

**Associated Universities Inc.
Flexible Spending Accounts Plan**

**Amended and Restated
Effective January 1, 2008**

PREAMBLE AND EXECUTION

WHEREAS, Associated Universities Inc., a corporation organized under the laws of the State of New York, herein referred to as the "Employer," desires to continue to recognize the contribution made to the Employer by its employees by rewarding those Eligible Employees who shall qualify hereunder and their Dependents by offering various, tax-favored employee benefits; and

WHEREAS, the Employer is mindful of its obligation to operate the Plan in a manner consistent with applicable law and regulation; and

WHEREAS, the Employer desires to amend and restate the Plan in its entirety to comply with applicable changes in the law and to reflect certain other changes.

NOW, THEREFORE, by virtue and in exercise of the amending power reserved to the Employer and pursuant to the authority delegated to the undersigned officer of the Employer by resolutions adopted by its Board of Directors, the Plan is hereby amended and restated in its entirety, which shall be effective as of January 1, 2008.

IN WITNESS WHEREOF, the undersigned has caused the Plan to be executed by its duly authorized officer this 11 day of June, 2009.

Associated Universities Inc.

Signature: Cynthia L Allen

Printed Name: Cynthia L. Allen

Title: AVI Controller

Associated Universities Inc. Flexible Spending Accounts Plan

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Associated Universities Inc. Flexible Spending Accounts Plan

ARTICLE I

ESTABLISHMENT OF PLAN

1.01 *Effective Date.*

The Associated Universities Inc. Flexible Spending Accounts Plan (“Plan”) is amended and restated effective January 1, 2008. The Plan was first effective on January 1, 1980.

1.02 *Purpose.*

The Plan has been previously established and maintained to provide a health care flexible spending account and a dependent care flexible spending account on a pre-tax basis to Eligible Employees of the Employer and their Dependents. In addition, the Plan also established and maintained premium payment rules to allow eligible Employees to pay the Employee’s cost for specified Employer sponsored employee benefit plans on a pre-tax basis. The Plan is intended to qualify under applicable sections of the Internal Revenue Code of 1986, as amended or may be amended from time to time, and is to be interpreted in a manner consistent with the applicable requirements of the Code. This document is also intended to satisfy the applicable requirements the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), where applicable.

1.03 *Duration.*

The Plan is to be maintained for the exclusive benefit of Covered Employees and their eligible Dependents and is established with the intention of being maintained for an indefinite period of time; however, Associated University Inc., in its sole discretion and in accordance with the provisions of Article VII, may amend or terminate the Plan or any provision of the Plan at any time.

ARTICLE II

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings unless a different meaning is plainly required by the context. Notwithstanding any provision to the contrary, words and phrases also defined in any applicable summary plan description shall supersede this Article when used in interpreting that summary plan description.

2.01 “Account”

The separate, unfunded and unsecured recordkeeping account established under the Plan for each Covered Employee for each Coverage Period. Each Covered Employee will have the following separate accounts for certain Benefit Programs selected by the Covered Employee:

- (a) ***Health Care Reimbursement Account.*** The account established for the payment of Health Care Expenses.
- (b) ***Dependent Care Reimbursement Account.*** The account established for the payment of Dependent Care Expenses.

There will be credited to each separate account the amounts specified in Section 5.02 and there will be charged against each separate account the amounts specified in Section 5.03. A Covered Employee may not use a credit in the Account of one Benefit Program to reimburse the Covered Employee for an expense incurred under another Benefit Program.

2.02 “Affiliate”

A business entity which is not the Employer but which is part of a “controlled group” or under “common control” with the Employer or which is a member of an “affiliated service group” that includes the Employer, as those terms are defined in §414(b), (c) and (m) of the Code. A business entity that is a predecessor to the Employer shall be treated as an Affiliate if the Employer maintains a plan of such predecessor business entity. A business entity shall also be treated as an Affiliate if, and to the extent that, such treatment is required by regulations prescribed by the Secretary of the Treasury under §414(o) of the Code. In addition to said required treatment, the Employer may, in its discretion, designate as an Affiliate any business entity which is not such a “common control,” “affiliated service group” or “predecessor” business entity but which is otherwise affiliated with the Employer, subject to such limitations as the Employer may impose.

2.03 “Annual Enrollment”

The annual period during which Eligible Employees may complete an Enrollment Election in a Benefit Program or Covered Employees may change their Enrollment Election in a Benefit Program as specified in Section 3.03.

2.04 “Benefit Program”

A benefit program approved by the Employer to be covered under the Plan for the purpose of providing benefits to Covered Employees. The separate Benefit Programs provided under the Plan have been described in a single Plan Statement for administrative convenience and to eliminate repetition of provisions common to all benefits.

2.05 “Claims Administrator”

The third party administrator, if any, to whom the Plan Administrator has delegated its authority to process and review claims for benefits and to distribute benefits under either or both the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account.

2.06 “COBRA”

The Consolidated Omnibus Budget Reconciliation Act of 1985, including applicable regulations for the specified section of COBRA. Any reference in this Plan Statement to a section of COBRA, including the applicable regulation, shall be considered also to mean and refer to any subsequent amendment or replacement of that section or regulation.

2.07 “Code”

The Internal Revenue Code of 1986, including applicable regulations for the specified section of the Code. Any reference in the Plan Statement to a section of the Code, including the applicable regulation, shall be considered also to mean and refer to any subsequent amendment or replacement of that section or regulation.

2.08 “Compensation”

The total cash compensation payable by the Employer to the Covered Employee during the Plan Year while the Covered Employee is in Recognized Employment, as determined before any reductions authorized by the Covered Employee under a Benefit Program or any other employee benefit plan.

2.09 “Coverage Period”

Relative to the Health Care Reimbursement Account and the Dependent Care Reimbursement Account and for any given Plan Year, the period commencing on the later of the first day of that Plan Year or the first date an Eligible Employee becomes a Covered Employee during said Plan Year and ending on the earlier of the date a Covered Person ceases to participate in the Plan or the last day of the Grace Period for such Plan Year.

2.10 “Covered Employee”

An Eligible Employee who elects to participate in one or more of the Benefit Programs offered under the Plan.

2.11 “Dependent”

For purposes of the Plan, the term Dependent means:

- (a) The legally married Spouse of an Employee or Qualified Beneficiary and the common-law Spouse of an Employee or Qualified Beneficiary, if common-law marriage is recognized by the State in which the Employee or Qualified Beneficiary reside. Provided however, that no Spouse shall qualify as a Dependent if such individual is covered for benefits as an Employee.
- (b) An unmarried child (including any stepchild, legally adopted child, foster child or child placed for adoption) of an Employee or Qualified Beneficiary. Provided however, that no child shall qualify as a Dependent if such individual is covered for benefits as an Employee; nor if such individual is a member on active duty with the Armed Forces. Provided further that each child shall also meet one of the following:
 - (1) Less than nineteen (19) years of age and primarily dependent upon the Employee or Qualified Beneficiary for support and maintenance; or
 - (2) Dependent upon the Employee or Qualified Beneficiary for medical support pursuant to a valid Qualified Medical Child Support Order; or
 - (3) Less than twenty-five (25) years of age, if a full-time student and satisfactory proof of student status is submitted to the Plan Administrator. “Full-time student” means enrolled in a college or university and satisfying the institution’s requirements for full-time student status. For a proprietary school, such as business college, professional school or trade school, “full-time student” means a minimum of twenty-five (25) hours of classroom attendance per week; or

- (4) Meets all of the following criteria:
 - (A) Unmarried and over the age of nineteen (19); and
 - (B) Dependent primarily on the Employee or Qualified Beneficiary for financial support and maintenance due to mental or physical handicap; and
 - (C) Incapable of self-sustaining employment; and
 - (D) Mental or physical handicap existed before the age of nineteen (19) and while covered under a medical benefits program offered by the Employer.

2.12 “Dependent Care Center”

Any facility that provides care for more than 6 individuals (excluding any individuals who reside there) and is paid for providing services for any of the individuals (regardless of whether it is operated for profit).

2.13 “Dependent Care Expenses”

Expenses incurred to enable a Covered Employee to be gainfully employed during any period during which the Covered Employee has one or more Qualifying Individuals and which are defined as “employment-related expenses” under §21(b)(2) of the Code.

In addition, if the Covered Employee is married, the Covered Employee’s spouse must be gainfully employed, actively seeking employment, a full-time student, or incapable of caring for himself or herself in order for an expense to qualify as a Dependent Care Expense reimbursable under the Dependent Care Reimbursement Account.

Dependent Care Expenses include only the following expenses for household services or for the care of a Qualified Individual:

- (a) All such expenses incurred within the Covered Employee’s household,
- (b) All such expenses incurred outside the Covered Employee’s household for the care of a Type A Qualifying Individual, subject to the last sentence of this definition; and
- (c) All such expenses incurred outside the Covered Employee’s household for the care of a Type B Qualifying Individual, but only if such Type B Qualifying Individual regularly spends at least 8 hours each day in the Covered Employee’s household, subject to the last sentence of this definition.

For purposes of the Dependent Care Reimbursement Account, the expense is incurred when the dependent care is provided, and not when the Covered Employee is formally billed, charged for, or pays for the dependent care. If a Dependent Care Center is used, such center must comply with all applicable laws and regulations of a state or unit of local government.

2.14 “Dependent Care Reimbursement Account”

A Benefit Program available under the Plan, that provides for the payment of certain qualified Dependent Care Expenses on a pre-tax basis. It is intended that the Benefit Program qualify as a separate, written plan under §125 and §129 of the Code. This Benefit Program is not subject to ERISA.

2.15 “Effective Date”

The effective date of the Plan shall be January 1, 2008, the amendment and restatement date, except if an earlier effective date is necessary to bring the Plan into compliance with applicable law, in which case the Effective Date is that earlier date.

2.16 “Eligible Employee”

For purposes of the Plan, the term Eligible Employee means any common law employee of the Employer who is regularly scheduled to work at least 20 hours per week. However, an individual who is classified by the Employer as a temporary employee, leased employee or contract employee as defined under Code §401(c), shall not be an “Eligible Employee” eligible to participate in the Plan regardless of whether, for employment tax or other purposes, the individual is subsequently determined not to be a leased employee, temporary employee or contract employee. For purposes of determining eligibility under the Plan, the classification to which an individual is assigned by the Employer shall be final and conclusive, regardless of whether a court or other entity subsequently finds that such individual should have been assigned to a different classification.

