NSM Insurance Group
SECTION 125 CAFETERIA PLAN

Effective Date: 01/01/2022

Package Version: 1
Form Edition: 18

NSM Insurance Group Cafeteria Plan (the "Plan")

This document constitutes both the formal Plan Document and also constitutes the Summary Plan Description for the NSM Insurance Group Cafeteria Plan (referred to as the "Plan" in this document).

The Plan provides to Eligible Employees and Dependents of NSM Insurance Group certain benefits, as described in this document. This document is designed as a plan document and a summary plan description, to provide Employees and their eligible Dependents with information about the Plan. The Employer intends that this Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), and that the benefits under the Plan be excludable from the Employee's income under Sections 105, 106 and 125(a) and other applicable sections of the Code.

Due to the nature of this Plan, many of the terms and conditions are a little complicated. In order to provide some clarity and simplify some of those terms so that they are presented in a more understandable manner, there are Summary Boxes within the document with helpful and useful summaries of the terms.

All terms and conditions of the Plan, including the Summaries, are subject to the discretion and interpretation of the Plan Administrator, except as specifically reserved for any insurer, if applicable.

Although the Employer's present intent is to continue this Plan indefinitely, please be advised and aware that the Employer retains the absolute right to substitute other coverage, initiate and change employee contribution amounts as permitted by law, and amend, change, modify, and/or completely terminate some or all of the benefits, plans, programs and insurance coverage under this Plan, at any time. Neither this document nor any other writing regarding the Plan will grant or confer any vested or other rights to any employee, former employee or any other person for future benefits beyond amounts payable for periods of time while the Plan is in effect and that are not specifically provided for in the Plan terms.

This Plan is effective as stated herein.

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NSM Insurance Group Cafeteria Benefit (the "Plan")

ARTICLE I - PLAN DATA AND INFORMATION ("PLAN DATA")

Description	Plan Information
1. Employer and Plan Sponsor	NSM Insurance Group
2. Address:	555 East North Lane, Conshohocken, PA 19428 610-808-9763
3. Plan Administrator:	NSM Insurance Group
4. Plan Name:	NSM Insurance Group Cafeteria Plan
5. Plan Type and Funding:	Cafeteria Plan Funded by Employee Payroll, and if indicated in 6(c) or 6(d), Employer Contributions
6. Benefit Offering:	
6(a) Pre-Tax Premium Payment	Yes
6(b) Flexible Spending Account Maximum Amount:	Yes Maximum Dollar Amount Applies
If Yes, Does Rollover Apply? Amount:	Yes - No FSA Grace Period Applies Maximum Dollar Amount Applies
6(c) Voluntary Insurance Premium Payment	No
Does the Employer Contribute toward Voluntary Insurance Premium Payments? Amount:	N/A N/A
6(d) Health Savings Account Maximum Amounts:	Yes Individual: Maximum Dollar Amount Applies Family: Maximum Dollar Amount Applies
Does the Plan Permit Catch-Up Contributions? Maximum Amount:	No N/A
Does the Employer Contribute toward Health Savings Accounts? Amount:	Yes $112.50 for single coverage, $210 for employee + Spouse & Employee + Child(ren), $310 for family coverage
6(e) Dependent Care Account Maximum Amounts:	Yes Married Jointly, or Head of Household: Maximum Dollar Amount Applies Married Filing Separately: Maximum Dollar Amount Applies

Description	Plan Information
7. Employer Identification Number:	20-1804371
8. Type of Administration:	See Article VIII
9. Agent for Service of Process:	The Employer Listed Above, At the Address Above
10. Plan Year:	Twelve Month Period Beginning: January 1
11. Effective Date:	01/01/2022
12. Eligible Employee:	Any Employee Who is Eligible for any Constituent Benefit Program for Purposes of any Pre-Tax Payments. All other Eligibility is Based upon Plan Rules and Employer Timing and Rules, including any annual enrollment requirements.
13. Participating Employers:	Below is a list of any other Employers who participate in the Plan: No other companies participate
14. Special Rules:	N/A

ARTICLE II - PURPOSE AND PARTICIPATION

2.1 Purpose of Plan

The Plan provides to Eligible Employees and Eligible Dependents of the Employee certain benefits, as described in this document. This document is designed as a plan document and a summary plan description, to provide Eligible Employees and their Eligible Dependents with information about the Plan. The Employer intends that this Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), and that the benefits under the Plan be excludable from the Employee's income under Sections 105, 106 and 125(a) and other applicable sections of the Code.

2.2 Eligibility

An Eligible Employee is defined in Article I, Part 12, and such Employee shall be eligible to participate in the Plan as of the date that such Employee satisfies the eligibility conditions stated or if later, when the Employee becomes eligible under the Employer's group medical plan. Any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.3 Effective Date of Participation

An Eligible Employee becomes a Participant on the entry date specified above in Article I, Part 12, or under the Employer's group medical plan, if later. The Eligibility provisions of the Employer's group medical plan are incorporated in this section by reference.

2.4 Application to Participate

An Employee who is eligible to participate in this Plan must during the applicable Election Period complete a Salary Redirection or Reduction Agreement, an application to participate, and election of benefits form provided by the Plan Administrator. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.3 hereof. The election is effective with the first pay period following the submission of all forms in a manner acceptable to the Plan Administrator or its designee.

2.5 Termination of Participation

A Participant is no longer a Participant in this Plan in the event that the Participant terminates employment, dies, or this Plan is terminated. If a Participant terminates employment and is reemployed and again becomes an Eligible Employee, such Eligible Employee shall again become a Participant in the Plan when the Employee satisfies the Eligibility Requirements. If such Employee was reemployed within 30 days of such Employee’s date of employment termination, such Employee shall return to his previous Plan elections in effect, unless the Plan Administrator determines that such Employee should be permitted to make new elections, consistent with the terms of the Plan and the Code.

2.6 Change in Employment Status

If a Participant ceases to be eligible to participate in the Plan because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made on behalf of the Participant, and further Benefit elections shall cease, subject to the limited Participant's right to continue coverage under any Insurance Contracts. Any balances in a limited Participant's Dependent Care Flexible Spending Account may be used during such Plan Year to reimburse the limited Participant for any allowable Employment-Related Dependent Care incurred during the Plan Year. If the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided that the other participation requirements are met and the required paperwork is submitted.

2.7 Benefits on Termination of Employment

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options under the Plan is as follows:

(a) Insurance Benefits. With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid, or if a healthcare plan, subject to COBRA continuation.

(b) Dependent Care Account. With regard to the Dependent Care Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related Dependent Care Expense reimbursements for claims incurred up to the date of termination and submitted within ninety (90) days after termination, unless your other plan terms and your third party administrator apply the Dependent Care Grace Period after termination of employment, based on the amount that remains in the Dependent Care Account of the Participant as of the date of termination.

