The Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period. If an eligible Employee makes an election to participate during an Open Enrollment Period, then the Employee becomes a Participant on the first day of the next Plan Year. The Salary Reduction Agreement may be provided electronically.

(c) Eligible Employee Who Fails to File a Salary Reduction Agreement. If an eligible Employee fails to file a Salary Reduction Agreement within the time frame described in Section 3.2(a) or (b), as applicable, then the Employee may not elect to participate in the Plan until the next Open Enrollment Period unless an event occurs that would justify an earlier mid-year election change as described in Article IX.

(d) Irrevocability of Elections. Unless an exception applies as described in Article VIII or Article IX, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

(e) Prohibition on Certain Elections and Election Changes. Notwithstanding any other provision of the Plan, other than this Section 3.2(e), no new elections and no election
changes may be made during the period of March 1 through March 31 of any Plan Year, except
new elections and election changes as provided under the HIPAA Special Enrollment provisions
of Section 9.4 and as may be permitted during the Open Enrollment Period for coverage in the
next Plan Year.

3.3 Termination of Participation

A Participant will cease to be a Participant in the Plan upon the earlier of:

- the date a Participant ceases to be an eligible Employee (except to the extent the
  Participant is eligible for and timely elects COBRA continuation coverage with
  respect to the Health FSA only);

- the expiration of the Period of Coverage for which the Participant has elected to
  participate (unless during the Open Enrollment Period for the next Plan Year the
  Participant elects or is deemed to elect to continue participating);

- the termination of the Plan;

- the date on which COBRA continuation coverage terminates, if such coverage
  was elected with respect to Health FSA Benefits, as described in Section 6.8 (but
  not beyond the end of the current Plan Year); or

- the date the Participant revokes his or her election to participate under a
  circumstance when such change is permitted under the terms of the Plan.

Termination of a Participant's participation in this Plan will automatically revoke the
Participant's elections and terminate the Qualified Benefits as of the date specified in the
Qualified Benefit Plan. Reimbursements from a Participant's Health FSA Account or DCAP
Account after the Participant's participation terminates will be made pursuant to Sections 6.8 and
7.8, respectively. Distributions from a Participant's HSA (whether before or after termination of
employment) and all other matters relating to a Participant's HSA are outside of this Plan and are
to be handled by the Participant and his or her trustee/custodian in accordance with the
agreement between them.

3.4 Participation Following Termination of Employment

A former Participant who is rehired within 31 calendar days of the date on which his or
her employment previously terminated will be reinstated with the same elections that such
individual had before termination. A former Participant who is rehired more than 31 calendar
days following termination of employment and who is otherwise eligible to participate in the
Plan pursuant to Section 3.1 may make new elections as a new hire, as described in
Section 3.2(a). Notwithstanding the foregoing, an election to participate in the Premium
Payment Component of the Plan will be reinstated only to the extent that coverage under the
Qualified Benefit Plan is reinstated. Likewise, an HSA Benefit election will only be reinstated if
an individual is an HSA-Eligible Individual.
3.5 FMLA Leaves of Absence

(a) Health Benefits. Notwithstanding any provision herein to the contrary, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Benefits under the Qualified Benefit Plans, the Health FSA Plan, and the HSA Component on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the premium for such coverage.

(i) Paid Leave Concurrent with FMLA. The Employer offers paid leaves of absence in certain circumstances, including: Maternity Leave (pre- and post-partum) and Parental Leave. The Employer may require Participants to continue participation in the Qualified Benefit Plan and the Health FSA Plan while they are on paid FMLA leave (provided Participants on paid non-FMLA leave are required to continue such benefits). If the Employer chooses to continue such benefits, then the Participant's share of the premiums for such Benefits shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis if that is the method used for paid non-FMLA leave).

(ii) Unpaid FMLA Leave. In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Benefits under the Qualified Benefit Plan and the Health FSA Plan during the leave to the extent required by FMLA. If the Participant elects to continue coverage while on leave, then the Participant may pay his or her share of the premium for such coverage in one of the following ways:

- by prepaying all or a portion of the premium for the expected duration of the leave on a pre-tax salary reduction basis from any taxable Compensation (including unused sick days or vacation days). Premiums may also be pre-paid on an after-tax basis. To prepay the premium, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available; provided, however, that pre-tax dollars may not be used to fund coverage during the next Plan Year;

- by paying the premium on an after-tax basis (or on a pre-tax basis to the extent that the payments are made from taxable Compensation (e.g., from unused sick days and vacation days)) on the same schedule as payments would have been made if the Participant were not on leave or under any other payment schedule permitted by Labor Regulations 29 C.F.R. 825.210(c) (e.g., on the same schedule as payments are made under Code Section 4980B (relating to COBRA continuation coverage), under the Employer's existing rules for payment by Employees on leave without pay, or under any other system voluntarily agreed to between the Employer and the Participant that is not inconsistent with this Section 3.5 or Labor Regulations 29 C.F.R. 825.210(c)); or
• under another arrangement agreed on between the Participant and the Plan Administrator (e.g., the Employer may fund coverage during the leave and withhold “catch-up” amounts upon the Participant's return).

If the Employer requires all Participants to continue participation in Qualified Benefit Plans and the Health FSA Plan during an unpaid FMLA leave, a Participant may elect to discontinue payment of the Participant's required premiums until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the premiums associated with the Qualified Benefit Plans not paid by the Participant during the leave. Upon returning from leave, the Participant will also be required to repay the premiums associated with the Health FSA Plan not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or an after-tax basis, as may be agreed upon by the Plan Administrator and the Participant.

If a Participant's coverage under the Qualified Benefit Plans or the Health FSA Plan ceases while on FMLA leave (e.g., for nonpayment of required contributions), then the Participant will be permitted to reenter the Qualified Benefit Plans or Health FSA Plan, as applicable, upon return from such leave on the same basis the Participant was participating in the Plans prior to the leave, or as otherwise required by the FMLA. Participants whose Qualified Benefit Plans or Health FSA Plan coverage terminated during the leave are entitled to be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. Notwithstanding the preceding sentence, with regard to the Health FSA Plan, a Participant whose coverage ceased will be entitled to elect whether to be reinstated in the Health FSA Plan at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from the Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Plan Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, entitlement to non-health benefits, such as DCAP Benefits, shall be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.6. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the premiums not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation on either a pre-tax or an after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.6 Non-FMLA Leaves of Absence

(a) Paid Non-FMLA Leave. The Employer offers paid leaves of absence in certain circumstances, including: Maternity Leave (pre- and post-partum) and Parental Leave. The Employer may require Participants to continue participation in the Qualified Benefit Plan and the Health FSA Plan while they are on paid leave. If the Employer chooses to continue such
benefits, then the Participant's share of the premiums for such Benefits shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis if that is the method used for paid non-FMLA leave).

(b) Unpaid Non-FMLA Leave. The employer offers unpaid leaves of absence in certain circumstances, including: Personal Leave of Absence (PLOA) and Medical Leave of Absence (Medical LOA). If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant shall continue to participate and the Contributions due for the Participant shall be paid by pre-payment before going on leave, by after-tax contributions while on leave or with catch-up contributions after the leave ends, as shall be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, the election change rules in Section 9.3 shall apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

3.7 USERRA Leaves of Absence

Notwithstanding any provision herein to the contrary, if a Participant goes on a qualifying leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), then to the extent required by USERRA, the Employer will continue to maintain the Participant's Qualified Benefits, Health FSA Benefits, and/or HSA Benefits on the same terms and conditions as if the Participant were still an active Employee. Entitlement to other Benefits shall be determined by the Employer's policy for providing such Benefits when the Participant is on other types of leave, as described above.