2.17 “Employer”

Associated Universities Inc., a corporation created under the laws of the State of New York, and any Participating Affiliate that adopts the Plan with the consent of the Employer, and any successor thereof that adopts the Plan.

2.18 “Enrollment Election”

A direction from an Eligible Employee who elects to become a Covered Employee in one or more Benefit Programs which provides for a reduction in the Compensation which otherwise would be paid to the Covered Employee by the Employer on each payday.

2.19 “ERISA”

The Employee Retirement Income Security Act of 1974, including applicable regulations for the specified section of ERISA. Any reference in this Plan Statement to a section of ERISA, including the applicable regulation, shall be considered also to mean and refer to any subsequent amendment or replacement of that section or regulation.

2.20 “Grace Period”

Grace Period means the period from the end of a Plan Year up to and including the March 15th immediately following the end of such Plan Year.

2.21 “Health Care Expenses”

The un-reimbursed expenses incurred for the health care (as defined in §213 of the Code) of the Covered Employee and the Covered Employee’s spouse and Dependents.

Amounts attributable to premium payments for health coverage are not reimbursable Health Care Expenses under the Health Care Reimbursement Account.

For purposes of the Health Care Reimbursement Account, the expense is incurred when the health care is furnished, and not when the Covered Employee is formally billed, charged for, or pays for the health care. If a fee is charged for a continuing course of treatment and is not related to a particular service (*e.g.*, orthodontics or pre-natal treatment), reimbursements will be made based upon either an allocation by the health provider for the expenses charged over the course of the health treatment or a reasonable payment plan established by the health provider for the health services provided.

2.22 “Health Care Reimbursement Account”

A Benefit Program available under the Plan, that provides for the payment of certain unreimbursed Health Care Expenses on a pre-tax basis. It is intended that this Benefit Program qualify as a separate, written, self-funded health reimbursement program under §105, §106 and §125 of the Code. This Benefit Program is subject to ERISA.

2.23 “Participating Affiliate”

The term “Participating Affiliate” means any Affiliate that adopts this Plan and makes contributions as required by the Employer.

2.24 “Plan”

The benefit program of the Employer established for the benefit of Eligible Employees, as set forth in a written instrument entitled “Associated Universities Inc. Flexible Spending Accounts Plan.” (As used herein, “Plan” refers to the legal entity established by the Employer and not to the document pursuant to which the Plan is maintained. That document is referred to herein as the “Plan Statement.”) This Plan may consist of both Benefit Programs that are subject to ERISA and

Benefit Programs that are not subject to ERISA. The Benefit Program that is subject to ERISA is part of the Associated Universities Inc. Employee Welfare Benefit Plan, which is designated as ERISA Plan Number 502.

2.25 “Plan Administrator”

The individual(s) or corporation(s) appointed by the Employer to carry out the administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Plan Administrator.

2.26 “Plan Statement”

Effective January 1, 2008, this written instrument entitled “Associated Universities Inc. Flexible Spending Accounts Plan,” as same may be amended from time to time.

2.27 “Plan Year”

The 12 consecutive month period beginning each January 1st and ending the following December 31st

2.28 “Premium Payment”

The cost to the Covered Employee of the medical and/or dental coverage elected by the Covered Employee under one or more of the plans maintained by the Employer.

2.29 “Premium Payment Program”

A Benefit Program available under the Plan, that provides for the payment, on a pre-tax basis, of the employee’s share of the cost for medical and dental benefits under one or more of the plans maintained by the Employer, as listed in Schedule A, the provisions of which are hereby incorporated in the Plan by reference. As a condition of receiving such benefits, each Covered Employee who has elected to receive such benefits shall automatically be enrolled in the Premium Payment Program. It is intended that this Benefit Program qualify as a separate, written, cafeteria plan under §125 of the Code. This Benefit Program is not subject to ERISA.

2.30 “Qualified Beneficiary”

Means any person afforded rights of continued medical coverage under COBRA as a result of a qualifying event as defined by COBRA and its regulations.

2.31 “Qualifying Individual”

For purposes of the Dependent Care Reimbursement Account, an individual that is either a “Type A Qualifying Individual” or a “Type B Qualifying Individual,” as defined as follows:

- (a) **Type A Qualifying Individual.** A Dependent of the Covered Employee (as defined in Code §152(a)(1) who has not attained age 13; or

- (b) ***Type B Qualifying Individual.*** A Dependent of a Covered Employee, or the spouse of a Covered Employee, who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the year.

2.32 ***“Recognized Employment”***

All services performed for the Employer by an individual classified by the Employer as an employee on both payroll and personnel records; subject, however, to the following:

- (a) ***Exclusions.*** Services classified by the Employer as being performed in the following categories of employment shall be excluded from Recognized Employment:
 - (1) Employment in a unit of employees whose terms and conditions of employment are subject to a collective bargaining agreement between the Employer and a union representing that unit of employees, unless (and to the extent) such collective bargaining agreement provides for the inclusion of those employees in the Plan,
 - (2) Employment of a nonresident alien who is not receiving any earned income from the Employer which constitutes income from sources within the United States,
 - (3) Employment of a highly compensated individual to the extent agreed to in writing by that individual, and
 - (4) Services of any leased employee within the meaning of Code §414(n), any leased owner, leased manager, shared employee, shared leased employee, independent contractor, other contract worker or other similar classification regardless of whether the individual is a common law employee of the Employer. The purpose of this provision is to exclude from participation in the Plan all persons who may actually be common law employees of the Employer, but who are not paid as though they were employees, regardless of the reason they are excluded from the payroll, and regardless of whether that exclusion conforms with correct tax law so long as it is made in good faith.
- (b) ***Non-Employees.*** Services performed for the Employer by an individual who is not classified by the Employer as an employee on both payroll and personnel records shall not be considered Recognized Employment. Without limiting the generality of the foregoing, such services shall include services performed by an individual classified by the Employer as a leased employee, leased owner, leased manager, shared employee, shared leased employee, temporary worker, independent contractor, contract worker, agency worker, freelance worker or other similar classification.

- (c) ***Effect of Classification.*** The Employer’s classification of an individual at the time of inclusion in or exclusion from Recognized Employment shall be conclusive for the purpose of the foregoing rules. No reclassification of an individual’s status with the Employer, for any reason, without regard to whether it is initiated by a court, governmental agency or otherwise and without regard to whether or not the Employer agrees to such reclassification, shall result in the individual being retroactively included in Recognized Employment. Notwithstanding anything to the contrary in this provision, however, the Plan Administrator may declare that a reclassified individual will be included in Recognized Employment prospectively. Any uncertainty concerning an individual’s classification shall be resolved by excluding the individual from Recognized Employment.

2.33 “Rules of Interpretation”

Whenever appropriate, words used herein in the singular may be read in the plural, or words used herein in the plural may be read in the singular; the masculine may include the feminine; and the words “hereof,” “herein” or “hereunder” or other similar compounds of the word “here” shall mean and refer to the entire Plan Statement and not to any particular paragraph or section of this Plan Statement unless the context clearly indicates to the contrary.

The titles given to the various sections of this Plan Statement are inserted for convenience of reference only and are not part of this Plan Statement, and they shall not be considered in determining the purpose, meaning or intent of any provision hereof. Any reference in this Plan Statement to a statute or regulation shall be considered also to mean and refer to any subsequent amendment or replacement of that statute or regulation. To the extent any provision of this Plan Statement is determined to be inconsistent with §105, §106, §125, or §129, as applicable, of the Code, such provision is modified accordingly and if such provision cannot be modified, then the provision is void.

2.34 “Spouse”

For purposes of the Plan, the term Spouse means the person who is legally married to the Eligible Employee under the laws of the state in which they reside. Notwithstanding the foregoing, for purposes of the Health Care Reimbursement Account and the Dependent Care Reimbursement Account, “Spouse” does not include a same-sex spouse.

ARTICLE III

ELIGIBILITY, BENEFIT ELECTIONS AND PARTICIPATION

3.01 Eligibility to Participate.

Each Eligible Employee shall be eligible to participate as follows:

- (a) ***Premium Payment Program.*** An Eligible Employee shall be eligible to participate in the Premium Payment Program at such time as the employee satisfies the eligibility requirements for participation in one or more of the medical and dental plans offered by the Employer.
- (b) ***Health Care Reimbursement Account.*** An Eligible Employee shall be eligible to participate in the Health Care Reimbursement Account immediately upon becoming an Eligible Employee.
- (c) ***Dependent Care Reimbursement Account.*** An Eligible Employee shall be eligible to participate in the Dependent Care Reimbursement Account immediately upon becoming an Eligible Employee.

3.02 Initial Enrollment.

- (a) ***Premium Payment Program.*** Each Eligible Employee who elects to receive medical and/or dental coverage by completing and returning an Enrollment Election to the Employer shall be automatically enrolled as a Covered Employee in the Premium Payment Program, as a condition of receiving the health coverage elected. If an Eligible Employee does not complete an Enrollment Election when first eligible to receive health coverage, such Eligible Employee may subsequently enroll in health coverage only at Annual Enrollment as described in Section 3.03 or at such time as the Eligible Employee has a status change event that permits enrollment as described in Section 4.03.
- (b) ***Health Care Reimbursement Account and Dependent Care Reimbursement Account.*** To become a Covered Employee in the Health Care Reimbursement Account or the Dependent Care Reimbursement Account, an Eligible Employee must complete an Enrollment Election in the manner required by the Employer. The Enrollment Election of an Eligible Employee shall be effective pursuant to administrative rules prescribed by the Plan Administrator, but shall not take effect prior to the date the Eligible Employee submits such Enrollment Election. If an Eligible Employee does not complete an Enrollment Election as provided in the preceding sentence, such Eligible Employee may subsequently enroll only at Annual Enrollment as described in Section 3.03, or at such time as the Eligible Employee has a permitted status change event that permits enrollment as described in Section 4.03.

3.03 Annual Enrollment.

During the Annual Enrollment period prescribed by the Plan Administrator in its discretion, the following may occur:

- (a) An Eligible Employee who does not enroll on the date described in Section 3.02 shall be allowed to enroll as a Covered Employee; or
- (b) Covered Employee may submit a new Enrollment Election changing prior benefit elections or terminating participation in a Benefit Program.

Any such Enrollment Election must be completed and submitted by the last day of the Annual Enrollment period and in any event before the beginning of the Plan Year for which it is to be effective. For purposes of the Premium Payment Program only, if no new Enrollment Election is submitted to the Employer, the Covered Employee's Enrollment Election in effect at the end of the prior Plan Year shall continue to be in effect during the next Plan Year. For purposes of the Health Care Reimbursement Account and the Dependent Care Reimbursement Account, if no new Enrollment Election is received, participation as a Covered Employee in the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account will terminate.