(c) COBRA. With regard to the Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Flexible Spending Account have already been made. After that, the health benefits under this Plan, including the Flexible Spending Account, shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 10.1 of the Plan. If the Plan is a Church Plan, then COBRA does not apply.

2.8 Death

In the event that a Participant dies, the Participant's Spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a Spouse or Dependent.

Summary - Purpose and Participation

Eligibility. You become eligible to participate in the Plan (referred to as an Eligible Employee or Participant), if you meet the requirements in the Plan Data Summary in Article I. That Plan Data also has additional useful information for you.

Termination of Eligibility. Your eligibility terminates if certain events occur, such as your termination of employment or death, but may be extended for certain benefits - See Section 2.7

ARTICLE III - CONTRIBUTIONS TO THE PLAN

3.1 Salary Reduction

Benefits under the Plan shall be financed by Salary Reduction to fund the Pre-Tax Premium amounts, the Flexible Spending Account, and the Dependent Care Accounts, as they may apply under the Plan, as indicated in the chart in Article I. The Voluntary Insurance Premium Payment, if selected, is funded in part by the Employer and by Salary Reduction, as applicable, depending upon the Voluntary Insurance selected by the Eligible Employee. Salary Reduction amounts may be changed from year to year.

A Participant may revoke a Benefit election or a Salary Reduction after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both are because of a change in status as described below in Article V.

3.2 Employer Contributions and Application of Contributions

As soon as administratively possible after each payroll period, the Employer shall apply the Salary Reduction amounts to the Benefits selected under this Plan and credit such amounts accordingly.

3.3 Periodic Contributions

Normally under the Plan, Salary Reduction amounts will be contributed to the Plan on a level and pro rata basis for each payroll period. However, the Plan Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period.

Summary - Contributions

Benefits and Salary Reduction. Salary Reduction amounts are those taken from your pay on a pre-tax basis, meaning that they are not subject to tax. These amounts are turned over to pay for certain of your benefits, such as medical, dental, vision, etc. Flexible Spending amounts and Dependent Care amounts are also taken from your pay pre-tax, subject to the limits which are described later, and can be used for medical expenses (Flexible Spending) and for Dependent Care.

Tax Savings Example. Suppose that you make $100.00, your tax rate is 25% and you need to pay $10.00 for your benefits. You would pay $25.00 in taxes and then $10.00 for your benefits, leaving you $65.00

In this pre-tax Salary Reduction portion of the Plan, we take the $10.00 off the top first, pre-tax. Then only $90.00 subject to tax, leaving you with more money, $67.50. So, there is a tax savings and advantage to the pre-tax benefits.

ARTICLE IV - BENEFITS

4.1 Benefit Options and Applicable Provisions

Each Participant may elect any one or more of the following optional benefits under the Plan, if, and only if, such benefit is marked as being provided under the Plan in the Plan Data in Article I.

(a) Pre-Tax Premium Payment (described in Section 4.2);

(b) Flexible Spending Account (described in Section 4.3);

(c) Voluntary Insurance Premium Payment (described in Section 4.4);

(d) Health Savings Accounts (described in Section 4.5); and

(e) Dependent Care Account (described in Section 4.6).

The terms and conditions that apply to each of these Benefit Options are provided in this document.

4.2 Pre-Tax Premium Payments

Under the Plan, Eligible Employees may reduce their compensation before applicable federal and most state taxes are deducted to pay for the employee portion of premiums for employee benefit programs sponsored by the Employer. These reductions in compensation are permitted under an agreement between the Employee and Employer ("Salary Reduction Agreement"). Under these Salary Reduction Agreements, the Employer reduces the Employee's taxable pay and applies such amounts towards the cost of the benefit options chosen by the Employee. The amount of compensation reduced pursuant to the Salary Reduction Agreement and applied by the Employer towards the cost of the benefit options is referred to herein as Pre-tax Premium Payments. These only apply for employee benefit options that cover the Employee and the Eligible Dependents, as defined in Code Section 152 (except as otherwise defined in Code Section 105 for health plan purposes, Code Section 21 for Dependent Care FSA purposes, and Code Section 223 for health savings account purposes under a separate plan for this purpose established by the Employer and only to the extent applicable). Employees may elect (and in certain cases, the Employer may require Employees) to pay any employee contribution on an after-tax basis and not subject to this Plan, including without limitation, for purposes of disability benefit payments, in order to take advantage of the tax benefits of paying for such benefits with after-tax dollars.

4.3 Flexible Spending Accounts for Health Benefits

(a) The Flexible Spending Account. If selected in the Plan Data, the Flexible Spending Account permits Eligible Employees to have pre-tax amounts withheld from their pay, subject to the limits that apply, and submit claims for the reimbursement of permitted Medical Expenses from the money held in the Flexible Spending Account for such Eligible Employee.

(b) Allowable Flexible Spending Amounts. A Participant who contributes to a Flexible Spending Account may be reimbursed for Allowed Medical Expenses. Allowed Medical Expense are those that are for an expense for "Medical Care" as defined by Code Section 213(d) that is incurred by the Employee or their Eligible Dependents that is not being reimbursed by any other source, and for which the Employee will not seek reimbursement for the expense from any other source. The maximum allowable amount is specified in Article I, and the maximum amount allowable by law may be selected. If the maximum amount allowable by law is selected, the amount automatically changes as the amounts are changed under law. See Section 4.5(f)(i) & (ii) if there is also a Health Reimbursement Account.

(c) Medical Care. "Medical Care" means any amount incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This also includes any over-the-counter drugs and medicines prescribed by a physician. Over-the-counter products and devices, other than drugs or medicine are included. If an item is merely beneficial for health (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect, the item is not included. See also the definition in the definition section.

(d) Flexible Spending Account Maximum and Rollover Amounts. The maximum amount that any Eligible Employee may contribute to the Flexible Spending Account is subject to the maximum amounts permitted by law. If selected in Article I, the amount may automatically increase, any time an increase is authorized by law. In addition, if this option is selected in the Plan Data in Article I, the Eligible Employee may rollover to the next year amounts left in their Flexible Spending Account up to allowable maximums, which amount is also subject to change, as permitted by law. If the rollover option is selected, any unused amount may be carried over to the next following Plan Year and used for expenses incurred in the next Plan Year, subject to the then applicable maximum amount. All maximum amounts listed may change as permitted by law, and if selected in Article I, this amount may automatically increase, as permitted by law.