ARTICLE IV. BENEFITS OFFERED AND FUNDING

4.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Section 3.2, Participants shall be given the opportunity to elect one or more of the following Benefits:

(a) Premium Payment Benefits, as described in Article V;

(b) Health FSA Benefits, as described in Article VI;

(c) DCAP Benefits, as described in Article VII; or

(d) HSA Benefits, as described in Article VIII.

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

4.2 Employer and Participant Contributions

(a) Employer Contributions. For Participants who elect Premium Payment Benefits, the Employer shall contribute a portion of the premium as provided in the open enrollment
materials furnished to Employees or on the Salary Reduction Agreement. There are no Employer contributions for Health FSA Benefits, or DCAP Benefits.

(b) Participant Contributions. Participants who elect Benefits shall pay their share of the cost of that coverage on a pre-tax Salary Reduction basis by completing a Salary Reduction Agreement.

4.3 Using Salary Reductions to Make Contributions

(a) Salary Reductions per Pay Period. The Salary Reduction for a pay period for a Participant is, for the Benefits elected, (1) an amount equal to the Plan Year Contribution for such Benefits (as described in Section 5.2 for Premium Payment Benefits, Section 6.2 for Health FSA Benefits, Section 7.2 for DCAP Benefits and Section 8.2 for HSA 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 (i.e., in the event of a shortage of reducible Compensation, amounts withheld may fluctuate). If a Participant increases his or her election under the Health FSA Component, the DCAP Component, or the HSA Component as otherwise permitted under this Plan, then the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Article IX, less the Salary Reductions made prior to such election change, divided by the number of pay periods remaining 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 (i.e., in the event of a shortage of reducible Compensation, amounts withheld may fluctuate).

(b) Considered Employer Contributions. Salary Reductions are applied by the Employer to pay for the Participant's share of the premiums for the Premium Payment Benefits, the Health FSA Benefits, the DCAP Benefits and the HSA Benefits elected by the Participant, and, for purposes of the Plan and the Code, are considered to be Employer contributions.

(c) Salary Reduction Balance Upon Termination of Coverage. If, as of the date that any elected coverage under the Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

4.4 Funding

All of the amounts payable under the Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy, if any. Nothing herein shall be construed to require the Employer to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under the Plan may be made. HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis.
There is no trust or other fund from which benefits are paid. While the Employer has complete responsibility for the payment of benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an outside paying agent to make benefit payments on its behalf.

The maximum contributions that may be made under the Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant contributions for Premium Payment Benefits, as described in Section 5.2, and (b) as described in Sections 6.4(b), 7.4(b) and 8.2 for Health FSA Benefits, DCAP Benefits and HSA Benefits, respectively.

ARTICLE V. PREMIUM PAYMENT COMPONENT

5.1 Benefits

An eligible Employee can elect to participate in the Premium Payment Component of the Plan by electing to pay for his or her share of the Contributions under the Qualified Benefit Plan with pre-tax Salary Reductions. Unless an exception applies as described in Article IX, an eligible Employee's election to participate or not to participate in the Premium Payment Component is irrevocable for the duration of the Period of Coverage to which it relates.

5.2 Contributions for Cost of Coverage

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

5.3 Qualified Benefits Provided Under the Qualified Benefit Plan

Qualified Benefits will be provided by the applicable Qualified Benefit Plan, not by this Plan. The types and amounts of Qualified Benefits, the requirements for participating in the Qualified Benefit Plan, and the other terms and conditions of coverage and benefits of the Qualified Benefit Plan are set forth in the Qualified Benefit Plan documents. All claims to receive benefits under the Qualified Benefit Plan shall be subject to and governed by the terms and conditions of the applicable Qualified Benefit Plan, and the rules, regulations, policies and procedures from time to time adopted in accordance therewith.

5.4 Qualified 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 Qualified Benefit Plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Qualified Benefit Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Qualified Benefits shall be paid on an after-tax basis.
ARTICLE VI. HEALTH FSA COMPONENT

6.1 Health FSA Benefits

An eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Health Care Expenses from the Health FSA (“Health FSA Benefits”), and (b) to pay the Contribution for such Benefits with pre-tax Salary Reductions. Unless an exception applies as described in Article IX, such election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 Contributions for Cost of Coverage of Health FSA Benefits

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

6.3 Eligible Health Care Expenses

Under the Health FSA Component, a Participant may receive reimbursement for Health Care Expenses incurred during a Period of Coverage for which an election is in force. In addition, certain individuals may receive reimbursement for Health Care Expenses incurred during a Grace Period from amounts remaining in their Health FSA Accounts for that Plan Year in accordance with Section 6.4(e).

(a) Incurred. A Health Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) Health Care Expenses. “Health Care Expenses” means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code Section 213(d); provided, however, that this term does not include expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Qualified Benefit Plan, other insurance, or any other accident or health plan. If only a portion of a Health Care Expense has been reimbursed elsewhere (e.g., because the Qualified Benefit Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VI. Notwithstanding the foregoing, the terms Health Care Expenses does not include the following:

i. Premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether sponsored by Employer or not);

ii. Medicines or drugs, unless the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin (for this purpose, the Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug and whether the requirement of a prescription has been satisfied);
iii. Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, “cosmetic surgery” means any procedure that is directed at improving a patient’s appearance that does not meaningfully promote the proper function of the body or prevent or treat illness or disease); or

iv. Any other expense otherwise excluded under the terms of this Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Health Care Expenses and may limit reimbursement of expenses described in such procedures.

6.4 Maximum and Minimum Benefits

(a) Maximum Reimbursement Available; Uniform Coverage. Reimbursement for Health Care Expenses of the maximum dollar amount elected by the Participant for a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 6.5. Notwithstanding the foregoing, no reimbursements shall be available for expenses incurred after coverage under the Health FSA Component has terminated, unless the Participant has elected COBRA continuation coverage as provided in Section 6.8. Payment shall be made to the Participant in cash as reimbursement for Health Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VI have been complied with.

(b) Maximum and Minimum Dollar Limits. Subject to Section 6.4(c), the maximum benefit amount that a Participant may elect to receive under the Plan in the form of reimbursements for Health Care Expenses incurred in any Period of Coverage for each Plan Year shall be $2,550. The minimum benefit amount under the Health FSA Component is $120. Reimbursements due for Health Care Expenses incurred by the Participant's Spouse or Dependents shall be attributed to the Participant, and charged against the Participant's Health FSA Account.

(c) Changes; No Proration. The Plan Administrator may change the maximum and minimum amounts for any Period of Coverage without the need to amend the Plan; provided that the maximum dollar limit shall not exceed the maximum amount permitted under Code Section 125(i). Any such changes shall be communicated to Employees through the Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year, or wishes to increase an election mid-year as permitted under Section 9.4, the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable. The Plan Year maximum will not be prorated. Notwithstanding the foregoing, the Plan Administrator may limit the elections of a Participant who is terminated and rehired during the same Plan Year to the extent necessary to comply with the requirements of Code Section 125(h).
(d) **Effect on Maximum Benefits if Election Change Permitted.** Any change in an election under Article IX affecting Plan Year contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions made by the Participant (if any) as of the end of the portion of the Period of Coverage immediately preceding the election change, to (2) the total contributions scheduled to be made by the Participant during the remainder of the Period of Coverage to the Participant's Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 3.5 for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) **Grace Periods; Special Rules for Claims Incurred During a Grace Period.** Notwithstanding any contrary provision in this Plan and subject to the conditions of Section 6.4(b), an individual may be reimbursed for Health Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA Account at the end of the Plan Year to which that Grace Period relates (“Prior Plan Year Health FSA Amounts”) if he or she is either: (1) a Participant with Health FSA coverage that is in effect on the last day of that Plan Year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

- Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.