3.04 Reduction in Compensation.

Each Enrollment Election shall provide for a reduction in the Covered Employee's Compensation of a specified dollar amount. Each payday, the Employer shall reduce the Covered Employee's Compensation by the total amount so authorized. The amount authorized shall be allocated among one or more of the available Benefit Programs as the Covered Employee indicates on the Enrollment Election, subject to the following rules:

- (a) **Minimum Reductions.** The minimum reduction in Compensation a Covered Employee may elect for each Benefit Program is as follows:
 - (1) **Premium Payment Program.** The entire cost to the Covered Employee of the medical and dental coverage elected.
 - (2) **Health Care Reimbursement Account.** Not less than \$300 per Plan Year, or such greater or lesser amount as the Employer may establish in advance of a particular Plan Year.
 - (3) **Dependent Care Reimbursement Account.** Not less than \$300 per Plan Year, or such greater or lesser amount as the Employer may establish in advance of a particular Plan Year.
- (b) **Maximum Reductions.** The maximum reduction in Compensation a Covered Employee may elect for each Benefit Program is as follows:
 - (1) **Premium Payment Program.** The entire cost to the Covered Employee of the medical and dental coverage elected.
 - (2) **Health Care Reimbursement Account.** A maximum of \$3,500 per Plan Year, or such greater or lesser amount as the Employer may establish in advance of a particular Plan Year.

- (3) ***Dependent Care Reimbursement Account.*** Subject to the limitations set forth in Section 5.05(b), a maximum of \$5,000 per Plan Year for a single Covered Employee or a married Covered Employee filing a joint income tax return, or a maximum of \$2,500 per Plan Year for a married Covered Employee filing a separate income tax return.

3.05 *Termination of Participation.*

Participation as a Covered Employee in any Benefit Program shall terminate upon the earliest of the following:

- (a) The last day of the month in which the Covered Employee ceases to be employed in Recognized Employment;
- (b) The last day of the month in which the Covered Employee ceases to be an Eligible Employee;
- (c) The last day of the Plan Year for which an Enrollment Election is effective;
- (d) The date the Covered Employee terminates the Enrollment Election as a result of and consistent with a permitted status change;
- (e) The last day of the month of the death of the Covered Employee;
- (f) If a Covered Employee fails to make any required payment, the last day of the month for which the Covered Employee made the required payment; or
- (g) The date any Benefit Program is terminated or amended so that the Covered Employee loses coverage.

3.06 *Form of Agreement.*

The Plan Administrator shall specify the procedure for making an Enrollment Election, any notices changing the Enrollment Election and all procedures for delivery and acceptance of elections, notices and changes.

ARTICLE IV

CHANGES TO BENEFIT ELECTIONS

4.01 General Rule.

An Eligible Employee's election regarding participation in a Benefit Program or the Enrollment Election of a Covered Employee may be changed at a time other than Annual Enrollment only as described in this Section.

4.02 Automatic Changes to Benefit Elections.

Upon the occurrence of one of the following events, the Enrollment Elections of a Covered Employee will be automatically changed as described below.

- (a) **Termination of Employment.** The Enrollment Election of a Covered Employee who terminates employment with the Employer shall be terminated automatically effective as of the last day of the month in which the Covered Employee ceases to be employed with the Employer.
- (b) **Return to Employment.** If a former Covered Employee returns to Recognized Employment within 30 days of termination, the terminated Enrollment Election in effect prior to the former Covered Employee's termination of employment and the elected reductions in Compensation shall be reinstated automatically for the remainder of the Plan Year, effective as of the first payroll period after the Covered Employee's return to Recognized Employment. The initial enrollment rules set forth in Section 3.02 shall apply to all rehired employees who return to Recognized Employment in the same Plan Year but more than 30 days after termination of employment or in a subsequent Plan Year.
- (c) **Job Reclassification or Change in Hours.** For the purposes of this Section, the term job reclassification shall include an increase or decrease in hours of employment.
- (d) **Loss of Eligibility.** If a Covered Employee ceases to be employed as an Eligible Employee due to a job reclassification, then the Covered Employee's Enrollment Election shall be terminated automatically effective as of the last day of the month in which the job reclassification occurred.
- (e) **Return to Eligibility.** If a former Covered Employee experiences a job reclassification and, as a result, again becomes an Eligible Employee in a subsequent Plan Year or more than 30 days after the date the former Covered Employee lost eligibility, the initial enrollment rules set forth in Section 3.02 shall apply.

If, however, the former Covered Employee returns to eligibility within 30 days or less after the date on which the former Covered Employee lost eligibility, the terminated Enrollment Election in effect prior to the job reclassification and the elected reductions in Compensation shall be reinstated automatically for the remainder of the Plan Year, effective as of the first payroll period after the former Covered Employee again becomes an Eligible Employee.

- (f) **Death.** The Enrollment Election of a Covered Employee who dies shall be terminated automatically as of the last day of the month of the Covered Employee's death.
- (g) **Nonpayment.** The Enrollment Election of a Covered Employee who fails to make any required payment shall be terminated automatically as of the last day of the month before the month in which such payment was due and not paid. With respect to Premium Payment Program, coverage under the underlying health plan shall be terminated for non-payment according to the rules contained in the related health care plan.
- (h) **Court Mandated Coverage.** For purposes of Premium Payment Program only, if health care coverage is required to be provided pursuant to a qualified medical child support order, the following consistency rules shall apply:
 - (1) For an Eligible Employee who is required to provide coverage, the Eligible Employee and children for whom coverage is required to be provided, will be enrolled automatically in the applicable plans and the Eligible Employee shall be enrolled automatically as a Covered Employee in Premium Payment Program.
 - (2) For a Covered Employee who is ordered to provide coverage, coverage under the applicable plans shall be added for the children identified in the order and such Covered Employee's Enrollment Election shall automatically be amended such that the reduction in Compensation is increased to equal the Covered Employee's entire cost of the health care coverage.
 - (3) If an order requires the Covered Employee's spouse, former spouse, or other individual to provide health coverage for a child or children, the Covered Employee may elect to cancel coverage for such child or children if the Covered Employee certifies or otherwise provides documentation establishing that such child or children are, in fact, covered by other health care coverage.
- (i) **Change in Premium Payment.** For purposes of Premium Payment Program only, if the Covered Employee's share of the cost of health coverage increases or decreases during the Plan Year, the Covered Employee's Enrollment Election shall automatically be amended such that the reduction in Compensation is increased or decreased to equal the entire cost of the health care coverage elected.

4.03 *Permitted Election Changes.*

An Eligible Employee may elect to enroll in a Benefit Program or a Covered Employee may revoke any existing Enrollment Election and may submit a new Enrollment Election to the Employer effective as of a date other than an Annual Enrollment date only as provided in this Section. The Plan Administrator may, in its discretion, require an Eligible Employee or Covered Employee to certify or otherwise provide documentation establishing that the employee has experienced one of the following permitted status change events, that such employee has or will obtain coverage under another employer plan, or such other information as the Plan Administrator deems necessary. Failure to provide such certification or documentation may result in the Plan Administrator denying a requested change.

- (a) ***Elections Due to a Change in Status.*** A Covered Employee may revoke any existing Enrollment Election and may submit a new Enrollment Election to the Employer effective as of a date other than an Annual Enrollment date if the Covered Employee experiences one of the following change in status events set forth in subsection (1) and the new Enrollment Election satisfies the consistency requirements set forth in subsection (2).
 - (1) ***Change in Status Events.*** The following are change in status events:
 - (A) A change to an Eligible Employee's or Covered Employee's legal marital status, including marriage, legal separation, divorce, annulment, or death of spouse;
 - (B) A change in an Eligible Employee's or Covered Employee's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
 - (C) A change in the employment status of the Eligible Employee or Covered Employee, or the Eligible Employee's or Covered Employee's spouse or Dependent, including:
 - (i) termination or commencement of employment;
 - (ii) a strike or lockout;
 - (iii) return from or commencement of an unpaid leave;
 - (iv) a change in worksite; and
 - (v) any other change in employment that affects benefits eligibility (including for the Dependent Care Reimbursement Account only, a change in work shift).
 - (D) A change such that an Eligible Employee's or Covered Employee's Dependent satisfies or ceases to satisfy the eligibility requirements of Dependents due to age, student status, or similar circumstance, or the Dependent is no longer a qualifying individual; and

- (E) A change in the Eligible Employee's or Covered Employee's residence; provided that a change in residence is a change in status event only for Premium Payment Program.
- (2) **Consistency Requirements.**
- (A) **General Rule.** In order for an election change to be "consistent with" a change in status event, the election change must be on account of and correspond with a change in status that affects the eligibility of an Eligible Employee or a Covered Employee or the spouse or Dependent of an Eligible Employee or a Covered Employee to receive coverage, including an increase or decrease in the number of the employee's family members who may benefit from coverage. An election change is also "consistent with" a change in status event if the election change is on account of and corresponds with a change in status that affects Dependent Care Expenses.
 - (B) **Loss of a Dependent.** If the change in status event is divorce, annulment, death of a spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements, a Covered Employee is only permitted to cancel accident or health coverage for that spouse or Dependent. The Covered Employee's accident or health coverage and the accident or health coverage of any other Dependent may not be canceled, unless some other permitted election change applies.
 - (C) **Gaining Eligibility Under Another Plan.** If, due to a change in legal marital status or change in employment status, a Covered Employee, or the spouse or Dependent of a Covered Employee gains eligibility for coverage under a cafeteria plan sponsored by the spouse or Dependent's employer, the Covered Employee may elect to decrease or cease coverage under the Plan for the Covered Employee or the Covered Employee's spouse or Dependent; provided that any individual for whom coverage ceases under the Plan becomes covered under the cafeteria plan sponsored by the spouse or Dependent's employer.
 - (D) **Tag Along Rule.** For the Premium Payment Program only, if due to a change in status event an Eligible Employee enrolls in health coverage or a Covered Employee elects to increase health coverage, at that time, the Eligible Employee or the Covered Employee may also enroll his or her spouse or eligible Dependents who were not previously covered for health care regardless of whether such individuals personally experienced the change in status event.

(b) ***Elections Due to a Leave of Absence.***

(1) ***USERRA.*** The Enrollment Elections of a Covered Employee on a leave of absence for military service and upon return to employment following such leave shall be administered pursuant to the rules set out in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), including applicable regulations.