4.4 Voluntary Insurance Premium Payment

(a) Voluntary Insurance Premium Payments - General. If selected in the Plan Data section in Article I, the Plan will provide for payment of insurance premium amounts for Voluntary Benefits offered to Eligible Employees by the Employer. The Employer will advise the Eligible Employees reasonably as to what Voluntary Benefit Plans or Programs are subject to this Plan. The payment of such premiums will be consistent with the Pre-Tax Premium payment requirements under Section 4.2 above, and will be limited in the amounts stated in the Plan Data provisions. Eligible Employees will be permitted to select from one or more Voluntary Benefit offerings and may elect to participate in any of them at their cost, subject to any payment amount provided by the Employer.

(b) Employer Payment of Voluntary Insurance Premium Amount. If selected in the Plan Data in Article I, the Employer will pay a certain dollar amount to be applied toward the purchase of Voluntary Benefit premiums for Eligible Employees. Such amount is limited by the dollar amount stated in the Plan Data. Eligible Employees may select from a list of optional Voluntary Insurance Benefit offerings for this purpose on forms provided to them by the Plan Administrator.

(c) Voluntary Benefits and Insurance Carriers. To the extent that Voluntary Benefits are selected by the Eligible Employee, the insurance carrier providing such benefit will arrange for contracts directly with the Employee and the insurer is the claims administrator for purposes of benefits under such insurance contracts. As such the insurer is also the claims administrator fiduciary and responsible for the processing and determination of claims under such Voluntary Benefits.

4.5 Health Savings Accounts

(a) Health Savings Accounts - General. If selected in Article I, this section applies to Health Savings Accounts established under the Plan to fund Health Savings Accounts ("HSA") within the meaning of Code Section 223. Contributions to such accounts are "HSA Contributions." Contributions may be made to the Accounts as permitted by law.

(b) Accounts. The Plan Administrator shall establish an HSA Contribution account for each Eligible Employee who elects such account. Each such account shall be credited with any HSA Contribution amounts, up to the maximums provided by the Plan. Any payment of Medical Care from such accounts shall be debited from such HSA Contribution Accounts. The accounts may be maintained as trust accounts, or custodial accounts, as determined by the Employer. The Employer may undertake the IRS Form 5305 series forms to establish accounts as deemed appropriate. If so, such forms are incorporated as part of the Plan. Otherwise, the terms and conditions stated herein apply.

(c) Maximums. The maximum HSA Contribution that may be made is subject to the maximum amounts permitted under the statute, as adjusted for cost of living increases. If selected in Article I, the amount may automatically increase as increases are authorized by law. Contributions to Archer Medical Savings Accounts or other Health Savings Accounts apply toward the maximums. Eligible Employees may also make Catch-Up contributions, if selected in Article I, up to the allowable maximums. The Employee, as owner of the account, is responsible to ensure that the maximum amounts are not exceeded.

(d) No Forfeitures. Balances accrued and remaining in the HSA Contribution account are nonforfeitable, and are carried forward and used to fund benefits in subsequent years. Rollovers from other accounts or to other accounts will be allowed under the Plan as permitted by law.

(e) Fund Investment. HSA assets will generally be maintained in cash or cash equivalents, unless the Employer determines they should be invested otherwise. No part of such funds will be invested in life insurance or collectables. No prohibited transactions will be engaged in with respect to such funds.

(f) Payment for Medical Care and Coordination with Any Flexible Spending. Payments from the HSA Contribution account shall be made for Medical Care, as that term is defined in Code Section 213, as directed by the Employee. The Employer is not required to confirm the validity of such expense as a medical expense under the Code and the Employee is responsible for the tax consequences of any payments hereunder. Such payments may be applied to the Employee, his or her Spouse, and Dependents. Payments may not be made in excess of the balance of the HSA Contribution account amount.

(i) *Coordination with Flexible Spending and other Plans*. If you contribute to an HSA or a separate Health Reimbursement Account Plan, and you also wish to contribute to and use a Flexible Spending Account Plan, the Employer may establish a policy to determine that you are not eligible to participate in the Flexible Spending Account (or one of the other plans), because of certain complex rules regarding coordination of these types of Plans. If permitted by the Employer and you may participate in the Flexible Spending, your enrollment in the HSA results in the Flexible Spending Account Plan automatically becoming a limited medical expenses reimbursement plan. In such case, Flexible Spending expenses cannot duplicate or be in the category of claims permitted by the HSA, and are limited to dental and vision benefits that are not covered by your group health plan. This limit on Flexible Spending Account payments would only apply if the Employer permits participation in both, and the Employee participates in both.

(ii) *Timing of Coordinated Benefits with Flexible Spending*. If you wish to participate in both Flexible Spending and the HSA, and the Flexible Spending is not a limited medical reimbursement plan that covers only vision and dental, you cannot elect HSA benefits or add HSA benefits until the conclusion of the payment period, or if applicable, the Grace Period under the Flexible Spending Account, unless that Account is already exhausted, to avoid the payment of benefits that are greater than the medical benefit amounts permitted when both are in place at the same time. If the Employer provides for an Employee to participate in both at the same time, it will establish policies and procedures to avoid improper payments and as stated above, may limit participation.

(g) Death. If the account owner dies, the interest is payable to the Spouse, if a Spouse survives the account owner and the Account becomes an HSA of the Spouse. Otherwise, all moneys that remain in the Account cease to be HSA assets as of the date of death, and become taxable as provided under the Code.

(h) Elections. Eligible Employees who elect HSA Contributions may start or stop such elections and may increase or decrease such elections, subject to the annual limitations, at times permitted by the Plan Administrator, and as long as such change is prospective. The Plan Administrator may impose any additional conditions or rules upon such elections or changes, including consideration for payroll practices and limitations.

(i) Continued Use. Any HSA Contribution amounts and accounts may be used by the Eligible Employee, even after termination of employment to the extent permitted by law. Transfers to accounts, other plans or for use by the Participant are also permitted to the extent permitted by law.

(j) Employer Contributions. The Employer may contribute to the HSA Accounts for a Participant as the Employer determines from time to time. If the Employer contributes toward the HSA account, it will be so indicated in Article I. Any such contributions are credited to the applicable account along with Employee contributions, if any.

4.6 Dependent Care Account

(a) The Dependent Care Account. If selected in the Plan Data, the Dependent Care Account is an account established for an Eligible Employee to which part of the Pre-Tax Premium amounts may be allocated. From these amounts the Eligible Employee may pay Employment-Related Dependent Care Expenses and then be reimbursed from that account for the care of the Qualifying Dependents of Participants.

(b) Permitted Employment-Related Dependent Care Expenses. Permitted Expenses are amounts paid for expenses of an Eligible Employee for those services which if paid by the Participant would be considered employment-related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Employee. The Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care.

(c) Additional Dependent Care Account Rules. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense is subject to the following additional rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) These amounts do not include payment to a child of an Employee who is under age 19.