- Health Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 6.7 will be reimbursed first from any available Prior Plan Year Health FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Health Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year Health FSA Amounts if the card is unavailable for such reimbursement. An individual’s Prior Plan Year Health FSA Amounts will be debited for any reimbursement of Health Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Health FSA Amounts.

- Claims for reimbursement of Health Care Expenses incurred during a Grace Period must be submitted no later than the end of the third month following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health FSA Amounts. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these
amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 6.6(b).

(f) Monthly Limits on Reimbursing OTC Drugs. Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant’s Health FSA Account in a single calendar month (even assuming that the drug otherwise meets the requirements of this Article VI, including that it has been prescribed (unless it is insulin) and is for medical care under Code Section 213(d)); stockpiling is not permitted.

6.5 Establishment of Accounts

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant who has elected to participate in the Health FSA Component of the Plan, but will not create a separate fund or otherwise segregate assets for this purpose. The Accounts so established will be merely recordkeeping accounts with the purpose of keeping track of contributions and determining forfeitures under Section 6.6.

(a) Crediting of Accounts. A Participant's Health FSA Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected by the Participant to be allocated to the Account.

(b) Debiting of Accounts. A Participant's Health FSA Account will be debited during each Plan Year for any reimbursement of Health Care Expenses incurred during the Period of Coverage or for reimbursement of Health Care Expenses incurred during any Grace Period to which he or she is entitled as provided in Section 6.4(e).

(c) Available Amount Not Based on Credited Amount. As described in Section 6.4(a), the amount available for reimbursement of Health Care Expenses is the Participant's Plan Year benefit amount, reduced by prior reimbursements during the Period of Coverage; it is not based on the amount credited to the Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Period of Coverage, but any such negative amount shall never exceed the dollar amount of Health FSA Benefits elected by the Participant for such Period of Coverage.

6.6 Forfeiture of Accounts; Use-It-or-Lose-It Rule

(a) Use-It-or-Lose-It Rule. Except as otherwise provided in Section 6.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) Use of Forfeitures. All forfeitures under the Plan shall be used as follows: (1) to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to any Participant in excess of
the Contributions paid by such Participant through Salary Reductions; (2) to reduce the Employer's cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be appropriately documented by the Plan Administrator); (3) to provide increased benefits or compensation to Participants in subsequent years in any fashion that the Plan Administrator deems appropriate, consistent with applicable regulations; and/or (4) in any other manner consistent with the Code Section 125 regulations and ERISA. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Health Care Expense was incurred shall be forfeited and applied as described above.

6.7 Reimbursement Claims Procedure for Health FSA

(a) Applying for Reimbursements. A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Claims Administrator in such form as the Claims Administrator may prescribe, by the end of the third month following the close of the Plan Year in which the Health Care Expenses were incurred, setting forth:

- the person or persons on whose behalf the Health Care Expenses have been incurred;
- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source; and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The application must be accompanied by bills, invoices or other statements from an independent third party showing the amounts of such expenses, together with any additional documentation that the Claims Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement are at least $5. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

(b) Timing of Reimbursement. The Employer will reimburse the Participant for his or her Health Care Expenses as soon as administratively practicable after the Claims Administrator approves the Participant's reimbursement request, pursuant to Section 10.1(a).
(c) **Appeals.** If the Claims Administrator denies (in whole or in part) a Participant's reimbursement request, the Participant may appeal such denial as provided in Section 10.1(b).

### 6.8 Reimbursements After Termination; COBRA

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements. Except as otherwise provided in Section 6.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), the Participant will not be able to receive reimbursements for Health Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Health Care Expenses incurred prior to termination, provided that the Participant (or the Participant's estate) files a claim by the end of the Grace Period following the end of the Plan Year.

Notwithstanding any provision herein to the contrary, to the extent required by COBRA, a Participant and the Participant's Spouse and Dependents, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event, shall be given the opportunity to continue coverage under the Health FSA Component on a self-pay basis for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 6.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). The Plan Administrator shall notify individuals who are eligible for COBRA continuation coverage of their right to elect such coverage. If COBRA continuation coverage is elected, it will be available only for the year in which the COBRA qualifying event occurs; such COBRA continuation coverage for the Health FSA Component will cease at the end of such Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis.

### 6.9 Named Fiduciary

The Employer is the named fiduciary for the Health FSA Component for purposes of ERISA Section 402(a).

### 6.10 Compliance with Laws

Health FSA Benefits shall be provided in compliance with ERISA, COBRA, HIPAA and all other applicable laws.

### 6.11 Coordination of Benefits

Health FSA Benefits are intended to pay benefits solely for Health Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA Account shall not be considered to be a group health plan for coordination of benefits purposes, and Health

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FSA Benefits shall not be taken into account when determining benefits payable under any other plan. If the Employer offers an HRA, then in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the HRA must pay first. Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, the Participant may choose to seek reimbursement from either the Health FSA or the HSA, but not both.

6.12 Electronic Payment Cards

If the Employer allows the Health FSA to be accessed by an electronic payment card (e.g., debit card, credit card, or similar arrangement), 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. In addition, the following provisions shall apply:

(a) **Initial and Periodic Certification.** Before receiving an electronic payment card, a Participant must certify that he or she will only use the card to pay for Health Care Expenses, will not use the card for expenses that have already been reimbursed, will not seek reimbursement under any other health plan for expenses paid for with the card, and will acquire and keep sufficient documentation (see subsection (d) below) for expenses paid with the card. The Participant must also agree to abide by any other the terms and conditions of the card program as set forth herein and in any cardholder agreement issued in conjunction with the card, including but not limited to payment of any fees for participation in the card program and the Plan’s right to recoup improper card payments by withholding amounts from Compensation and offsetting against other Health FSA claims. The Participant must reaffirm these agreements during each subsequent Open Enrollment Period in order for the card to remain activated. In addition, these agreements are reaffirmed each time the Participant uses the card. Failure to abide by these agreements may result in deactivation of the card.

(b) **Deactivation of Card.** A Participant’s card will be deactivated when participation in the Health FSA ceases or at other times as set forth herein (e.g., for failure to comply with the Plan’s substantiation and recoupment procedures). A Participant whose card has been deactivated must request reimbursement for Health Care Expenses through other methods (e.g., by submitting paper claims).

(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 balance (or credit limit, as applicable) must be limited to the amount of the Participant’s available reimbursement as described in Section 6.4. Each time the card is swiped, the Participant certifies to the Plan that the expense for which payment under the Health FSA is being made is a Health Care Expense that has not already been reimbursed from another source and that reimbursement for the expense will not be sought from another source. Use of a card to pay for a service or product is not considered to be a claim for benefits under the Plan; a claim does not arise until a paper or electronic reimbursement request is submitted.
(d) **Documentation.** For each expense that is paid with the card, the Participant 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. The documentation must be retained until the close of the Plan Year following the Plan Year in which the card transaction occurred. If the Participant is asked to provide the documentation to the Plan, he or she must do so within the period specified in the request. A Participant who is unable to provide adequate or timely substantiation upon request from the Plan must repay the Plan for the unsubstantiated expense. In addition, the Participant’s card may be deactivated.

(e) **Correction of Improper Payments.** Participants 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. If the Plan is unable to recoup an improper payment, the Employer will treat the payment as it would treat any other business indebtedness. If the debt is not collected and the Employer forgives the indebtedness, the payment will be treated as wages in the year in which the indebtedness was forgiven.