(2) ***Special Rules for Unpaid FMLA Leaves of Absence.***

(A) ***Premium Payment Program and Health Care Reimbursement Account.*** A Covered Employee who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 (FMLA) may elect to revoke the Enrollment Election for Premium Payment Program and the Health Care Reimbursement Account for the remainder of the Plan Year on commencement of the leave. A Covered Employee on FMLA leave or returning from FMLA leave shall have the same right as any other Covered Employee to change the Enrollment Election consistent with a permitted election change. If a Covered Employee does not return to employment after an unpaid FMLA leave, the Employer shall have the right to recover any amounts in arrears.

(B) ***Continuation of Participation under the Premium Payment Program and Health Care Expense Account.*** If a Covered Employee desires to continue participation in the medical and/or dental benefit plans maintained by the Employer and /or desires to continue participation in the Health Care Reimbursement Account during unpaid FMLA leaves of absence, the Covered Employee shall, prior to commencement of the leave, agree that either:

(i) the Covered Employee's Compensation shall be reduced under the Premium Payment Program and/or the Health Care Expense Account, prior to the commencement of the leave, in an amount calculated to equal the amount that would have been contributed to the Premium Payment Program and/or the Health Care Expense Account during the period of leave, had the Covered Employee remained in active employment; or

(ii) during the period of unpaid FMLA leave of absence, all Premium Payments that would have been contributed through the Premium Payment Program and/or all amounts that would have been contributed to the Health Care Expense Account during the period of leave shall be remitted on an after-tax basis by the Covered Employee to the Employer, in a manner and at such time as is mutually agreed to by the Covered Employee and the Employer.

- (C) ***Dependent Care Expense Account.*** During periods of unpaid FMLA leave of absence, contributions to the Dependent Care Expense Account shall cease.
- (3) ***Leaves of Absence.***
 - (A) ***Paid Leave.*** A Covered Employee's Enrollment Election shall remain in effect and all reductions in Compensation shall continue during a leave of absence for which the Covered Employee continues to receive Compensation.
 - (B) ***Non-FMLA Unpaid Leave.*** During periods of unpaid leave of absence, the Enrollment Election of a Covered Employee, relative to the Premium Payment Program, the Health Care Reimbursement Account and the Dependent Care Reimbursement Account, shall terminate.

If a Covered Employee desires to continue participation in the medical and/or dental benefit plans maintained by the Employer, the Covered Employee shall, subject to the approval of the Employer and prior to commencement of the leave, agree to be direct billed for the amount of the Premium Payments falling due during the period of unpaid leave. Any such direct billed payments shall be made in a manner and at such time as is mutually agreed to by the Covered Employee and the Employer and will be made on an after-tax basis.

If the Covered Employee fails to make any payments during the unpaid leave of absence, medical and/or dental benefits will be lost at the end of the month for which the last payment is made, and, on return from leave, the Covered Employee's Compensation will be reduced to pay for any required contributions that went into arrears during the leave for the last month of coverage.

The Enrollment Election of a former Covered Employee will, upon return to Recognized Employment that confers eligibility for enrollment during the same Plan Year in which the Enrollment Election terminated, be reactivated for the remainder of the Plan Year at the same level of reduction in Compensation in effect prior to the leave of absence.

A Covered Employee on unpaid leave or returning from unpaid leave shall have the same right as any other Covered Employee to change the Enrollment Election consistent with a permitted election change. If a Covered Employee does not return to employment after an unpaid leave, the Employer shall have the right to recover any amounts in arrears.

- (c) **Permitted Election Changes Applicable Only to Dependent Care Reimbursement Account.**
 - (1) An Eligible Employee may enroll in the Dependent Care Reimbursement Account by completing an Enrollment Election within the time period prescribed by the Plan Administrator; and
 - (2) A Covered Employee may increase or decrease, as appropriate, the amount of reduction in Compensation elected under the Dependent Care Reimbursement Account to correspond with the increase or decrease in eligible Dependent Care Expenses.
 - (3) If an Eligible Employee or Covered Employee experiences a significant change in dependent care coverage similar to the addition of a benefit option or a significant curtailment of coverage, as determined in the sole discretion of the Plan Administrator, then:
 - (A) An Eligible Employee may enroll in the Dependent Care Reimbursement Account by completing an Enrollment Election within the time period prescribed by the Plan Administrator; and
 - (B) A Covered Employee may increase, decrease, or cancel the amount of reduction in Compensation elected under the Dependent Care Reimbursement Account to correspond with the change in dependent care coverage.
- (d) ***Permitted Election Changes Applicable Only to Premium Payment Program.***
 - (1) ***Special Enrollment.*** If an Eligible Employee, or the spouse or Dependent of an Eligible Employee, experiences a special enrollment event under §9801(f) of the Code, and such person or persons enroll for health coverage under the Plan by completing an Enrollment Election within 30 days or less of the special enrollment event, then the Eligible Employee shall be enrolled automatically as a Covered Employee in the Premium Payment Program. If a Covered Employee, or the spouse or Dependent of a Covered Employee, experiences a special enrollment event under §9801(f) of the Code, and the Covered Employee increases his or her health coverage within 30 days or less of the special enrollment event, then the Covered Employee's Enrollment Election shall automatically be increased to equal the cost to the Covered Employee of the health coverage elected. A special enrollment event under §9801(f) of the Code occurs if there is either:

- (A) ***A Loss of Coverage.*** An Eligible Employee, a spouse or Dependent of an Eligible Employee, or a spouse or Dependent of a Covered Employee who (i) has a loss of other coverage due to either: (a) exhaustion of COBRA coverage, (b) termination of the employer's contribution to the other coverage, or (c) a loss of eligibility due to such causes as legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; (ii) previously declined health coverage at a time when and because the individual had other coverage; and (iii) the loss of other coverage is not due to a failure to pay premiums or termination for cause, such as making fraudulent claims or intentional misrepresentation; or
- (B) ***A New Dependent is Gained.*** An Eligible Employee or Covered Employee gains a new Dependent through marriage, birth, adoption or placement for adoption of a child.

If the special enrollment is due to loss of coverage or marriage, the enrollment shall be effective as of the first day of the calendar month following the date the Enrollment Election is completed. If the special enrollment event is due to the birth, adoption, or placement of adoption of a child, the enrollment shall be effective as of the date of such event.

- (2) ***Entitlement to Medicare or Medicaid.*** If a Covered Employee, spouse or Dependent becomes entitled to coverage under Part A or Part B of Medicare or Medicaid, the Covered Employee may elect to cancel health coverage for such Covered Employee, spouse or Dependent under one or more of the plans maintained by the Employer, in which case the amount of reduction in Compensation elected under the Premium Payment Program will be decreased automatically to reflect the reduction in the Covered Employee's cost of health coverage.

If an Eligible Employee, Spouse or Dependent loses eligibility for coverage under Part A or Part B of Medicare, the Eligible Employee may elect to commence or increase health coverage for such Eligible Employee, Spouse or Dependent under one or more of the plans maintained by the Employer, in which case the amount of reduction in Compensation elected under the Premium Payment Program will be increased automatically to reflect the increase in the Eligible Employee's cost of health coverage.

- (3) Effective April 1, 2009, an Eligible Employee may enroll in health coverage for the Employee and his or her Spouse and/or Dependent if (a) the Eligible Employee or Dependent loses eligibility for coverage under Medicaid or the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP"), or (b) becomes eligible for premium assistance under Medicaid or CHIP. To exercise the special enrollment rights in this Section 4.03(d)(3), the Eligible Employee must submit a completed enrollment form to the Plan Administrator within 60 days after the loss of such coverage or the eligibility for premium assistance, in which case the amount of reduction in Compensation elected under the Premium Payment Program will be increased automatically to reflect the increase in the Eligible Employee's cost of health coverage.
- (e) ***Deadline for Permitted Election Changes.*** Except as provided in Section 4.03(d)(3), a new Enrollment Election must be completed within 30 days or less of the date when permitted election change event occurs. Unless otherwise specified, the new reduction in Compensation will be effective as of the first payroll period following the date the change to the Enrollment Election is effective. The new Enrollment Election shall remain in effect for the remainder of the Plan Year, except as changes are permitted under this Section. The reductions in Compensation for the remainder of the Plan Year shall be equal to the amount of reduction in Compensation elected after the permitted election change divided by the number of pay periods remaining in the Plan Year, but in no event shall such reduction in Compensation exceed the permitted maximum reduction in compensation set forth in Section 3.04(b).

ARTICLE V

ACCOUNTS AND BENEFITS

5.01 *Separate Accounts.*

For each Covered Employee who elects coverage under the Benefit Programs, the Employer shall establish a separate Account each Plan Year for the Benefit Programs selected; except for the Premium Payment Program, for which there is no Account. The Account shall be established for recordkeeping purposes only, and it shall not represent a trust fund or other segregation of assets for the benefit of the Covered Employee. A Covered Employee may not use a credit in one Account to reimburse the Covered Employee for an expense payable under any other Benefit Program or plan sponsored by the Employer.

5.02 *Credits to Accounts.*

Each reduction in Compensation shall be credited to the applicable separate Account as elected by the Covered Employee for the Plan Year in which the reduction occurs.

- (a) ***Credit to Health Care Reimbursement Account.*** Each Covered Employee's Health Care Reimbursement Account shall be credited on the later of the first day of the Plan Year or the first date an Eligible Employee becomes a Covered Employee during said Plan Year with the total amount of reduction in Compensation specified by the Covered Employee on the Enrollment Election for that Plan Year. Thus, the entire amount of reduction in Compensation elected by the Covered Employee on the Enrollment Election minus any amount previously reimbursed for Health Care Expenses shall be available to the Covered Employee at any time during the Coverage Period, regardless of the amount actually contributed by the Covered Employee to the Account through reductions in Compensation.
- (b) ***Credit to Dependent Care Reimbursement Account.*** Each payday there shall be credited to the Covered Employee's Dependent Care Reimbursement Account an amount equal to the amount of reduction in Compensation authorized by the Covered Employee on the Enrollment Election then in effect.
- (c) ***Modification to Account Credits.*** If an Enrollment Election is modified by a Covered Employee due to a permitted status change as provided in Section 4.03, the credits to the applicable Account shall be adjusted as of the effective date of such change and pursuant to rules established by the Plan Administrator.
- (d) ***No Investment Credits.*** No Account shall be credited with any interest or other investment return.