(d) Qualifying Dependent. For purposes of the Dependent Care Account payments, the term "Qualifying Dependent" means an Employee's Dependent (as that term is defined in Code Section 152(a)(1)) who has not attained age 13), a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or a child that is deemed to be a Qualifying Dependent described in paragraph (c) (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) Dependent Care Account Maximum. The maximum amount that any Eligible Employee may contribute to the Dependent Care Account each Plan Year is the lesser of: (i) $5,000 (if married filing a joint return or head of a household) or $2,500 (if married filing separate returns); (ii) taxable compensation; or (iii) spouse's actual or deemed earned income (a spouse who is a full-time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents). There is no carry forward available for Dependent Care Accounts. All maximum amounts listed may change if permitted by law and if selected in Article I, this amount may automatically increase if the law allows.

4.7 Forfeitures

Any amount that is in the Flexible Spending Account that remains at the end of a Plan Year, that is not rolled over to the Plan Year that follows if this Plan so permits rollovers, and is not used by the time periods for submitting claims for Account payments in Article VI below, will be forfeited. Similarly, any amount that is in the Dependent Care Account that remains at the end of a Plan Year that is not used by the time periods for submitting claims for Account payments in Article VI below, will be forfeited. Any amounts allocable to Voluntary Insurance Premium Payments that are not used for a Plan Year, are not payable in cash and are forfeited. Any amount that is forfeited may be used by the Employer to pay the reasonable administrative costs or toward any benefit plan obligation of the Employer, as determined in the discretion of the Plan Administrator.

Summary - Benefits

Once Eligible, you may elect to participate in any of the benefits that are offered under the Plan, as selected by the Employer. The Employer is not required and may not offer all of the benefits that are provided for under the Plan. For example, some Employers may choose only the first option, the Pre-Tax Premium Payment option. Others may add only the Voluntary Insurance Premium Payment, etc. Overall, as selected in the Plan Data in Article I, the benefits that may be offered and their terms in general are as follows:

(a) Pre-Tax Premium Payment. If selected by the Employer, your portion of the health and welfare benefit premiums (medical, dental, vision, etc.) will be paid for with pre-tax dollars. You may elect (or in some cases, the Employer may require you) to pay for benefits with after-tax dollars, outside this Plan if you wish. This may be an advantage for certain disability benefits. See the Plan Administrator or your tax advisors for more information.

(b) Flexible Spending Account. If selected by the Employer and you are Eligible and elect to participate, you may have pre-tax money taken from your pay toward an account that you can use for medical expenses. There are rules about what are proper medical expenses. See 4.3(c) above for more details. There is a cap, but this cap amount can change each year. Some Employers will permit you to rollover unused portions, and others do not. See the Plan Data for this. If the Employer permits both Flexible Spending and HSA, special rules apply.

(c) Voluntary Insurance Premium Payment. If selected by the Employer and you are Eligible, you will be offered certain types of Voluntary Insurance and your Employer may select to contribute toward that additional Voluntary Insurance. See the Plan Data for applicable dollar amounts.

(d) Health Savings Accounts. If selected by the Employer and the Group Health Plan sponsored by your Employer is a plan type that is permitted to have with it a Health Savings Account, this Plan permits your pre-tax payments toward a Health Savings Account that is your account that you may use for eligible health care expenses. This account is governed by the tax laws and is your account to use under the Plan and in future years for other group health plans for medical care as permitted by the tax laws. See the Plan Administrator for information regarding how these amounts may be transferrable or usable if you happen to terminate employment with your employer. If the Employer allows HSA and Flexible Spending, the Flexible Spending is limited to dental and vision not covered by HSA and special rules apply. Check with your Plan Admnistrator.

(e) Dependent Care Account. If selected by the Employer and you are Eligible, you may have pre-tax money taken from your pay to use for Dependent Care Assistance payments. The maximum is up to $5,000 for married couples filing jointly. The care must meet certain criteria and be provided by certain providers or caregivers. See Section 4.6 for more details. All maximum amounts can change each year.

ARTICLE V - PARTICIPANT ELECTIONS AND CHANGES

5.1 Initial Elections

An Employee who becomes an Eligible Employee and who is covered by the Employer's insured health and welfare benefits shall automatically participate in the Pre-Tax Premium Payment provisions of this Plan, unless such Eligible Employee elects otherwise.

An Employee who is an Eligible Employee as of the first day of a Plan Year, or becomes an Eligible Employee during a Plan Year, may elect to participate in the other options under this Plan. These include the Flexible Spending Account, Voluntary Insurance Premium Payment, Health Savings Account and Dependent Care Account provisions of the Plan for all or the remainder of such Plan Year, except as may be provided otherwise. To do so, the Eligible Employee must make such an election reasonably before the date of eligibility by completing any forms and providing any consent that the Plan Administrator reasonably requires.

5.2 Subsequent Annual Elections

During the Election Period prior to each subsequent Plan Year, each Eligible Employee will be given the opportunity to elect which Plan benefit options such Eligible Employee wishes to participate in. Such election is made on forms provided by the Plan Administrator and is effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. The Plan Administrator may choose to have existing elections apply to subsequent Plan Years without a need for a new Plan election, and if so, Participants will be notified and allowed to make new elections. In addition:

(a) An Eligible Employee who failed to initially elect to participate, may elect different or new Benefits under the Plan during the Election Period.

(b) An Eligible Employee may terminate Plan participation for the coming Plan Year by notifying the Administrator, in writing, during the Election Period.

(c) An Eligible Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period to participate in the Plan, unless there is a Change in Status, as described in this Article.

5.3 Change in Status and Change In Participation Under the Plan

(a) Change in Status - Defined. Any Eligible Employee who is participating in the Plan may change a Benefit election after the Plan Year has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a Change in Status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

(b) Change in Status Events. Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Plan Administrator. For the purposes of this subsection, a Change in Status shall only include the following events or other events permitted by Treasury regulations:

(1) *Change in Marital Status*: In the event of a change in the Employee's marital status, including marriage, divorce, death of a Spouse, legal separation or annulment. Any such change in the Election must be consistent with the divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Election under the Plan to cancel accident or health insurance coverage must be only for the individual involved in such event;

(2) *Number of or Change in Status of Dependents*: Events that change an Eligible Employee's number of or the identity of Dependents, including birth, adoption, placement for adoption, attainment of a specified age, or death of a Dependent, and for the Flexible Spending Account and Dependent Care Account, the Dependent becoming or ceasing to be a "Qualifying Dependent" as defined in Section 4.6;

(3) *Employment Status*: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, or a change in worksite. If the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment. If the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under COBRA under the Employer's group health plan or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation;

(4) *Change in Place of Residence*: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage);

(5) *Election Revocation to Obtain Marketplace Coverage*: Consistent with guidance by the Internal Revenue Service, and any regulations issued under Treas. Reg. §1.125, the Plan permits an Eligible Employee to prospectively revoke an election for coverage under the Pre-Tax Premium portion of this Plan as stated in Section 4.2 (but not the Flexible Spending Account provisions in Section 4.3) if the following conditions are met:

(i) Employee is in employment status and reasonably expected to average at least 30 hours per week and there is a change of status so that the Employee will be expected to average less than 30 hours per week, even if such reduction does not result in the Employee ceasing to be Eligible under the group health plan;

(ii) The revocation of the election corresponds to the intention of the employee to enroll in another plan that provides minimum essential coverage, with that coverage being effective no later than the first day of the second month following the month that includes the date the original coverage is revoked. The Plan Administrator may rely upon the reasonable representation of the Employee in this regard;

(iii) The employee is eligible for a Marketplace plan; or

(iv) The revocation corresponds to the enrollment in the Marketplace plan.