**ARTICLE VII. DCAP COMPONENT**

7.1 **DCAP Benefits**

An eligible Employee can elect to participate in the DCAP Component by electing (a) to receive benefits in the form of reimbursements for Dependent Care Expenses, and (b) to pay the Contributions for such benefits with pre-tax Salary Reductions. Unless an exception applies as described in IX, such election is irrevocable for the duration of the Period of Coverage to which it relates.

7.2 **Contributions for Cost of Coverage for DCAP Benefits**

The Plan Year Contribution for a Participant's DCAP Benefits is equal to the Plan Year benefit amount elected by the Participant subject to the dollar limits set forth in Section 7.4.

7.3 **Eligible Dependent Care Expenses**

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

(a) **Incurred.** A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense are furnished, and not when the Participant is formally billed for, charged for, or pays for the Qualifying Dependent Care Services.

(b) **Dependent Care Expenses.** “Dependent Care Expenses” are expenses that are considered to be employment-related expenses under Code Section 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the eligible Employee to obtain Qualifying Dependent Care Services; provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent
Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.

(c) **Qualifying Individual.** “Qualifying Individual” means:

- a tax dependent of the Participant as defined in Code Section 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code Section 152(a)(1);

- a tax dependent of the Participant as defined in Code Section 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

- 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 Section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code Section 152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

(d) **Qualifying Dependent Care Services.** “Qualifying Dependent Care Services” means the following: services that both (1) relate to the care of a Qualifying Individual that enables the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed:

- in the Participant's home; or

- outside the Participant's home for (1) the care of the Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility on a regular basis and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(e) **Exclusion.** Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant or his or her Spouse;

- a Participant's Spouse;

- a Participant's child (as defined in Code Section 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or
• a parent of a Participant's under age 13 qualifying child (as defined in Code Section 152(a)(1)).

7.4 Maximum and Minimum Benefits

(a) Maximum Reimbursement Available. Reimbursement for Dependent Care Expenses incurred during a Period of Coverage shall not exceed the balance in the Participant's DCAP Account as of the date of reimbursement (i.e., the year-to-date amount that has been withheld from the Participant's Compensation for DCAP Benefits for the Period of Coverage, less any Dependent Care Expense reimbursements previously paid to the Participant for such Period of Coverage). Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied. Notwithstanding the foregoing, no reimbursement otherwise due to a Participant hereunder shall be made to the extent such reimbursement, when combined with the total amount of Dependent Care Expense reimbursements made to date for the calendar year, would exceed the smallest of:

• the Participant's Earned Income for the calendar year;

• the Earned Income of the Participant's Spouse for the calendar year (a Spouse of a Participant who (1) is not employed during a month in which the Participant incurs Dependent Care Expenses, and (2) is either incapacitated or a Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or

• $5,000 if one of the following applies:

  (i) the Participant is married and files a joint federal income tax return;

  (ii) the Participant is married, files a separate federal income tax return and meets the following conditions; (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP Component); (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or

  (iii) the Participant is single or is the head of the household for federal income tax purposes.

• $2,500 if the Participant is married and resides with the Spouse, but files a separate federal income tax return.
• $1,600 if the Participant is a highly compensated employee as defined by Code Section 414(q), the maximum eligible reimbursement may vary as determined by the Plan Administrator from time to time and communicated to Employees as permitted in Section 7.4(c), below.

(b) Maximum and Minimum Dollar Limits. Subject to Section 7.4(a) and 7.4(c), the maximum benefit amount that a Participant may elect to receive under the Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage for each Plan Year shall be $5,000 ($2,500 in the case of a married Participant who files a separate return). The minimum Plan Year benefit amount under the DCAP Component is $120.

(c) Changes; No Proration. The Plan Administrator may change the maximum and minimum amounts for any Period of Coverage without the need to amend the Plan. Any such changes shall be communicated to Employees through the Salary Reduction Agreement or another document. If a Participant enters the DCAP Component mid-year, or wishes to increase an election mid-year as permitted under Section 9.3, the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable. The Plan Year maximum will not be prorated.

(d) Effect on Maximum Benefits if Election Change Permitted. Any change in an election under Article IX affecting Plan Year contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change, as further limited by Section 7.4(a). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the amount of the contributions made by the Participant (if any) for Dependent Care Benefits as of the end of the portion of the Period of Coverage immediately preceding the election change, to (2) the total contributions scheduled to be made by the Participant during the remainder of the Period of Coverage to the DCAP Account, reduced by (3) any reimbursements during the Period of Coverage.

7.5 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component of the Plan, but will not create a separate fund or otherwise segregate assets for this purpose. The Accounts so established will be merely recordkeeping accounts with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) Crediting of Accounts. A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected by Participants to be allocated to the Account.

(b) Debiting of Accounts. A Participant's DCAP Account will be debited during each Plan Year for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.
(c) **Available Amount is Based on Account Balance.** As described in Section 7.4(a), the amount available for reimbursement of Dependent Care Expenses shall not exceed the year-to-date amount withheld from the Participant's Compensation for reimbursement of Dependent Care Expenses, reduced by prior reimbursements during the Period of Coverage; it is based on the amount credited to the Account at a particular point in time. Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

### 7.6 Forfeiture of Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under the Plan shall be used as follows: (1) to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing DCAP Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; (2) to reduce the Employer's cost of administering the Plan during the Plan Year (all such administrative costs shall be appropriately documented by the Plan Administrator); (3) to provide increased benefits or compensation to Participants in subsequent years in any fashion that the Plan Administrator deems appropriate, consistent with applicable regulations; and/or (4) in any other manner consistent with the Code Section 125 regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

### 7.7 Reimbursement Procedure

(a) **Applying for Reimbursements.** A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Claims Administrator in such form as the Claims Administrator may prescribe by the end of the third month following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

- the person or persons on whose behalf the Dependent Care Expenses have been incurred;
- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the expense was or is to be paid, and the taxpayer identification number (Social Security number, if an individual) of such person, organization or entity;
- a statement that such expenses have not otherwise been paid and are not expected to be paid through any other source;
• the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant; and

• other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application must be accompanied by bills, invoices, or other statements from an independent third party showing the amounts of such Dependent Care Expenses, together with any additional documentation that the Claims Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement are at least $5.

(b) **Timing of Reimbursement.** The Employer will reimburse the Participant for his or her Dependent Care Expenses as soon as administratively practicable after the Claims Administrator approves the Participant's reimbursement request, pursuant to Section 10.1(a).

(c) **Appeals.** If the Claims Administrator denies (in whole or in part) a Participant's reimbursement request, the Participant may appeal such denial as provided in Section 10.1(b).

7.8 **Reimbursements From DCAP After Termination of Participation**

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant (or the Participant's estate) files a claim by the end of the Grace Period following the end of the Plan Year.

7.9 **Participant Report**

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.

**ARTICLE VIII. HSA COMPONENT**

8.1 **HSA Benefits**

An Eligible Employee can elect to participate in the HSA Component by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's HSA established and
maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited. This funding feature constitutes the HSA Benefits offered under this Plan. As described in Article IX, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed if administratively feasible or, if not administratively feasible, the first day of the subsequent calendar month.

HSA Benefits cannot be elected with Health FSA Benefits. In addition, a Participant who has an election for Health FSA Benefits that is in effect on the last day of a Plan Year cannot elect HSA Benefits for any of the first two calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA Account is $0 as of the last day of that Plan Year.

8.2 Contributions for Cost of Coverage for HSA; Maximum Limits

The annual Contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant, but in no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the Contribution is made ($3,350 for single and $6,750 for family are the statutory maximum amounts for 2016).

An additional catch-up Contribution of $1,000 may be made for Participants who are age 55 or older.