5.03 Debits to Accounts.

- (a) **Debit for Health Care Expense Claims.** As of each date that benefits are paid from the Health Care Reimbursement Account during a Coverage Period, there shall be deducted from the Covered Employee's Account for the related Plan Year an amount equal to the amount of the benefit paid to the Covered Employee for Health Care Expenses. In no event shall the amount of Health Care Expenses reimbursed during a Coverage Period exceed the annual amount of reduction in Compensation elected by the Covered Employee on the Enrollment Election for the related Plan Year.
- (b) **Debit for Dependent Care Expense Claims.** As of each date that benefits are paid from the Dependent Care Reimbursement Account during a Coverage Period, there shall be deducted from the Covered Employee's Account for the related Plan Year an amount equal to the amount of the benefit paid to the Covered Employee for Dependent Care Expenses. In no event shall any amount be reimbursed which would exceed the Account balance determined as of the date the claim is paid. That is, the payment shall not exceed the total amount of the reduction in Compensation elected by the Covered Employee in the Enrollment Election and in fact withheld from the Covered Employee's Compensation less any amounts previously reimbursed to the Covered Employee for that Coverage Period.
- (c) **Forfeitures.** For each Benefit Program, the Covered Employee's Account for any Plan Year shall only be used to pay claims incurred by the Covered Employee during the related Coverage Period. However, relative to both the Health Care Reimbursement Account and the Dependent Care Reimbursement Account, to the extent that claims are incurred during any period of time during which one Coverage Period extends beyond the start of the subsequent Coverage Period, benefits shall first be paid from any available balance in the Covered Employee's Account from the earlier Plan Year. Only after the Covered Employee's Account from the prior Plan Year has been exhausted, may claims incurred during the period of time during which one Coverage Period extends beyond the start of the subsequent Coverage Period be paid from the subsequent Plan Year's Account.

Any amount remaining in the Covered Employee's Account after all allowable claims attributable to that Coverage Period have been paid shall be forfeited. Such forfeited amounts may be used by the Employer to offset the reasonable administration expenses of the Plan or as otherwise permitted under §125 of the Code and other applicable regulations.

- (d) **No Plan Expenses.** No Account shall be charged for any expenses incurred by the Employer in administering the Plan.

5.04 Claims for Health Care Expenses and Dependent Care Expenses.

The Plan provides benefits to a Covered Employee in the form of reimbursement for Health Care Expenses and Dependent Care Expenses, subject to limitations described herein.

- (a) **Written Application for Health Care Expenses and Dependent Care Expenses.** Reimbursements from the Health Care Reimbursement Account and the Dependent Care Reimbursement Account shall not be made under such Benefit Program until the Claims Administrator has received a written claim from the Covered Employee. The Claims Administrator shall process each such Dependent Care Expense claim in accordance with the claims procedure described in Section 8.04 and each Health Care Expense claim in accordance with the claim procedure described in Section 8.05.
- (b) **Deadline.** All claims for reimbursement of Health Care Expenses and Dependent Care Expenses incurred in a given Plan Year must be postmarked no later than March 31 of the following year or another time established by the Plan Administrator within which such claims must be presented. Any claims received after that date shall not be paid.
- (c) **Proof.** No written claim will be paid unless:
 - (1) **Proof of Expense.** The Covered Employee adequately documents in writing the Health Care Expense or Dependent Care Expense as to its incurrence, amount and qualification to be paid. A copy of the provider's statement of services to the Covered Employee shall be adequate proof that such expense was incurred if it establishes the amount of the expense for the service, the nature of the service, the recipient of the service and the date the service was provided. In addition, the Covered Employee must provide the name and address of the service provider. No Health Care Expense or Dependent Care Expense will be reimbursed unless it is incurred in the Coverage Period corresponding to the Plan Year in which the pre-tax contributions were made.
 - (2) **No Tax Credit.** The Covered Employee represents in writing that no federal income tax credit has been or will be taken with regard to an expense that is reimbursed under any Benefit Program.
 - (3) **Duplication.** The Covered Employee represents in writing that the amount of the claim has not been reimbursed by any other source. If a Covered Employee receives benefits under a Benefit Program and also is reimbursed for such expenses from any other source at any time, the Covered Employee shall repay such benefits to the Employer to the extent of the duplication.

- (4) **Employment Status of Spouse.** For Dependent Care Expenses only, a Covered Employee who is married must provide the Claims Administrator with a written certification that the Covered Employee's spouse is employed, looking for work, a full-time student for at least 5 months of the year, or incapable of caring for himself or herself and satisfactory proof, as determined by the Plan Administrator, of the earned income or deemed income of the Covered Employee's spouse.

5.05 Limitations on Reimbursement of Dependent Care Expenses.

- (a) **No Payments for Services of Dependents.** A Covered Employee shall not be reimbursed for any Dependent Care Expenses paid for services rendered by the following:
 - (1) his or her child, if the child has not attained age 19 at the close of the taxable year in which the services were performed; or
 - (2) a Dependent, if a deduction under §151(c) of the Code (relating to personal exemptions for Dependents) is allowable to the Covered Employee or the spouse of the Covered Employee for the taxable year in which the services were performed.
- (b) **Earnings Limitations for Dependent Care Expenses.** Subject to the maximum reduction in Compensation limitation set forth in Section 3.04, the amount of Dependent Care Expenses paid under the Plan to a Covered Employee during his or her taxable year shall not exceed the lesser of:
 - (1) \$5,000 for a single Covered Employee or a married Covered Employee filing a joint income tax return, or \$2,500 for a married Covered Employee filing a separate income tax return (if a Covered Employee is married to another Covered Employee, the sum of the total reduction in compensation elected by both Covered Employees shall not exceed \$5,000);
 - (2) the Covered Employee's earned income for the 12-month period ending on the last day of the Covered Employee's taxable year; or
 - (3) if the Covered Employee is married, the earned income of the Covered Employee's spouse for the 12-month period ending on the last day of the such spouse's taxable year. (If the spouse has no earned income, for each month in which the spouse is either a full-time student or incapable of caring for himself or herself, such spouse shall be deemed to have earned income of \$250 per month if there is one Qualifying Individual or \$500 per month if there are two or more Qualifying Individuals.)

For purposes of this provision, "earned income" shall have the meaning given to it under §32(c)(2) of the Code, but shall not include any amounts paid or incurred by the Employer for dependent care assistance to a Covered Employee.

- (c) **Identifying Information Required.** A Covered Employee shall not be reimbursed for any Dependent Care Expense unless the Covered Employee provides the Claims Administrator with the name, address and taxpayer identification number of the person providing the service, and agrees to include such information in his or her personal income tax return for the Plan Year, or, if such provider is a tax-exempt entity under §501(c)(3) of the Code, the Covered Employee agrees to include the name and address of such provider on his or her personal income tax return for the Plan Year.

5.06 Other Exclusions and Limitations.

- (a) **New Covered Employees.** No benefit payment shall be made for any Premium Payment, Health Care Expense, or Dependent Care Expense incurred prior to the Covered Employee's enrollment in the applicable Benefit Program.
- (b) **No Advances.** No benefit payment shall be made which would cause the Covered Employee's Dependent Care Reimbursement Account from which such payment could be made to have a balance of less than zero.
- (c) **Dependent Care Expense Limitation.** Benefits shall not be paid from the Dependent Care Reimbursement Account for services provided outside the Covered Employee's household at a camp where the Qualifying Individual stays overnight.

5.07 Benefit Payments.

After the Covered Employee's right to reimbursement for a Health Care Expense or a Dependent Care Expense has been established, the Claims Administrator shall make the appropriate payment as soon as practicable. All benefits under the Plan other than Premium Payments shall be paid directly to the Covered Employee and not to any provider of the Health Care Expenses or Dependent Care Expenses with respect to which the claim is presented.

5.08 Termination of Enrollment Election.

Upon termination of an Enrollment Election, a Covered Employee's Health Expenses and Dependent Care Expenses will be handled in the following manner.

- (a) **Health Care Expense Claims.** Claims incurred by the Covered Employee on or after the effective date of the termination of the Enrollment Election shall not be eligible for reimbursement under the Health Care Reimbursement Account. Claims incurred by the Covered Employee before the effective date of the termination of the Enrollment Election shall be paid to the extent they would have been paid had the Enrollment Election not been terminated if they are postmarked no later than March 31 of the following year. If, after the payment of such claims, the Health Care Reimbursement Account is not exhausted, the remaining balance in the Account shall be forfeited.

Upon termination of a Covered Employee's Enrollment Election, any portion of reduction in Compensation actually withheld from the Covered Employee's Compensation and credited to the Covered Employee's separate Health Care Reimbursement Account that relates to the period on and after the effective date of the termination of the Enrollment Election (regardless of the Covered Employee's claims or reimbursements which relate to periods before such date) shall be refunded to the Covered Employee.

- (b) ***Dependent Care Expense Claims.*** Claims incurred by the Covered Employee before, on and after the effective date of the termination of the Enrollment Election shall be eligible for reimbursement under the Dependent Care Reimbursement Account to the extent of the Covered Employee's Account balance on the effective date of the termination of the Enrollment Election; provided such claims are incurred within the Coverage Period in which the effective date of the termination of the Enrollment Election occurred and otherwise meet the requirements for reimbursement set forth in this Plan Statement and provided that such claims are postmarked no later than March 31 of the following year. If, after the payment of such claims, the Account of the Covered Employee is not exhausted, the remaining balance in the Account shall be forfeited.

5.09 *Impact of Covered Employees Death on Health Care and Dependent Care Reimbursement Accounts.*

If a Covered Employee dies, the personal representative of the Covered Employee's estate may present claims for the following benefits under the Plan, which shall be paid to the same extent that they would if the Covered Employee had survived:

- (a) Benefits for Health Care Expenses or Dependent Care Expenses incurred prior to the Covered Employee's death; and
- (b) Benefits for Dependent Care Expenses incurred by the surviving spouse after the Covered Employee's death but during the Coverage Period in which the death occurred.

All such benefit payments shall be made to the personal representative of the Covered Employee's estate. The portion of reduction in Compensation credited to any Account of the Covered Employee that relates to the period after the date of the Covered Employee's death (regardless of the Covered Employee's claims or reimbursements which relate to periods before them) shall be refunded to the Covered Employee's personal representative. If, after the payment of such claims, the Covered Employee's Account is not exhausted, the remaining balance in the Account shall be forfeited.

5.10 HEART Reservist Withdrawals

Effective January 1, 2009, if a Covered Employee is in the military reserves and is called to active duty for at least 180 days, the Covered Employee may withdraw unused amounts in his or her Health Care Reimbursement Account, in accordance with the Heroes Earnings Assistance and Relief Tax Act of 2008 (“HEART”) and the terms of this Section 5.10. To be eligible for such withdrawal, the Covered Employee must be enrolled in the Health Care Reimbursement Account and be a member of a reserve component of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard reserve, or the Reserve Corps of the Public Health Service.