(c) Special enrollment rights. The Election for accident or health coverage may be changed during a Plan Year and a new election made that corresponds with the special enrollment rights provided in Code Section 9801(f), which include those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPS") if the Participant meets the sixty (60) day notice requirement. Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(d) Qualified Medical Support Order. In the event of a judgment, decree, or order (including approval of a property settlement) ("Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(e) Medicare or Medicaid. A Participant may change elections or may cancel accident or health coverage for the Participant or any Dependent, if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), as permitted by law. If such person loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(f) Cost Increase or Decrease. If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease any Salary Redirections for all affected Participants. If costs increase, the Plan Administrator may permit affected Participants to make changes and revoke elections on a prospective basis.

(g) Addition of a New Benefit. If a new benefit is added, the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) Changes in Other Coverage. A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(i) Change in Dependent Care Provider. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Account only if the cost change is imposed by a dependent care provider who is not related to the Participant.

Summary - Participation Elections and Changes

Eligibility and Participation. Once you become eligible, see the Plan Data again for those requirements, you may receive forms and information from your Employer. You need to complete the information and may need to authorize the payroll deductions. You need to complete fully and accurately any forms provided in order to enroll.

Annual Elections. Generally, once you make the election, you are set for that year. Each year, your Employer may ask you to respond on whether you wish to continue your participation. If you do not, you should make sure to contact the proper department at your Employer to be sure that you can stop the benefits if you wish. Please note that you cannot just turn off and on these benefits, unless special circumstances apply.

Benefit Changes - When They Can Be Made. You are permitted to change your benefits and the elections under the Plan if certain circumstances apply. These include:

- Change in Marital Status
- Change in your Dependents
- Change in your Employment status, including an hours reduction that might permit you to change to one of the marketplace exchanges from your Employer plan
- And others...

If you think a circumstance has arisen that may entitle you to change your Benefits under the Plan, take a look at this Article V, or contact your Plan Administrator.

ARTICLE VI - CLAIMS AND CLAIMS PROCEDURES

6.1 Flexible Spending Account Claims

(a) Reimbursement for Flexible Spending Accounts in General. The Plan Administrator will pay to the Participant, all valid and timely Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year, and if applicable, after the actual Plan Year in accordance with the Grace Period provisions and as provided in the Plan. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care (when incurred), not when the Participant is billed, charged or pays for it. The amount and limit of such payments is determined in this Section.

(b) Reimbursement Throughout the Plan Year. The Plan Administrator shall administer reimbursements to each Eligible Employee for all allowable Medical Expenses, up to a maximum of the amounts determined under the Plan and designated by the Participant. Reimbursements shall be made available to the Participant throughout the year, without regard to the level of Cafeteria Plan Benefit dollars that have already been allocated to the Plan to fund such reimbursement at any given point in time. Participants are only entitled to reimbursements for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) Payment and Applications for Payment. Payments under this Plan are generally made directly to the Participant. The Plan Administrator may, in the Plan Administrator's sole discretion, direct payments directly to a service provider. The application for payment or reimbursement shall be made to the Plan Administrator on a form provided by the Plan Administrator, and will include any information reasonably requested by the Plan Administrator to establish the validity of such Payment under the Plan.

(d) Grace Period. Medical Expenses incurred during the Grace Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Grace Period relates. "Grace Period" under the Plan with respect to any Plan Year is the time period ending on the fifteenth day of the third calendar month after the end of such Plan Year. During this Grace Period, Medical Expenses and Employment-Related Dependent Care Expenses incurred by a Participant will be deemed to have been incurred during such Plan Year. If the Plan permits Rollovers, no Grace Period applies.

(e) Claims for Reimbursement. Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively feasible. Participants must submit all claims within seventy-seven (77) days after the end of the Plan Year, or if applicable, the Grace Period for such Medical Expense claims to be considered for reimbursement. If a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within ninety (90) days after termination of employment, unless the Grace Period applies and your other plan terms and your third party administrator apply the Grace Period after termination of employment.

6.2 Dependent Care Account Claims

(a) Reimbursement for Dependent Care Accounts in General. The Plan Administrator will pay to the Participant, all valid and timely Dependent Care Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year, and after the actual Plan Year in accordance with the Grace Period provisions and as provided in the Plan. Dependent Care Expenses are treated as having been incurred when the Participant is provided with the Dependent Care (when incurred), not when the Participant is billed, charged or pays for it. The amount and limit of such payments is determined in this Section.

(b) Reimbursement Throughout the Plan Year. The Plan Administrator will pay reimbursements to each Eligible Employee for all allowable Dependent Care Account Expenses up to the maximum amounts under the Plan. Unlike the Flexible Spending Account, the Plan Administrator will only pay amounts that are already in the Eligible Participant's Account.

(c) Payment and Applications for Payment. Payments under this Plan are generally made directly to the Participant. The Plan Administrator may, in the Plan Administrator's sole discretion, direct payments directly to a service provider. The application for payment or reimbursement shall be made to the Plan Administrator on a form provided by the Plan Administrator, and will include any information reasonably requested by the Plan Administrator to establish the validity of such Payment under the Plan, including the gathering of the following information:

i. The Dependent or Dependents for whom the services were performed;

ii. The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

iii. The relationship, if any, of the person performing the services to the Participant;

iv. If the services are being performed on a child of the Participant, the age of the child;

v. A statement as to where the services were performed;

vi. If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least eight (8) hours a day in the Participant's household;

vii. If the services were being performed in a day care center, a statement that the day care center complies with all applicable laws and regulations of the state of residence, that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and the amount of fee paid to the provider;

viii. If the Participant is married, a statement containing the following: (1) the Spouse's salary or wages if he or she is employed, or if the Participant's Spouse is not employed, that he or she is incapacitated, or (2) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(d) Dependent Care Grace Period. Dependent Care Expenses incurred during the Dependent Care Grace Period, up to the remaining account balance, may be deemed to have been incurred during the Plan Year to which the Dependent Care Grace Period relates. "Dependent Care Grace Period" under the Plan with respect to any Plan Year is the time period ending on the fifteenth day of the third calendar month after the end of such Plan Year. During this Dependent Care Grace Period, Dependent Care Expenses incurred by a Participant will be deemed to have been incurred during such Plan Year.