In addition, the maximum annual Contribution shall be reduced by any matching (or other) Employer Contribution made on Participant's behalf.

8.3 Recording Contributions for HSA

As described in Section 8.5, the HSA is not an employer-sponsored employee benefit plan; instead, it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The Employer may, however, limit the number of HSA providers to which it will forward contributions that the Employee makes via pre-tax Salary Reductions. Any list of HSA providers to which the Employer will forward contributions is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in a HSA.

8.4 Tax Treatment of HSA Contributions and Distributions

The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code § 223.
8.5 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan

HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefit plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of “qualified eligible medical expenses” as set forth in Code § 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

ARTICLE IX. IRREVOCABILITY OF ELECTIONS; EXCEPTIONS

9.1 Irrevocability of Elections

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

- participation in the Plan;
- Salary Reduction amounts; or
- election of particular component plan benefits.

However, as described further in Section 9.5, an election to make a Contribution to an HSA can be changed at any time on a prospective basis.

9.2 Procedure for Making New Elections

(a) Timing of New Elections. A Participant (or an eligible Employee who, when first eligible under Section 3.2(a) or during the Open Enrollment Period under Section 3.2(b), declined to become a Participant) may make a new election within 60 calendar days of the occurrence of an event described in Section 9.4, but only if the new election is made on account of and is consistent with the event and is not otherwise prohibited under Section 3.2(e) or any other provision of this Plan.

(b) Effective Date of New Election. Elections made pursuant to this Section 9.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows a further election change. Except as provided in Section 9.4(e) for HIPAA special enrollment rights in the event of birth, adoption or placement for adoption, all
election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the date the Participant files his or her new Salary Reduction Agreement with the Plan Administrator or the date of the event permitting the election change, if later, but, as determined by the Plan Administrator, may become effective later to the extent the coverage in the applicable Qualified Benefit commences later).

(c) Effect of New Election Upon Amount of Benefits. Sections 6.4 and 7.4 describe the effect of an election change on the maximum and minimum benefits under the Health FSA Component and the DCAP Component, respectively.

9.3 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 9.4, including a Change in Status, for the applicable Component. “Change in Status” means any of the events described below, as well as any other events included under subsequent changes to Code Section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations 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 or 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 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 benefit plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly paid, union to non-union, or full-time to part-time (or vice versa), with the consequences that the employee ceases to be eligible for the 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.
9.4 Events Permitting Election Changes Other than for HSA Benefits

A Participant may change an election as described below upon the occurrence of the stated event for the applicable component of the Plan. Any election change pursuant to this Section 9.4 must be made in accordance with the procedures described in Section 9.2.

(a) Open Enrollment Period (Applies to Premium Payment Benefits, Health FSA Benefits and DCAP Benefits). A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2(b).

(b) Termination of Employment (Applies to Premium Payment Benefits, Health FSA Benefits and DCAP Benefits). A Participant's elections under the Plan will terminate upon the termination of the Participant's employment in accordance with Sections 3.3 and 3.4, as applicable.

(c) FMLA (Applies to Premium Payment Benefits, Health FSA Benefits, and DCAP Benefits). A Participant may change his or her election upon a FMLA leave in accordance with Section 3.5.

(d) Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits and DCAP Benefits). A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 9.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the employer of the Participant's Spouse or Dependent (referred to as the general consistency requirement). A Change in Status that affects eligibility under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse or Dependents) who may benefit from the coverage.

Notwithstanding the foregoing, cancellation or reduction of Health FSA coverage will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

The Plan Administrator, in its sole discretion and on a uniform and nondiscriminatory basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming the general consistency requirement is satisfied, a requested change must also satisfy the following specific consistency requirements for a Participant to be able to alter his or her election based on the specified Change of Status.

(1) Loss of Spouse or Dependent Eligibility. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (i) the Spouse involved in the divorce, annulment,
or legal separation, (ii) the deceased Spouse or Dependent, or (iii) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

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

(3) **Special Consistency Rule for DCAP Component.** The Participant may change or terminate his or her election under the DCAP Component upon a Change of Status only if: (i) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the DCAP Component; or (ii) the election change or termination is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion available under Code Section 129.

(e) **HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, but not to Health FSA Benefits or DCAP Benefits).** If a Participant or a Participant's Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by Code Section 9801(f), then the Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such special enrollment rights. A HIPAA special enrollment right will arise in the following circumstances:

(1) A Participant or the Participant's Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage under another group health plan and eligibility for such coverage is subsequently lost because: (i) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (ii) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or
(2) A new Dependent is acquired as a result of marriage, birth, adoption or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment right attributable to the birth, adoption or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 60 days).

(3) A Participant or his or her Dependent:

(A) was covered under a Medicaid or State child health plan under and coverage under such plan was terminated as a result of loss of eligibility for such coverage, provided that the Participant requests coverage under the Plan not later than 60 days after the date of termination of such coverage; or

(B) becomes eligible for assistance with respect to coverage under the Plan under a Medicaid or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), provided that the Participant requests coverage under the Plan not later than 60 days after the date the Participant or his or her Dependent is determined to be eligible for such assistance.

For purposes of this Section 9.4(e), the term “loss of eligibility” includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an EPO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and in the case of EPO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Certain Judgments, Decrees and Orders (Applies to Premium Payment Benefits and Health FSA Benefits, but not to DCAP Benefits). If a judgment, decree or order (an “Order”) resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may (1) change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage), or (2) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.
(g) Medicare and Medicaid (Applies to Premium Payment Benefits and Health FSA Benefits, but not to DCAP Benefits). If a Participant or a Participant's Spouse or Dependent who is enrolled in an accident or health benefit under the Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the accident or health coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant may reduce, cancel, commence or increase his or her Health FSA Benefits, as applicable. Further, if a Participant or a Participant's Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant may commence, increase, cancel or reduce, as applicable, coverage under the Health FSA Component.

(h) Change in Cost (Applies to Premium Payment Benefits and DCAP Benefits, but not to Health FSA Benefits). For purposes of this Section 0.4(h), “similar coverage” means coverage for the same category of benefits for the same individual(s) (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (i) a health flexible spending account is not similar coverage with respect to an accident or health plan that is not a health flexible spending account, (ii) an EPO and a PPO are considered to be similar coverage, and (iii) coverage by another employer, such as the Spouse's or Dependents employer, is treated as similar coverage.

(1) Automatic Increase or Decrease for Insignificant Cost Changes. If the Participant's share of the premium for a Qualified Benefit Plan increases or decreases during a Period of Coverage by an insignificant amount, then the Salary Reductions under each affected Participant's election shall be prospectively increased or decreased to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease in affected Employees' Salary Reduction Contributions. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease in cost is “insignificant” based on all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change.

(2) Significant Cost Increases. If the Participant's cost for a Qualified Benefit significantly increases during a Period of Coverage, the Participant may (i) make a corresponding prospective increase or decrease in his or her Salary Reduction contributions, (ii) revoke his or her election for that Qualified Benefit and, in lieu thereof, receive on a prospective basis coverage under another Qualified Benefit that provides similar coverage, or (iii) drop coverage prospectively if there is no other Qualified Benefit available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and whether a substitute Benefits Package Option constitutes “similar coverage.”
(3) **Significant Cost Decreases.** If the Participant's cost for a Benefit Package Option significantly decreases during a Period of Coverage, the Plan Administrator may permit the following election changes: (i) Participants enrolled in such coverage may make a corresponding prospective decrease in his or her Salary Reduction contributions; (ii) Participants who are enrolled in a Qualified Benefit other than the Qualified Benefit that has decreased in cost may change their elections on a prospective basis to elect the Qualified Benefit that has decreased in cost; and (iii) Employees who are otherwise eligible under Section 3.1 may elect the Qualified Benefit that has decreased in cost on a prospective basis, subject to the terms and limitations of the Qualified Benefit. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a cost decrease is significant and whether a substitute Benefits Package Option constitutes “similar coverage.”