A qualifying Covered Employee may withdraw the excess (if any) of (a) the amount he or she had contributed to the Health Care Reimbursement Account through his or her salary reduction contributions, over (b) the amount of health care reimbursements he or she had received from such Account at the time of the withdrawal request. The Covered Employee must request this withdrawal before the end of the Plan Year in which he or she is called to active duty, in accordance with procedures specified by the Plan Administrator.

5.11 Non-Discrimination Rules

In accordance with Section 129 of the Code, the following rules apply to the Dependent Care Reimbursement Accounts:

- (a) No more than 25% of all benefits for Dependent Care Expenses under the Plan for any Plan Year shall be made from the Dependent Care Reimbursement Accounts of Covered Employees who are 5% or more owners (or the spouse or other dependent of such an owner), as described in Section 129(d)(4) of the Code.
- (b) If the average Dependent Care Expense reimbursements provided to Employees who are not highly compensated (within the meaning of Section 414(q) of the Code) under the Plan for any Plan Year is less than 55% of the average Dependent Care Expense reimbursements provided to highly compensated Participants, the benefits provided to highly-compensated Participants shall be taxable to such Participants. In applying the test set forth in this paragraph (c), Employees whose annual compensation (as determined under Section 414(q)(7) of the Code) is less than \$25,000 may be excluded.
- (c) The Plan Administrator may, in its discretion, limit the Dependent Care elections of highly-compensated participants to ensure that the Plan meets the tests set forth above and to avoid taxation of the Dependent Care benefits to such participants.
- (d) A statement of the total Dependent Care reimbursements provided to a Covered Employee under the Plan for the Plan Year shall be furnished to him or her by January 31 of the next Plan Year.

ARTICLE VI

FUNDING

6.01 *Source of Funds*

The Employer shall pay all benefits due under the Benefit Programs offered in the Plan from its general assets. For the purposes of the Plan, reductions in Compensation applied by the Employer to pay Premiums Payments for the Covered Employees are considered Employer contributions. In no case shall any amounts be segregated in a trust or other separate fund for the benefit of Covered Employees. All benefits due under the Plan shall be general, unsecured claims on the assets of the Employer.

ARTICLE VII

AMENDMENT AND TERMINATION

7.01 *Amendment.*

The Employer shall have the power by written instrument to amend this Plan Statement at any time and in any respect and for any reason either prospectively or retroactively or both.

7.02 *Termination of Plan.*

The Employer reserves the right to terminate the Plan or any Benefit Program by written instrument in whole or in part at any time and for any reason, including the right to terminate any part of the Plan or any Benefit Program as it pertains to any one or more classes of Covered Employees while maintaining that part for any other class or classes of Covered Employees.

7.03 *Adoption by Other Employers.*

- (a) *Adoption by Consent.* The Employer may consent to the adoption of the Plan by any Affiliate subject to such conditions as the Employer may impose, including special rules for employees of partnerships, S-corporations, LLCs, and other similar entities.
- (b) *Procedure for Adoption.* Any such adopting business entity shall initiate its adoption of the Plan by delivery of a certified copy of the resolutions of its board of directors (or other authorized body or individual) adopting this Plan Statement to the Employer. Upon the consent by the Employer to the adoption by the adopting business entity, the adoption of the Plan by the adopting business entity shall be effective as of the date specified by the Employer. If such adopting business entity is not a corporation, any reference in this Plan Statement to its board of directors shall be deemed to refer to such entity's governing body or other authorized individual.
- (c) *Effect of Adoption.* Upon the adoption of the Plan by an adopting business entity as heretofore provided, the adopting business entity shall be a Participating Affiliate hereunder in all respects. Each adopting business entity, as a condition of continued participation in the Plan, delegates to the Employer the sole power and authority over all Plan matters except that the board of directors of each adopting business entity shall have the power to amend this Plan Statement as applied to it by establishing a successor plan and to terminate participation in the Plan as applied to it. Each reference herein to the Employer shall include the Employer and all Participating Affiliates unless the context clearly requires otherwise.

ARTICLE VIII

CLAIMS DETERMINATIONS

8.01 *Determinations.*

Benefits under the Plan will be paid only if the Plan Administrator, or other person or persons to whom such authority has been delegated pursuant to Section 9.02 of the Plan Statement, decides in its discretion that the applicant is entitled to them. The Plan Administrator has discretionary authority to grant or deny benefits under the Plan. The Plan Administrator shall have the sole discretion, authority and responsibility to interpret and construe this Plan Statement and all relevant documents and information, and to determine all factual and legal questions under the Plan, including but not limited to the entitlement of all persons to benefits and the amounts of their benefits. The Plan Administrator shall make such determinations as may be required from time to time in the administration of the Plan. The discretionary authority shall include all matters arising under the Plan including, but not limited to, the determination of whether a medical child support order is a qualified medical child support order and the interpretation and administration of a qualified medical child support order.

8.02 *Rules.*

Any rule not in conflict or at variance with the provisions of this Plan Statement may be adopted by the Plan Administrator or other person or persons to whom such authority has been delegated pursuant to Section 9.02 of the Plan, including a Claims Administrator, if any; provided that the Plan Administrator may revoke or revise any rule adopted by a Claims Administrator at any time and for any reason, in its sole discretion. The rules, regulations, interpretations and determinations made by the Plan Administrator or any authorized person shall, subject only to the Plan's claims procedures, be final and binding on Covered Employees.

8.03 *Method of Executing Documents.*

Information to be supplied or written notices to be made or consents to be given by the Employer or the Plan Administrator under the Plan may be signed in the name of the Employer by any officer or by any employee who has been authorized to make such certification or to give such notices or consents.

8.04 *Claim and Review Procedure for Dependent Care Reimbursement Account Claims.*

Until modified by the Plan Administrator or a Claims Administrator with the consent of the Plan Administrator, the following claims procedure shall be the claims procedure for the resolution of disputes and disposition of Dependent Care Reimbursement Account claims arising under this Plan Statement.

- (a) **Initial Claim.** Any Covered Employee or former Covered Employee or beneficiary of either may file with the Claims Administrator a written request for benefits under this Plan Statement in a form and manner prescribed by the Plan Administrator or a Claims Administrator. All requests for reimbursement of Dependent Care Expenses incurred in a given Coverage Period must be postmarked no later than March 31, of the year immediately following the related Plan Year. Any claim not received by these deadlines will be denied as untimely and shall not be paid.

Within 30 days after the filing of such request, the Claims Administrator shall notify the claimant in writing or electronically whether the request is upheld or denied, in whole or in part, or, not more than 30 days from the date the claim was filed, shall furnish the claimant a written notice describing specific special circumstances requiring a specified amount of additional time (but not more than 15 additional) to reach an initial benefit determination on the request. 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. If the request is denied, in whole or in part, the Claims Administrator shall state in writing:

- (1) the specific reasons for the denial;
 - (2) the specific references to the relevant provisions of the Plan or Plan Statement on which the denial is based;
 - (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
 - (4) an explanation of the claims review procedure set forth in this Section.
- (b) ***Request for Review Procedure for Claims.*** Within 180 days after receipt of an initial benefit determination in which benefits have been denied, in whole or in part, the claimant may file with the Plan Administrator or a Claims Administrator a written request for a review and may, in conjunction therewith, submit written issues and comments. The claimant shall be provided upon request and free of charge reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Within 60 days after the request for review was filed, the Claims Administrator shall make a decision on the request for review and notify the claimant in writing or electronically of the Plan Administrator's or a Claims Administrator's decision.

(c) **General Rules.**

- (1) No inquiry or question shall be deemed to be an initial request for benefits, a request for review, or a claim of any type unless made in accordance with the claims procedure.
- (2) The Plan Administrator or a Claims Administrator may require that any initial request for benefits or request for review be filed on forms to be furnished by the Claims Administrator upon request. However, the time period in which the Claims Administrator shall make a determination based on a request for review will begin as of the date on which the request for review is filed in accordance with the Plan's claim and review procedures, regardless of whether all the information necessary to make a benefit determination accompanies the request for review.
- (3) All decisions on initial requests for benefits and requests for review shall be made by the Claims Administrator.
- (4) The Plan Administrator or a Claims Administrator may, in its discretion, hold one or more hearings.
- (5) Claimants may be represented by a lawyer or other representative at their own expense, but the Plan Administrator, Employer or the Claims Administrator reserves the right to require the claimant to furnish written authorization. A claimant's representative shall be entitled to copies of all notices given to the claimant.
- (6) All determinations by the Plan Administrator or the Claims Administrator shall be served on the claimant in writing. If a decision or notice is not received by a claimant within the time specified, the initial request for benefits or request for review, as applicable, shall be deemed to have been denied.
- (7) The claimant or the claimant's representative shall have a reasonable opportunity to review a copy of the Plan Statement and, if a claim is denied, other relevant documents in the possession of the Plan Administrator or the Claims Administrator.
- (8) The Plan Administrator or the Claims Administrator may, in its discretion, rely upon any applicable statute of limitations as a basis for denial of any claim.

8.05 Claim and Review Procedure for Health Care Reimbursement Account Claims.

Until modified by the Plan Administrator or a Claims Administrator with the consent of the Plan Administrator, the following claims procedure shall be the claims procedure for the resolution of disputes and disposition of Health Care Reimbursement Account claims arising under this Plan Statement.

- (a) **Initial Claim.** Any Covered Employee or former Covered Employee or beneficiary of either may file with the Claims Administrator a written request for benefits under this Plan Statement in a form and manner prescribed by the Claims Administrator. All requests for reimbursement of Health Care Expenses incurred in a given Plan Year must be postmarked no later than March 31, of the following year. Any claim not received by these deadlines will be denied as untimely and shall not be paid.