(e) Claims for reimbursement. If a Participant fails to submit a claim within seventy-seven (77) days after the end of the Dependent Care Grace Period, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within ninety (90) days after termination of employment, unless your other plan terms and your third party administrator apply the Dependent Care Grace Period after termination of employment.

6.3 Claims for Voluntary Insurance Premium Payments

The Participants choose which of the Voluntary Insurance Premium Payment benefits they wish to receive. The Employer pays its portion, if any, up to the maximum amount specified under the Plan in the Plan Data section in Article I. The Participant must complete any forms needed to designate the benefits and to authorize any deductions. The insurance carrier providing such Voluntary benefits will arrange for contracts directly with the Employee and the insurer is the claims administrator for purposes of benefits under such insurance contracts. As such the insurer is also the claims administrator fiduciary and responsible for the processing and determination of claims under such Voluntary Benefits.

6.4 Debit and Credit Card Processing (Optional)

(a) Use of Debit or Credit Cards. The Plan Administrator may set up a procedure to permit the use of debit and/or credit (stored value) cards. If so, the card may only be used for Medical Expenses and the Participant will need to certify that the card is used only for Medical Expenses.

(b) Card Issuance. Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant. The card will be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Flexible Spending Account portion of the Plan. The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year.

(c) Card Use. The cards may only be used for Medical Expense purchases and expenses to pay for co-payments for doctor and other medical care, the purchase of drugs, and the purchase of medical items such as eyeglasses, syringes, crutches, etc.

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

(e) Correction Methods. If it is determined that a particular purchase is not a valid Medical Expense, the Plan Administrator may obtain repayment of the improper amount by the Participant, withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law, substitute the defective payment for other payments and if these do not work, the Employer may treat the amount as a loan and the Participant agrees to pay back such loan.

6.5 Claims Procedure - Claims and Review on Decision

(a) Claims for Reimbursement. Participants must follow the terms of the Plan to file claims for benefits under the Flexible Spending Account, the Voluntary Insurance Premium Payment and Dependent Care Account. Those procedures are described in this document and are subject to the discretionary authority of the Plan Administrator. All claims must be filed within the times specified under the Plan.

1 *Denied Claims*. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within ninety (90) days after the claim is filed, unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim will be written in a manner calculated to be understood by the claimant and will provide:

- specific references to the pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and
- an explanation of the Plan's claim procedure.

2 *Appeal of a Denied Claim*. After receipt of a claim denial, the claimant has 180 days after the issuance of the claim denial by the Plan Administrator to submit an appeal in writing. The claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

- request a review on decision, by writing to the Plan Administrator and requesting a review on decision, which is an appeal - this must be in writing;
- review pertinent documents; and

- submit issues and comments in writing for consideration by the Plan Administrator.

3 *Review on Decision - Appeal*. Once the claimant has submitted a written request for a review on decision, which is an appeal, decision on the review by the Plan Administrator will be made within the Applicable Appeal Response Period after receipt of a request for review, unless special circumstances require an extension of time for processing the appeal. If the Plan Administrator requires more time, it will provide notice to the claimant in writing prior to the expiration of the initial Appeal Response Period to state that additional time will be required and the Plan Administrator will provide a reasonable explanation as to the need for additional time. The Applicable Appeal Response Period and any extension of time is determined under the following Chart:

Benefit	Initial Appeal Response Period	Extension Period
Flexible Spending Account	30 days	15 days
Voluntary Insurance Premium	60 days	60 days
Dependent Care Account	60 days	60 days

4 *Review on Decision - Content*. The decision by the Plan Administrator on the claim will be in writing, written in a manner calculated to be understood by the claimant and will provide:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial was based;
- 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;
- a description of the Plan's review procedures and the time limits applicable to such procedures;
- a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and
- if the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

5 The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual. The review on decision may be made by an external claim processor delegated for such purpose by the Plan Administrator.

(b) Time Periods Strictly Enforced. The periods of time for filing claims under the Plan for benefits, for filing for appeal and for responding to an appeal will be strictly enforced.

Summary - Claims and Procedures

Pre-Tax Premium Payment. Unless you opt out, if you are making contributions toward your benefits with your Employer, the Employer is taking out that money on a pre-tax advantaged basis. You may be required to fill out certain forms, but this is otherwise going to be automatic and you do not need to file claim forms or make periodic requests for this.

Flexible Spending Account. All claims for benefit under the Plan must be filed with any required substantiating documentation, on forms and by a method determined by the Plan Administrator. You should be sure to complete the forms carefully and completely. You may submit claims during the year. If the Plan does not provide for Rollover amounts, the Plan may have a Grace Period that allows you to use up any remaining credit in your account by the fifteenth day of the third month after the close of the year. Normally you have seventy-seven (77) days from that date to submit the claim for reimbursement. If you terminate employment you have ninety (90) days to get in any claims, unless your other plan terms and your third party administrator apply the Grace Period after termination of employment. See Article I for information on whether these apply.

Voluntary Insurance Premium Payment. The Voluntary Insurance Premium Payment option is very easy. If your Employer has selected this option, you can choose from the available Voluntary Insurance Benefit options. If you use up any Employer payment, you can still contribute toward this Insurance yourself. Once you are purchasing Voluntary Insurance through the Premium Payment option, you do not need to file any claims. Any payments taken from your pay will be automatic. If there are any changes in those amounts, or in the Voluntary Insurance being made available, you will be notified. Any claims for benefits are filed with the insurance carrier that applies.

Dependent Care Account. All claims for benefit under the Plan must be filed with any required substantiating documentation on forms and by a method determined by the Plan Administrator. You should be sure to complete the forms carefully and completely. You may submit claims during the year. The Plan has a Dependent Care Grace Period that allows you to use up any remaining credit in your account by the fifteenth day of the third month after the close of the year. Normally you have seventy-seven (77) days from that date to submit the claim for reimbursement. If you terminate employment you have ninety (90) days to get in any claims, unless your other plan terms and your third party administrator apply the Dependent Care Grace Period after termination of employment.

Debit Cards. If the Plan permits, your Employer may provide for payment of the Flexible Spending amounts through a credit or debit card, and you will be given information about how to use it. But, see the rules on your requirements and substantiation.