(4) **Limitation on Change in Cost Provisions for DCAP Component.** The above “Change in Cost” provisions apply to the DCAP Component only if the cost change is imposed by a dependent care provider who is not a “relative” of the employee. For this purpose, a relative is an individual who is related as described in Code Sections 152(a)(1) through (8), incorporating the rules of Code Sections 152(b)(1) and (2).

(i) **Change in Coverage (Applies to Premium Payment Benefits and DCAP Benefits, but not to Health FSA Benefits).** The definition of “similar coverage” under Section 9.4(h) also applies to this Section 9.4(i).

(1) **Significant Curtailment or Cessation of Coverage.** If coverage under a Qualified Benefit is “significantly curtailed” (as defined below) during a Period of Coverage, but the coverage curtailment does not result in a “loss of coverage” (as defined below), an affected Participant may revoke his or her election for the affected coverage, and in lieu thereof, elect prospective coverage under another Qualified Benefit that provides similar coverage. If the coverage curtailment results in a “loss of coverage” (as defined below) during the Period of Coverage, an affected Participant may revoke his or her election for the affected coverage, and may either (i) elect prospective coverage under another Qualified Benefit that provides similar coverage, or (ii) drop coverage if no other Qualified Benefit providing similar coverage is offered by the Employer. Coverage under a plan is deemed “significantly curtailed” only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally. A “loss of coverage” means a complete loss of coverage under a Qualified Benefit (including the elimination of a Qualified Benefit, an EPO ceasing to be available where a Participant or a Participant's Spouse or Dependent resides, or a Participant or a Participant's Spouse or Dependent losing all coverage under the Qualified Benefit by reason of an overall lifetime or Plan Year limitation). In addition, the Plan Administrator, in its sole discretion and on a uniform and consistent basis, may treat the following as a loss of coverage:
• a substantial decrease in the medical care providers available under a Qualified Benefit (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a PPO or an EPO);

• a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or the Participant's Spouse or Dependent is currently in a course of treatment; or

• any other similar fundamental loss of coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is “significant” or a “loss of coverage” has occurred.

(2) Addition or Significant Improvement of a Qualified Benefit. If during a Period of Coverage the Plan adds a new Benefits Package Option or significantly improves an existing Qualified Benefit, the Plan Administrator may permit the following election changes: (i) Participants who are enrolled in a Qualified Benefit other than the newly added or significantly improved Qualified Benefit may change their election on a prospective basis to elect the newly added or significantly improved Qualified Benefit; and (ii) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Qualified Benefit on a prospective basis, subject to the terms and limitations of the Qualified Benefit. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether there has been an addition of, or a significant improvement in, a Qualified Benefit.

(3) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or the Participant's Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including, but not limited to, the following: a state children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code 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, subject to the terms and limitations of the applicable Benefits Package Option(s).

(4) Change in Coverage Under Another Employer's Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under another employer's plan (including a plan of the Employer or a plan of the Participant's Spouse's or Dependent's employer), so long as (i) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations, or
(ii) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the other employer plan.

(5) **DCAP Benefits.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in dependent care service providers. For example, (i) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider, and (ii) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

(j) **Additional Election Changes Pursuant to IRS Notice 2014-55 (Applies to Premium Payment Benefits for Medical Benefit Plan coverage only).** Notwithstanding any other provision of the Plan to the contrary, the following additional election changes shall be permitted beginning on April 1, 2015:

(1) An employee who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Medical Benefit Plan coverage, provided that the employee (i) requests the election change within the Plan’s election period and (ii) certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the Medical Benefit Plan coverage is revoked.

(2) An employee who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Medical Benefit Plan coverage, provided that the employee (i) requests the election change within the Plan’s election period and (ii) certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Medical Benefit Plan coverage.

Election changes made pursuant to this Section 9.4(j) will become effective no earlier than the first day of the next calendar month following the date that the election change request is filed (as determined by the Plan Administrator, election changes may become effective later to
the extent that the other coverage commences later), and shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event recognized under IRS regulations or other guidance allows for a further election change. Election changes under this Section 9.4(j) shall be further subject to the terms and conditions of the Medical Benefit Plan and shall not be permitted unless a corresponding change is allowed under that plan (i.e., to drop Medical Benefit Plan coverage for the employee or related individuals during the Plan Year).

9.5 Election Modifications for HSA Benefits

As set forth in Section 9.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election change shall be effective no later than the first day of the next calendar month following the date that the election change was filed, if administratively feasible or, if not administratively feasible, the first day of the subsequent calendar month. No Benefit Package Option election changes can occur as a result of a change in HSA election except as otherwise described in this Article IX. For example, a Participant generally would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described in Section 9.4 for Health FSAs otherwise applied. A Participant entitled to change an election as described in this Section 9.5 must do so in accordance with the procedures described in Section 9.2.

9.6 Election Modifications Required by Plan Administrator

(a) Qualified Status of Plan. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions (including Salary Reductions for HSA Benefits) 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 the 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 the Plan, or (d) satisfy any of the Code's 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 until the defect is corrected.

(b) Mistakes. The Plan Administrator may, at any time, retroactively amend or allow an eligible Employee to retroactively change an election due to an administrative, arithmetic, data entry, clerical or other mistake; provided the Plan Administrator can reasonably determine that there is clear and convincing evidence of such mistake. Such clear and convincing evidence may be met by the Employee's providing facts to establish that it is “impossible” for such Employee to benefit from the mistaken election (e.g., mistakenly selected DCAP Benefits when the Employee in fact has no children). In addition to clear and convincing evidence, (1) the Employee must provide a sworn statement as to the nature of the mistake and intended election; (2) all requests to change such mistakes must be made within 90 days of the first payroll period for which the election takes effect; (3) the Employee must keep the mistake and correction
confidential; and (4) the Employee may not make any further corrections for three Plan Years following the Plan Year in which the mistake was corrected.

**ARTICLE X. CLAIMS PROCEDURE**

**10.1 Reimbursement Benefits Claim Review**

(a) Initial Claims. Claims for Premium Payment Benefits, Health FSA Benefits, DCAP Benefits or HSA Benefits (e.g., the right to pay insurance premiums or make HSA contributions with pre-tax dollars or the right to make election changes due to a Change in Status) must be filed in writing with the Claims Administrator in a timely manner. The Claims Administrator may prescribe a form or forms for filing such claims, and, if it does so, a claim will not be deemed properly filed unless such form is used, but the Claims Administrator shall provide a copy of such form to any person whose claim for Benefits is improper solely for this reason.

Claims that are properly filed will be reviewed by the Claims Administrator, which will make its decision with respect to such claim and notify the claimant, or his or her designated representative (the “Claimant”), in writing of such decision within 90 days (30 days in the case of a claim related to Health FSA Benefits) after the Claims Administrator receipt of the written claim, provided that the 90-day period (30-day period in the case of a claim related to Health FSA Benefits) can be extended for up to an additional 90 days (15 days in the case of a claim related to Health FSA Benefits) if the Claims Administrator (1) determines that the extension is necessary due to matters beyond the control of the Plan, and (2) notifies the Claimant in writing, prior to the expiration of the original 90-day period (30-day period in the case of a claim related to Health FSA Benefits), of the extension, the reasons therefor, and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Claims related to Health FSA Benefits shall be subject to such additional procedures as are specified in 29 C.F.R. 2560.503-1 for post-service claims under group health plans.