Within 30 days after the filing of such request, the Claims Administrator shall notify the claimant in writing or electronically whether the request is upheld or denied, in whole or in part, or, not more than 30 days from the date the claim was filed, shall furnish the claimant a written notice describing specific special circumstances requiring a specified amount of additional time (up to 15 additional days) to reach an initial benefit determination on the request. 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. If the request is denied, in whole or in part, the Plan Administrator or a Claims Administrator shall state in writing:

- (1) the specific reasons for the denial;
- (2) the specific references to the pertinent provisions of the Plan or Plan Statement on which the denial is based;
- (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (4) an explanation of the claims review procedure set forth in this Section, including a statement of the claimant's right to bring a civil action under §502(a) of ERISA following an adverse benefit determination on review; and;
- (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

(b) **Request for Review Procedure for Claims.** Within 180 days after receipt of an initial benefit determination in which benefits have been denied, in whole or in part, the claimant may file with the Claims Administrator a written request for a review and may, in conjunction therewith, submit written issues and comments. The claimant shall be provided upon request and free of charge reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Within 60 days after the request for review was filed, the Plan Administrator or a Claims Administrator shall make a decision on the request for review and notify the claimant in writing or electronically of the Plan Administrator's or a Claims Administrator's decision. If the request for review is denied, in whole or in part, the Plan administrator or a Claims Administrator shall state in writing:

- (1) the specific reasons for the denial;
- (2) the specific references to the pertinent provisions of the Plan or Plan Statement on which the denial is based;
- (3) a statement of the claimant's right to bring a civil action under §502(a) of ERISA following an adverse benefit determination on review; and;
- (4) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- (5) a statement of the claimant's rights to be provided upon request and free of charge reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits and a statement that the claimant and the Plan may have voluntary alternative dispute resolution options, such as mediation, and that the claimant can contact the local U.S. Department of Labor Office for more information.

(c) **General Rules.**

- (1) No inquiry or question shall be deemed to be an initial request for benefits, a request for review, or a claim of any type unless made in accordance with the claims procedure.

- (2) The Claims Administrator may require that any initial request for benefits or request for review be filed on forms to be furnished by the Claims Administrator upon request. However, the time period in which the Plan Administrator or Claims Administrator shall make a determination based on a request for review will begin as of the date on which the request for review is filed in accordance with the Plan's claim and review procedures, regardless of whether all the information necessary to make a benefit determination accompanies the request for review.
- (3) All decisions on initial requests for benefits and requests for review shall be made by the Claims Administrator.
- (4) The Plan Administrator or a Claims Administrator may, in its discretion, hold one or more hearings.
- (5) The review of a denied initial request will be conducted by the appropriate named fiduciary of the plan, who is neither the individual that made the individual benefit determination nor a subordinate of the individual who made the initial benefit determination. The review of a denied claim will not afford deference to the initial determination.
- (6) Claimants may be represented by a lawyer or other representative at their own expense, but the Employer or the Claims Administrator reserves the right to require the claimant to furnish written authorization. A claimant's representative shall be entitled to copies of all notices given to the claimant.
- (7) All determinations by the Employer or the Claims Administrator shall be served on the claimant in writing.
- (8) The claimant or the claimant's representative shall have a reasonable opportunity to review a copy of the Plan Statement.
- (9) The Employer or the Claims Administrator may, in its discretion, rely upon any applicable statute of limitations as a basis for denial of any claim.

8.06 *Exhaustion of Administrative Remedies.*

Notwithstanding any provision in this Plan Statement, the exhaustion of the above claim and review procedure is mandatory for resolving every claim and dispute arising under the Plan. In any subsequent legal action all explicit and all implicit determinations by the Plan Administrator or Claims Administrator (including, but not limited to, determinations as to whether the initial request for benefits or request for review was timely filed) shall be afforded the maximum deference permitted by law

8.07 *Knowledge of Fact Imputed to Beneficiary and Others.*

Knowledge of all facts that a Covered Employee or eligible Dependent knew or reasonably should have known shall be imputed to every claimant who is or claims to be a beneficiary of the Covered Employee or eligible Dependent or otherwise claims to derive an entitlement by reference to the Covered Employee, eligible Dependent or beneficiary for the purpose of applying the previously specified periods.

8.08 *Information Furnished by Covered Employee, Eligible Dependent or Beneficiary.*

Neither the Employer, the Plan Administrator nor the Claims Administrator shall be liable or responsible for any error in the computation of the benefits of a Covered Employee, eligible Dependent or beneficiary resulting from any misstatement of fact or law made by the Covered Employee, eligible Dependent or beneficiary, directly or indirectly, to the Employer, the Plan Administrator or Claims Administrator and used by it in determining the Covered Employee's or eligible Dependent's or beneficiary's benefits. Neither the Employer, the Plan Administrator nor the Claims Administrator shall be obligated or required to increase the benefits of such Covered Employee, eligible Dependent or beneficiary which, on discovery of the misstatement, are found to be understated as a result of such misstatement of the Covered Employee, eligible Dependent or beneficiary. However, the benefits of any Covered Employee, eligible Dependent or beneficiary that are overstated by reason of any such misstatement shall be reduced to the amount appropriate in view of the truth.

ARTICLE IX

ADMINISTRATIVE MATTERS

9.01 *Delegation of Responsibilities.*

Functions generally assigned to the Employer shall be discharged by the Plan Administrator or the Employer's officers or delegated and allocated as provided herein. The Employer may delegate or redelegate and allocate and reallocate to one or more persons, jointly or severally, whether or not such persons are officers or employees, such functions assigned to the Employer or the Plan Administrator hereunder as may from time to time be advisable. Any such delegation or allocation of responsibilities shall be made in writing.

9.02 *Plan Administrator.*

The administration of the Plan shall be under the supervision of the Employer, as Plan Administrator. It shall be a 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.

9.03 *Authority.*

The Plan Administrator shall have the authority to:

- (a) establish rules for the functioning of the Plan, to the extent consistent with the provisions of the Plan Statement;
- (b) keep a record of all its administrative acts and decisions and keep all books of account, records and other data as may be necessary for the proper administration of the Plan;
- (c) notify the Employer of any action taken and, when required, notify any other interested person or persons;
- (d) determine from the records of the Employer the compensation, service records, status and other facts regarding Covered Employees and other employees;
- (e) to the extent required by law, cause to be compiled at least annually, from the records of the Plan Administrator and the reports and accountings of the Employer, a report and accounting of the status of the Plan and the Accounts of the Covered Employees, and make it available to each Covered Employee who shall have the right to examine that part or portion of such report and accounting (or a true and correct copy of such part) which sets forth that Covered Employee's benefits;
- (f) prescribe forms to be used for applications for participation, claims, notifications, etc., as may be required in the administration of the Plan;
- (g) set up such rules as are deemed necessary to carry out the terms of this Plan Statement;

- (h) perform all other acts reasonably necessary for administering the Plan and carrying out the provisions of this Plan Statement and performing the duties imposed on it;
- (i) resolve all questions of administration of the Plan not specifically referred to in this Section; and
- (j) delegate or redelegate to one or more persons, jointly or severally (including delegation to a Claims Administrator), and whether or not such persons are employees of the Employer, such functions assigned to the Plan Administrator hereunder as it may from time to time deem advisable.

9.04 *Automatic Removal.*

If any individual appointed a Plan Administrator is a director, officer or employee when appointed as Plan Administrator, then such individual shall be automatically removed as Plan Administrator at the earliest time such individual ceases to be a director, officer or employee. This removal shall occur automatically and without any requirement for action by the Employer or any notice to the individual so removed.

9.05 *Fiduciary Principles.*

Each fiduciary hereunder, in the exercise of each and every power or discretion vested in them by the provisions of this Plan Statement, shall (subject to the applicable provisions of ERISA) discharge their duties with respect to the Plan:

- (a) solely in the interest of the Covered Employees;
- (b) for the exclusive purpose of providing benefits to Covered Employees and their beneficiaries;
- (c) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- (d) in accordance with the documents and instruments governing the Plan, insofar as they are consistent with the provisions of ERISA.

9.06 *Limitation on Authority.*

No action taken by any fiduciary, if authority to take such action has been delegated or redelegated to it hereunder, shall be the responsibility of any other fiduciary except as may be required by ERISA. Except to the extent imposed by ERISA, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all of the responsibility imposed upon such other fiduciary by this Plan Statement or by ERISA or by any regulations or rulings issued thereunder.

9.07 *Conflict of Interest.*

If any officer, director or employee of the Employer to whom authority has been delegated or redelegated hereunder shall also be a Covered Employee in any Benefit Program, the individual shall have no authority with respect to any matter specially affecting his or her individual interest including the interest of a Dependent hereunder (as distinguished from the interests of all Covered Employees or a broad class of Covered Employees), all such authority being reserved exclusively to the Plan Administrator, other officers or employees, as the case may be, to the exclusion of such Covered Employee, and such Covered Employee shall act only in his or her individual capacity in connection with any such matter.

9.08 *Dual Capacity.*

Individuals, firms, corporations or partnerships identified herein or delegated or allocated authority or responsibility hereunder may serve in more than one capacity.

9.09 *Indemnity.*

Except as prohibited by applicable law, the Employer shall indemnify and hold harmless from any and all liabilities, costs and expenses (including legal fees), to the extent not covered by insurance, the Plan Administrator of the Plan, and each officer, director, employee of the Employer, who is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding with respect to the Plan, whether imposed under ERISA or otherwise, wherever brought, whether civil, criminal, administrative or investigative by reason of the fact that the individual is or was a fiduciary or administrator of the Plan (as defined in ERISA), or by reason of acting in any other capacity in connection with such plans. No such indemnification, however, shall be required or provided if such liability arises (i) from the individual's claim for his own benefit, (ii) from the proven gross negligence or the bad faith of the individual, or (iii) from the criminal misconduct of such individual if the individual had reason to believe the conduct was unlawful.

The termination of any action, suit or proceeding by judgment, order, settlement, conviction or upon a plea of no lo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith, was grossly negligent and, with respect to any criminal action or proceeding, had reasonable cause to believe that the individual's conduct was unlawful. This indemnification shall continue as to an individual who has ceased to be the Plan Administrator of the Plan, or officer, director, employee of the Employer, and shall inure to the benefit of the heirs, executors and administrators of such an individual.

ARTICLE X

COMPLIANCE

10.01 Compliance With Law.

Relative to the Health Care Reimbursement Account, participation in, eligibility for, benefits provided by, and administration of the Plan will comply with ERISA and other applicable legal requirements, as they may be amended or enacted in the future (such requirements are referred to collectively in this Section as “the Law”). The Employer will apply the provisions of this Plan Statement in a manner that complies with the Law. In the event the Law is amended in such a way that any provision of this Plan Statement would fail to comply with the Law, the Employer will administer the Plan, with regard to the subject matter of such provision, in a manner that complies with the Law, as determined by the Employer, and need not be bound by the literal language of this Plan Statement to the extent that it conflicts with the Law.