Claims Procedures. In the event that you make a claim for a benefit under the Plan and it is denied, you have a right to file a formal appeal. The procedure is detailed in Section 6.5 (a) and you should be sure to follow that procedure, carefully. Each step of the appeal process does require that you write to the Plan Administrator, so make sure you process your claim in writing, not just orally.

ARTICLE VII - DISCRIMINATION RULES

7.1 Discrimination Rules

(a) Intent to be Nondiscriminatory - Section 125. It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of Highly Compensated Employees for purposes of contributions or eligibility amounts as required for qualification of the Plan under Code Section 125.

1. *25% Concentration Test*. It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

2. *Adjustment to Avoid Test Failure*. If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. If the Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in a manner consistent with the regulations, or that results in the test passing by means determined by the Plan Administrator as reasonable. Such manner may include the following allocation. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

(b) Intent to be Nondiscriminatory for Dependent Care Account Benefits. It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

1. *25% Test for Shareholders*. It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

2. *Adjustment to Avoid Test Failure*. If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. If the Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in a manner consistent with the regulations, or that results in the test passing by means determined by the Plan Administrator as reasonable. Such manner may include the following allocation. First, the Benefits designated for the Dependent Care Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

(c) HSA Comparability Rules. Any contribution to the HSA as authorized by the Participant to and under this Plan shall comply with Treas. Reg. Section 54.4980G-5 and any superseding guidance.

Summary - Discrimination Rules

Every Plan that offers the benefits and options provided under this Plan is subject to certain complex tax discrimination related rules. Participants do not need to do anything in regards to this testing. The Employer and Plan Administrator will evaluate this as they deem necessary and if by some chance your benefits are affected, which is rare, you will be notified.

The HSA comparability rules are the responsibility of the Employer and if there is any problem with your HSA account, you will be notified.

ARTICLE VIII - ADMINISTRATION

8.1 Plan Administration

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details. The Plan Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan consistent with Section 11.1;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan;

(f) To approve reimbursement requests and to authorize the payment of benefits;

(g) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and

(h) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

8.2 Named Fiduciary

The Plan Administrator is the named fiduciary pursuant to ERISA Section 402 and is responsible for the management and control of the operation and administration of the Plan.

8.3 General Fiduciary Responsibilities

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries in accordance with its terms and in accordance with the standards imposed upon fiduciaries under ERISA Section 404.

8.4 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law. This is subject to the forfeiture provisions stated herein, but such forfeitures are non-assignable to third parties.

8.5 Payment of Expenses

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder.

8.6 Insurance Control Clause

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

8.7 Indemnification

(a) Employer Indemnity. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

(b) Employee Indemnity. If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

8.8 Right of Recovery

If the Plan Administrator determines that the Plan has made payments that are not authorized under the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Participant on whose behalf such payment was made. Each Participant agrees to an equitable lien in favor of the Plan regarding any erroneous payment under the Plan. Any such erroneous payments must be returned to the Plan within thirty (30) days. If not, the Plan Administrator may deduct the amount of the erroneous payment from any future benefits.

Summary - Administration

Plan Administrator. The Plan Administrator has broad authority to operate this Plan. This authority includes interpretation of the document, determination of procedures, making rules, deciding questions, retaining third parties and others for administration, and supervising any claims. The Plan Administrator has full discretionary authority with respect to all determinations under this Plan, including the determination of facts, the interpretation of the Plan or its terms, and with respect to all decisions and determinations under this Plan. This discretionary authority is to be interpreted in the broadest sense permitted under law.

Assignment. Your benefits under the Plan may not be assigned to anyone else.

Indemnification. The Employer indemnifies certain plan officials including the Plan Administrator. As a Participant in the Plan, you also indemnify the Plan if you are overpaid or make any misrepresentations. This means that if you are overpaid, you owe the money back and if you make a misrepresentation, in addition to any consequence under policies of your Employer, you can lose benefits under the Plan.

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

9.1 Amendment

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

9.2 Termination

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

Summary - Amendment and Termination

This Plan may be amended or terminated at any time, by the Employer. This right is absolute and any amendment or termination may be made without your consent.

Certain benefits under this Plan are subject to forfeiture under the Flexible Spending Account and the Dependent Care Account, if account amounts that are from your pay are not used during the time-frames permitted. So, be careful in your selections under those two programs under the Plan.

ARTICLE X - COBRA

10.1 COBRA Coverage

COBRA coverage applies only with respect to certain aspects of this Plan. In the event that the Employer sponsor has less than the required twenty (20) employees during the applicable testing period, or the Employer sponsor is a Church and the Plan is a Church Plan, then COBRA does not apply. If COBRA applies, this section applies.

(a) COBRA Coverage. Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the Flexible Spending Account under the Plan unless the Employer sponsoring the Flexible Spending Account is not subject to these rules (e.g., the employer is a "small employer" or the Flexible Spending Account is a Church Plan). The Plan Administrator can advise whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules).

(b) When Coverage May Be Continued. Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A "Qualified Beneficiary" is the Participant, covered Spouse and/or covered Dependent child at the time of the Qualifying Event. A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee's Termination of employment or reduction in hours of employment	✓	✓	✓
2. Divorce or Legal Separation		✓	
3. Child ceasing to be an eligible Dependent			✓
4. Death of the Covered Employee		✓	✓

(c) Cost Parameters. The Participant generally does not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement available for the remainder of the Plan Year.

(d) Type of Continuation Coverage. If the Participant chooses continuation coverage, they may continue the level of coverage in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for COBRA recipients and other Qualified Beneficiaries as well. After electing COBRA coverage, Participants will be eligible to make a change in their benefit elections with respect to the Flexible Spending Account upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year. If continuation coverage is not chosen Flexible Spending coverage will end with the date it is otherwise lost.

(e) Notice Requirements. Participants and covered Dependents (including the Spouse) must notify the COBRA Administrator (if a COBRA Administrator is not identified in the Plan Information Summary, then contact the Plan Administrator) in writing of a divorce, legal separation, or a child losing dependent status under the Plan within sixty (60) days of the later of (i) the date of the event; or (ii) the date on which coverage is lost because of the event. Written notice must identify the Qualifying Event, the date of the Qualifying Event and the qualified beneficiaries impacted by the Qualifying Event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn provide Notice of the right to choose continuation coverage by sending the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. An employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan, or in the event of a subsequent divorce or other similar event.

(f) Election Procedures and Deadlines. Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, the Participant must complete the Election Form(s) and return it to the COBRA Administrator identified in the Plan Information Summary within sixty (60) days from the date the Participant would lose coverage for one of the reasons described above or the date notice is sent of the right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of continuation coverage rights.

(g) Cost. The Participant will have to pay the entire cost of continuation coverage. The cost of continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after the election. Subsequent contributions are due the 1st day of each month; however, there is a 30-day grace period following the due date in which to make the contribution. Failure to make contributions within this time period will result in automatic termination of continuation coverage.