If the claim is wholly or partially denied, the written response to the Claimant shall include:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provisions on which the denial is based;
3. A description of any additional material or information necessary for the Claimant to perfect his or her claim and an explanation why such material or information is necessary;
4. A description of the Plan's claim appeal procedure (and the time limits applicable thereto), as set forth in Section 10.1(b), including, in the case of a claim for Health FSA Benefits, a statement of the Claimant's right to bring a civil action...
under Section 502(a) of ERISA following an adverse determination (i.e., a denial) on appeal; and

(5) In the case of a denial related to Health FSA Benefits:

(A) if an internal rule, guideline, protocol or other similar criterion was relied upon in deciding to deny the claim, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or similar criterion was relied upon in deciding to deny the claim and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request; or

(B) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment supporting the denial, 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.

(b) Appealing Denied Reimbursement Benefit Claims. If a claim for Health FSA Benefits or DCAP Benefits is denied in whole or in part, the Claimant may appeal such denial by filing a written appeal with the Claims Administrator within 60 days (180 days in the case of a claim for Health FSA Benefits) of receiving written notice that the claim has been denied. Such written request for appeal should include:

(1) A statement of the grounds on which the appeal is based;
(2) Reference to the specific Plan provisions which support the claim;
(3) The reason(s) or argument(s) why the Claimant believes the claim should be granted and evidence supporting each reason or argument; and
(4) Any comments, documents, records or other information relating to the claim that the Claimant wishes to include.

The Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant (within the meaning of 29 C.F.R. 2560.503-1(m)(8)) to his or her claim.

Any appeal will be considered by the Claims Administrator, which will make its decision with respect thereto, and notify the Claimant in writing of such decision, within 60 days after the Claim Administrator's receipt of the written appeal; provided that with respect to appeals related to DCAP Benefits, the 60-day period can be extended for up to an additional 60 days if the Claims Administrator determines that special circumstances require an extension of time to process the appeal and the Claimant is notified in writing of the extension, and the reasons therefor, prior to the commencement of the extension. Appeals related to Health FSA Benefits shall be subject to such additional procedures as are specified in 29 C.F.R. 2560.503-1 for the review of post-service claim denials under group health plans.
In considering any appeal, the Claims Administrator (1) will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the Claims Administrator initial determination, and (2) will not afford deference to the Claims Administrator initial denial.

In the event the claim is denied on appeal, the written denial will include:

(1) The specific reason or reasons for the denial;

(2) Reference to the specific Plan provisions on which the denial is based;

(3) In the case of a denial related to Health FSA Benefits, a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (within the meaning of 29 C.F.R. 2560.503-1(m)(8)) to his or her claim;

(4) In the case of a denial related to Health FSA Benefits, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA; and

(5) In the case of a denial related to Health FSA Benefits:

   (A) if an internal rule, guideline, protocol or other similar criterion was relied upon in deciding to deny the claim, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or similar criterion was relied upon in deciding to deny the claim and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request;

   (B) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment supporting the denial, 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; and

   (C) the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or your State insurance regulatory agency.”

(c) Statute of Limitation and Standard of Review. A Claimant may not bring an action under Section 502(a) of ERISA or otherwise with respect to his or her claim until he or she has exhausted the foregoing procedure. Any such action must be filed in a court of competent jurisdiction within 180 days after the date on which the Claimant receives the Committee's written denial of the Claimant's claim on appeal or it shall be forever barred. Any further review, judicial or otherwise, of the Claims Administrator's decision on the Claimant's claim will be limited to whether, in the particular instance, the Claims Administrator abused its...
discretion. In no event will such further review, judicial or otherwise, be on a de novo basis, as the Claims Administrator has discretionary authority to determine eligibility for benefits and to construe and interpret the terms of the Plan to the extent necessary to make benefit determinations.

10.2 Claims Procedures for Qualified Benefits

Except as noted herein with respect to the Premium Payment Benefits, Health FSA Benefits, DCAP Benefits, and HSA Benefits, Claims and reimbursements for Qualified Benefits shall be administered in accordance with the claims procedures for the applicable Qualified Benefit, as set forth in the plan documents or summary plan description for the applicable Qualified Benefit Plan.

ARTICLE XI. HIPAA PROVISIONS FOR HEALTH FSA

11.1 General

As a HIPAA Health Plan, the Health FSA shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

11.2 Definitions

For purposes of this Article, the following definitions shall apply:

(a) “Breach” shall mean the acquisition, access, use, or disclosure of an individual’s PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan determines there is a low probability that the PHI has been compromised. A Breach does not include: (1) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement, and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) “Breach Notification Rule” means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(c) “Electronic Protected Health Information” or “Electronic PHI” means PHI that is transmitted by or maintained in electronic media.

(d) “Health Care Operations” is as defined under 45 CFR §160.501.
(e) “HIPAA Health Plan,” as defined under 45 CFR §160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR §160.103.

(f) “Payment” is as defined under 45 CFR §160.501, and means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(g) “Privacy Policy” means the Employer HIPAA Privacy Policy.

(h) “Privacy Rule” means the regulations issued under HIPAA set forth in subpart E of 45 CFR Part 164.

(i) “Protected Health Information” or “PHI” means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care to a Participant, Spouse, or Dependent, or payment for such health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant, Spouse, or Dependent; and (3) is received or created by or on behalf of the Health FSA.

(j) “Responsible Employee” means an employee (including a contract, temporary, or leased employee) of the Health FSA or of the Employer whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the employee will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 11.3. A Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates or receives PHI on behalf of a Health FSA, even though the employee’s duties do not (or are not expected to) include creating or receiving PHI. Responsible Employees are within the Employer’s HIPAA firewall when they perform Health FSA functions.

(k) “Security Incident,” as defined under 45 CFR §164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.


11.3 Responsible Employees

Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a Health FSA. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health FSA administration functions that the Employer performs on behalf of a Health FSA pursuant to Section 11.4.
(a) Employer employees who perform the following functions on behalf of the Health FSA are Responsible Employees: (1) claims determination and processing functions; (2) Health FSA vendor relations functions; (3) benefits education and information functions; (4) Health FSA administration activities; (5) legal department activities; (6) Health FSA compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions.

(b) In addition to those individuals described in subsection (a), the Health FSA HIPAA privacy officer and security official, and Employer employees to whom the Health FSA HIPAA privacy officer and security official have delegated any of the following responsibilities, shall also be Responsible Employees: (1) implementation, interpretation, and amendment of the Privacy Policy; (2) Privacy Rule, Breach Notification Rule, or Security Rule training for Employer employees; (3) investigation of and response to complaints by Participants, Spouses, Dependents, and/or employees; (4) preparation, maintenance, and distribution of the health FSA’s privacy notice; (5) response to requests by Participants, Spouses, or Dependents to inspect or copy PHI; (6) response to requests by Participants, Spouses, or Dependents to restrict the use or disclosure of their PHI; (7) response to requests by Participants, Spouses, or Dependents to receive communications of their PHI by alternate means or in an alternate manner; (8) amendment and response to requests to amend the PHI of Participants, Spouses, or Dependents; (9) response to requests by Participants, Spouses, or Dependents for an accounting of disclosures of their PHI; (10) response to requests for information by the Department of Health and Human Services; (11) approval of disclosures to law enforcement or to the military for government purposes; (12) maintenance of records and other documentation required by the Privacy Rule, Breach Notification Rule, or Security Rule; (13) negotiation of Privacy Rule, Breach Notification Rule, and Security Rule provisions and/or reasonable security provisions into contracts with third-party service providers; (14) maintenance of Health FSA PHI or Electronic PHI security documentation; or (15) approval of access to Electronic PHI by Participants, Spouses, or Dependents.