10.02 Nondiscrimination.

Coverage and benefits provided under the Plan are intended to with any relevant nondiscrimination provisions of the Code or ERISA, including the tests set forth in Section 5.11 with respect to the Dependent Care Reimbursement Accounts.

10.03 Remedial Action.

The Employer shall restrict enrollment or reduce benefits, or both, in such manner as the Employer shall determine, to comply with the requirements of this Section.

ARTICLE XI

COBRA CONTINUATION COVERAGE

11.01 General Rule.

Continuation coverage as provided by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is only available for the Health Care Reimbursement Account, and not for the Premium Payment Program or the Dependent Care Reimbursement Account. If a qualified beneficiary (as defined by COBRA and its regulations) loses coverage under the Health Care Reimbursement Account as a result of a qualifying event (as defined by COBRA and its regulations), and has a balance remaining in his or her Health Care Reimbursement Account at such time, the qualified beneficiary may continue participation in the Health Care Reimbursement Account for the remainder of the Plan Year in which the qualifying event occurs by completing and returning a COBRA election form to the designated COBRA administrator and then making Premium Payment contributions to the Health Care Reimbursement Account on an after-tax basis.

11.02 Election.

The qualified beneficiary will have 60 days from the later of the date coverage is lost or the date of the notice of right to continuation coverage, to complete an election of continuation coverage. If the election is not completed within the 60-day period, the qualified beneficiary will not have continuation coverage under the Health Care Reimbursement Account and will have no further rights to elect such coverage under the Plan.

11.03 Premium.

The applicable premium for continuation coverage may be up to 102 percent of the total cost of the coverage elected. The qualified beneficiary will have 45 days from the date continuation coverage is elected to pay the initial Premium Payment for continuation coverage (which shall include all monthly payments due beginning with the month coverage was lost and ending with the month in which the 45 days expires). Subsequent Premium Payments must be received by the COBRA administrator by the first day of the month. If subsequent Premium Payments are not received within 30 days of the first day of the month, the continuation coverage elected will be terminated and the qualified beneficiary will have no further rights to elect continuation coverage under the Health Care Reimbursement Account. Even if continuation coverage is elected, benefits will not be paid from the Health Care Reimbursement Account until all the premiums which are due have been paid without regard to any grace period.

11.04 Maximum Coverage Period.

The maximum period for continuation coverage is the remainder of the Plan Year in which the qualifying event occurs.

11.05 Termination Before the End of Maximum Coverage Period.

Continuation coverage may end prior to the expiration of the maximum coverage period. The following events will cause the elected continuation coverage to terminate immediately:

- (a) Employer no longer provides group health benefits to any of its employees; or
- (b) Qualified beneficiary fails to pay the premium for the continuation coverage elected (*i.e.*, within 30 days of the first day of the month); or
- (c) Qualified beneficiary becomes covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that the individual has, after the date continuation coverage is elected.

11.06 Compliance

Relative to the Health Care Reimbursement Account, to the extent this Plan Statement does not specify COBRA rights in accordance with Code §4980B, the Employer shall administer the continuation rights in accordance with Code §4980B. In addition, the Plan Administrator shall adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Article XI.

ARTICLE XII

HIPAA PRIVACY AND DATA SECURITY PROVISIONS

12.01 HIPAA Provisions.

This Plan is part of the Associated Universities, Inc. Employee Welfare Benefit Plan (the “Welfare Plan”) and is subject to the Welfare Plan’s provisions regarding protected health information under the Health Insurance Portability and Accountability Act of 1996.

ARTICLE XIII

MISCELLANEOUS

13.01 No Assignment.

No Covered Employee or Dependent shall have any transmissible interest in any benefit under the Plan nor shall any Covered Employee or Dependent have any power to anticipate, alienate, dispose of, pledge or encumber the same, nor shall the Employer recognize any assignment thereof, either in whole or in part, nor shall any benefit be subject to attachment, garnishment, execution following judgment or other legal process, provided that a Covered Employee or Dependent may authorize, to the extent anticipated by the applicable provisions of this Plan Statement, that benefits due or receivable under the Plan be made available to the facility or other provider furnishing services for which such benefits are payable. This Section shall not prevent the Employer from complying with §609 of ERISA.

13.02 Facility of Payment.

In case of the legal disability, including minority, of a Covered Employee or beneficiary entitled to receive any direct payment under the Plan, payment shall be made, if the Employer shall be advised of the existence of such condition:

- (a) To the duly appointed guardian, conservator or other legal representative of such Covered Employee or beneficiary; or
- (b) To a person or institution entrusted with the care or maintenance of the incompetent or disabled Covered Employee or beneficiary, provided such person or institution has satisfied the Employer that the payment will be used for the best interest and assist in the care of such Covered Employee or beneficiary, and provided further, that no prior claim for said payment has been made by a duly appointed guardian, conservator or other legal representative of such Covered Employee or beneficiary.

Any payment made in accordance with the foregoing provisions of this Section shall constitute a complete discharge of any liability or obligation of the Employer and the Plan therefore. In the event of the death of the Covered Employee or beneficiary, claims for expenses incurred prior to the Covered Employee's or beneficiary's death may be presented by the personal representative of the Covered Employee's or beneficiary's estate and benefit payments not completed at death shall be made to the personal representative.

13.03 Named Fiduciaries.

The Employer and the Plan Administrator appointed hereunder shall be named fiduciaries for the purpose of §402(a) of ERISA.

13.04 Administrator.

The Employer shall be the administrator for purposes of §3(16)(A) of ERISA.

13.05 Service of Process. In the absence of any designation to the contrary by the Employer, the Office of the Corporate Counsel of the Employer is designated as the appropriate and exclusive agent for the receipt of service of process directed to the Plan in any legal proceeding, including arbitration, involving the Plan.

13.06 Validity.

The invalidity or unenforceability of any provision of the Plan shall not affect the validity or enforceability of any other provision of the Plan that shall remain in full force and effect.

13.07 Governing Law.

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law.

13.08 No Employment Rights.

Neither the terms of this Plan Statement nor the benefits hereunder nor the continuance thereof shall be a term of the employment of any employee, and the Employer shall not be obliged to continue the Plan. The terms of this Plan Statement shall not give any employee the right to be retained in the employment of the Employer.

13.09 No Guarantee.

Neither the Employer nor any of the Employer's officers in any way secure or guarantee the payment of any benefit or amount that may become due and payable hereunder to any Covered Employee. Neither the Employer nor any of the Employer's officers shall be under any liability or responsibility (except to the extent that liability is imposed under ERISA) for failure to effect any of the objectives or purposes of the Plan by reason of the insolvency of the Employer.

13.10 No Co-Fiduciary Responsibility.

Except as is otherwise provided in ERISA, no fiduciary shall be liable for an act or omission of another person with regard to a fiduciary responsibility that has been allocated to or delegated in this Plan Statement or pursuant to procedures set forth in this Plan Statement.

SCHEDULE A

Effective January 1, 2008, the Benefit Programs maintained by the Employer, the provisions of which are incorporated into the Plan by reference, for which the employee's share of the premium may be paid on a pre-tax basis through the Premium Payment Program of the Plan.

- The medical benefits provided by the Connecticut General Life Insurance Company under the Associated Universities Inc. Employee Welfare Benefit Plan
- The dental benefits administered by Eastern Benefit Systems, Inc. under the Associated Universities Inc. Employee Welfare Benefit Plan
- The medical benefits provided by the Connecticut General Life Insurance Company under the Associated Universities Inc. Comprehensive Medical Insurance Plan

**FIRST AMENDMENT TO THE
ASSOCIATED UNIVERSITIES INC.
FLEXIBLE SPENDING ACCOUNTS PLAN**

As Amended and Restated Effective January 1, 2008

* * *

The Associated Universities Inc. Flexible Spending Accounts Plan (the "Plan") is hereby amended in the following respects, effective as of January 1, 2011:

1. Section 2.11 of the Plan is replaced in its entirety with the following language:

2.11 "***Dependent.***" For purposes of the Plan, the term Dependent means:

- (a) the Participant's opposite-sex spouse
- (b) any child of the Participant who is under age 26, (provided, however, that for purposes of the Health Care Reimbursement Account, "Dependent" also includes a child of the Participant through the end of the calendar year in which he or she reaches age 27); and
- (c) any other individual who qualifies as the Participant's dependent under Code Section 152, or who would qualify as such a dependent if not for the limit on income in 152(d)(1)(B) or the conditions of Section 152(b)(1) and (b)(2).

Nothing in this Section shall extend eligibility for coverage under any dental plan offered by the Employer beyond that provided under the terms of such plan.

2. Section 2.21 of the Plan is amended by adding the following language at the end of the first paragraph thereof:

Notwithstanding the foregoing, effective January 1, 2011, a medicine or drug (other than insulin) shall be considered a qualifying health care expense only if such medicine or drug is obtained through a prescription.

3. Section 3.04(b)(2) is amended in its entirety to read as follows:

(2) ***Health Care Reimbursement Account.*** A maximum of \$3,500 per Plan Year, or such greater or lesser amount as the Employer may establish in advance of a particular Plan Year; provided, however, that effective January 1, 2013, in no event will such maximum amount

exceed \$2,500 (adjusted for inflation in accordance with the rules of Section 125(i)(2) of the Code).

* * *

IN WITNESS WHEREOF, Associated Universities Inc. has caused this instrument to be executed by its duly authorized officer on this 17th day of December, 2010, effective as of the dates set forth above.

ASSOCIATED UNIVERSITIES INC.

By: Cynthia Allen
Cynthia Allen
Associate Vice President – Administration
and Corporate Controller

**SECOND AMENDMENT TO THE
ASSOCIATED UNIVERSITIES, INC.
FLEXIBLE SPENDING ACCOUNTS PLAN**

As Amended and Restated Effective January 1, 2008

* * *

The Associated Universities Inc. Flexible Spending Accounts Plan (the "Plan") is hereby amended as follows, effective as of the first day of the month following the date of execution below:

1. Section 2.37 of the Plan is amended in its entirety to state as follows:

2.37 "Spouse"

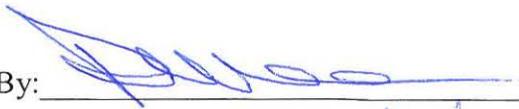
For purposes of the Plan, the term Spouse means the person who is legally married to the Employee or Qualified Beneficiary under the laws of the state in which the marriage was entered into.

* * *

IN WITNESS WHEREOF, Associated Universities Inc. has caused this instrument to be executed by its duly authorized officer on this 20th day of August, 2013.

ASSOCIATED UNIVERSITIES, INC.

By: _____


Vice President - Administration