11.4 Permitted Uses and Disclosures

Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the Health FSA, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health FSA’s own Payment and Health Care Operations functions;

(b) uses and disclosures for another HIPAA Health Plan’s Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider’s treatment activities;

(d) disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA
Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;

(e) disclosures of a Participant’s, Spouse’s, or Dependent’s PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g);

(f) disclosures to a Participant’s, Spouse’s, or Dependent’s family members or friends involved in the Participant’s, Spouse’s, or Dependent’s health care or payment for the Participant’s, Spouse’s, or Dependent’s health care, or to notify a Participant’s, Spouse’s, or Dependent’s family in the event of an emergency or disaster relief situation;

(g) uses and disclosures to comply with workers’ compensation laws;

(h) uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;

(i) disclosures to the Secretary of Health and Human Services to demonstrate the Health FSA’s compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;

(j) uses and disclosures for other governmental purposes, such as for national security purposes;

(k) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(l) uses and disclosures to identify a decedent or cause of death, or for tissue-donation purposes;

(m) uses and disclosures required by other applicable laws; and

(n) uses and disclosures pursuant to the Participant’s authorization that satisfies the requirements of 45 CFR §164.508.

11.5 **Prohibited Uses and Disclosures**

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.

(a) **Genetic Information.** Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term “underwriting purposes” includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.
(b) **Employment-Related Actions.** Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

(c) **Other Benefits.** Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted in Section 11.4, shall not be a permitted use or disclosure.

### 11.6 Certification Requirement

The Health FSA shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

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

(b) to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Health FSA agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Health FSA any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 10.4, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health FSA, available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

(i) if feasible, to return or destroy all PHI and Electronic PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI when no longer needed for the purpose for which disclosure was made, except
that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI and Electronic PHI infeasible;

(j) to take reasonable steps to ensure that there is adequate separation between the Health FSA and the Employer’s activities in its role as Health FSA sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the FSA.

The Employer hereby certifies, and the Health FSA hereby receives such certification, that the Employer agrees to comply with the foregoing requirements.

11.7 Mitigation

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

(a) The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

11.8 Breach Notification

Following the discovery of a Breach of unsecured PHI, the Health FSA shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Health FSA shall notify the media in accordance with 45 CFR §164.406. “Unsecured PHI” means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.
ARTICLE XII. ADMINISTRATION

12.1 Plan Administrator

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

12.2 Powers of the Plan Administrator

The Plan Administrator shall have and exercise all discretionary and other authority to control and manage the operation and administration of the Plan, except such authority as may be specifically allocated otherwise under the terms of the Plan, and shall have the power to take any action(s) necessary or appropriate to carry out such authority. Without limiting the foregoing, and in addition to the authority and duties specified elsewhere herein, the Plan Administrator shall have the exclusive right and discretionary authority:

(a) to construe and interpret the terms and provisions of the 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 the Plan;

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

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

(d) 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 the Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of the 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 the Plan;

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

(g) to appoint and employ such individuals or entities to assist in the administration of the Plan as it determines to be necessary or desirable, including legal counsel and benefit consultants;
(h) to sign documents for the purposes of administering the Plan, or to designate an individual or individuals to sign documents for the purposes of administering the Plan;

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

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

(k) take all steps that it deems necessary or advisable to correct mistakes in administering the Plan, including, without limitation, directing the Employer to withhold any amounts due the Plan or the Employer from Compensation paid by the Employer.

12.3 Reliance on Participant, Tables, Etc.

The Plan Administrator may rely on the direction, information or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. In addition, the Plan Administrator may, to the extent permitted by law, rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys or other experts employed or engaged by the Plan Administrator.

12.4 Provision for Third-Party Service Providers

The Plan Administrator, subject to the approval of the Employer, may employ the services of such persons as it deems 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.

12.5 Fiduciary Liability

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

12.6 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan, and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan, but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.
12.7 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 do so, then such payment and all subsequent payments otherwise due such Participant or other person shall be forfeited following a reasonable time after the date any such payment first becomes due.

12.8 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 Section 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.

ARTICLE XIII. GENERAL PROVISIONS

13.1 Expenses

All expenses and costs incurred in connection with the administration and operation of the Plan shall be paid by forfeitures to the extent provided in Sections 6.6 and 7.6, and then by the Employer. For HSA Benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's HSA trustee/custodian. Any such HSA fees shall be the responsibility of the Participant, unless the Employer determines, in its sole discretion, that it will pay part or all of such fees.

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 the Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

13.3 Amendment and Termination

The Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate the Plan at any time by resolution of the Board or by any person or persons authorized by the Board to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in the Plan. The Plan Administrator shall also have the right to amend the Plan if there are no substantial costs associated with such amendment.
13.4 No Guarantee of Tax Consequences

The Employer does not make any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether any payment under the 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.

13.5 Indemnification of Employer

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

13.6 Nonassignability of Rights

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to be taken 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 such extent as may be required by law.

13.7 Construction

Whenever any words are used herein in the masculine, they shall be construed as though they were used in the feminine in all cases where they would so apply; and wherever any words are used in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be. The words “hereof,” “herein,” “hereunder” and other similar compounds of the word “here” shall mean and refer to this entire document and not to any particular article or section. The headings of the various articles, sections and subsections are inserted for convenience of reference and are not to be regarded as part of the Plan or as indicating or controlling the meaning or construction of any provision. The text shall control if any ambiguity or inconsistency exists between the headings and the text.

13.8 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of the Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of the Plan as herein set forth, the provisions of the Plan shall be controlling.

13.9 Code and ERISA Compliance

It is intended that the Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. (ERISA applies to the Health FSA Component but not to the Premium Payment Component, the DCAP Component or the HSA Component.) The Plan
shall be construed, operated and administered accordingly, and, in the event of any conflict between any part, clause or provision of the 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 the Plan shall be deemed superseded to the extent of the conflict.

13.10 Severability

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

13.11 Governing Law

The Plan shall be construed, administered and enforced according to the laws of the State of Washington to the extent not superseded by the Code, ERISA or other federal law.

* * * * *

IN WITNESS WHEREOF, the Employer has executed this amended and restated Plan as of the date appearing below.

AMAZON CORPORATE LLC

By: ________________________________

Its: ________________________________

Date: ________________________________
**Appendix A**

**Qualified Benefits**

The benefits listed below are available to eligible Employees who elect such benefits. Any eligible Employee who fails to return an enrollment form at the time and in the manner prescribed by the Plan Administrator shall not be entitled to the listed benefits until the next Open Enrollment Period, unless a mid-year election change is permitted by the Plan. A participating Employee's level of coverage will be consistent with the family status reported on company records for such Employee. The insurance contract, policy or other documents governing any particular Qualified Benefit Plan or policy shall control the actual benefits to be provided thereunder.

- Health FSA Plan
- DCAP Plan
- HSA Component
- In-Network Only Plan
- Standard Plan
- Shared Deductible Plan (non-HRA coverage)
- Health Savings Plan
- Unity Health Plan
- Kaiser Permanente Health Plan
- Dental Plan
- Vision Plan
Appendix B

Related Employers Not Participating in the Amazon.com Section 125 Plan

Each of the Related Employers listed below is not an “Employer” for purposes of the Plan to the extent provided below:

A9.com, Inc. (Alexa Internet Inc.)

Zappos.com, Inc.

Related Employers participating in the A9.com plan intended to comply with Code Section 125

Related Employers participating in the Zappos.com plan intended to comply with Code Section 125