(h) When Continuation Coverage Ends. The maximum period for which coverage may be continued is the end of the Plan Year in which the Qualifying Event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the Qualifying Event (depending on the type of Qualifying Event and the level of Non-Elective contributions provided by the Employer). Participants will be notified of the applicable maximum duration of continuation coverage when a Qualifying Event occurs. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for continuation coverage is not paid on time or it is significantly insufficient (Note: if payment is insufficient by the lesser of 10% of the required premium, or $50, 30 days to cure the shortfall will be given);
- if coverage becomes available under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- if the Participant becomes entitled to Medicare; or
- if the employer no longer provides group health coverage to any of its employees.

Summary - COBRA Coverage

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. Certain smaller employers and Church Plans are not subject to COBRA. These rules apply to the Flexible Spending portion of the Plan unless the Employer sponsoring the Flexible Spending Account is not subject to these rules (e.g., the employer is a "small employer" or the Plan is a Church Plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules).

If COBRA applies and your coverage is terminated, you may be eligible, and the economics make sense (it does not cost you more than you can recover to continue your coverage), then you may be eligible to continue coverage in the Flexible Spending portion of the Plan - only - for up to 18 months, sometimes longer.

See the COBRA rules above and inquire with your Plan Administrator if you have any questions.

ARTICLE XI - MISCELLANEOUS

11.1 Plan Interpretation

The Plan Administrator is responsible and is the fiduciary for all determinations under the Plan, except for any made by an insurance company. In such determinations, that are not specifically reserved to an insurer, the Plan Administrator has full discretionary authority with respect to all determinations under this Plan, including the determination of facts, the interpretation of the Plan or its terms, and with respect to all decisions and determinations under this Plan. This discretionary authority is to be interpreted in the broadest sense permitted under law.

11.2 Gender and Number

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 Exclusive Benefit and Forfeitures

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan, except with respect to permitted forfeitures of benefits provided in this Plan.

11.4 No Contract

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.5 No Guarantee of Tax Consequences

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

11.6 Funding

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.7 Governing Law

This Plan is governed by federal law, including without limitation, ERISA, the Code and the regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State where the Employer is headquartered.

11.8 Severability

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

11.9 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.10 Family and Medical Leave Act (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

11.11 Uniform Services Employment and Reemployment Rights Act (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

11.12 HIPAA Privacy and Electronic Security Standards

(a) Application. If the Flexible Spending Account under this Cafeteria Plan is subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) Disclosure of PHI. The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(c) PHI for Administrative Purposes. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care.

(d) PHI Disclosed to Certain Workforce Members. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

1. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

2. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) Certification. The Employer must provide certification to the Plan that it agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

5. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

6. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

7. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

9. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

(f) Security Standards. Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards") apply as follows:

1. *Implementation*. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. *Agents or subcontractors shall meet security standards*. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. *Employer shall ensure security standards*. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.18.

4. *Other HIPAA Rules and Policy*. Any other HIPAA Rules or Policy of the Employer, if they apply to this Plan, shall supersede these HIPAA provisions and apply in their place.

11.13 Mental Health Parity and Addiction Equity Act

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

Summary - Miscellaneous Items

From the items above, here are some highlights:

Interpretation. The Plan Administrator has complete and absolute rights to interpret the terms of this Plan, to determine facts that arise with respect to the Plan and to make determinations on benefits under the Plan. This right is very broad and complete and it is to be given deference and the broadest effect under the law.

No Other Rights. This Plan does not create any employment contract or other contract between the Employer and its Employees.

Funding. This Plan is funded by Employee and Employer contributions (if selected) as provided in this Plan. Voluntary Benefits are funded through the purchase of insurance with the carriers indicated.

Laws. This Plan will comply with the Family and Medical Leave Act ("FMLA"), the Uniform Services Employment and Reemployment Rights Act ("USERRA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and the Mental Health Parity and Addiction Equity Act.

ARTICLE XII - DEFINITIONS

"Administrator" means the individual(s) or corporation appointed by the Employer to carry out the administration of the Plan. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper 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 Administrator.

"Affiliated Employer" means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

"Benefit" or "Benefit Options" means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

"Cafeteria Plan Benefit Dollars" means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

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

"Compensation" means the amounts received by the Participant from the Employer during a Plan Year.

"Dependent" means any individual who qualifies as a dependent under an Insurance Contract for purposes of that Contract or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan. The requirement that a Dependent child have full-time student status in order to extend coverage past a stated age will generally not apply if the child's failure to maintain full-time status is due to a medically necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating physician certifies in writing that the child is suffering from a serious illness or injury, and that the leave of absence or other change in enrollment is medically necessary, coverage may continue for up to one year after the date the medically necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the medically necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully insured) if the changed coverage continues to provide coverage for dependent children. However, this extension does not extend coverage beyond the date that a child fails to meet the dependent eligibility requirements other than the requirement to be a full-time student. Except for a student who is on a medically necessary leave of absence, full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term. Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law.

"Dependent Care Flexible Spending Account"; or "Dependent Care Account" means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

"Earned Income" means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

"Effective Date" means the effective date stated in Article I, Part 11.

"Election Period" means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

"Eligible Employee" means any Employee who has satisfied the provisions of Eligibility under Article II of the Plan. An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

"Employee" means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

"Employer" is defined in Article I.

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

"Grace Period" is defined in this document and may apply to Flexible Spending and Dependent Care. Grace Period means, with respect to any Plan Year, the time period ending on the fifteenth day of the third calendar month after the end of such Plan Year, during which Medical Expenses and Employment-Related Dependent Care Expenses incurred by a Participant will be deemed to have been incurred during such Plan Year. No Grace Period applies for Flexible Spending if there is a Rollover permitted under the Plan.

"Health Flexible Spending Account" means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

"Health Savings Account" (referred to as "HSA") means an account established for Participants pursuant to this Plan to which part of their contribution dollars are allocated and are credited with amounts withheld from the Participant's compensation and applied to an account for the benefit of and use by the Participant for Medical Care expenses as permitted to be used by the Participant as described under this Plan.

"Highly Compensated Participant" means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the five (5) highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

"Insurance Contract" means any contract issued by an Insurer underwriting a Benefit.

"Insurance Premium Payment Plan" means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

"Insurer" means any insurance company that underwrites a Benefit under this plan.

"Key Employee" means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

"Marketplace Plan" means a Qualified Health Plan established through the competitive marketplace in accordance with Section 1311 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

"Medical Care" means any expense for medical care within the meaning of the term "Medical Care" as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Care" expense can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

"Participant" means any Eligible Employee who elects to become a Participant under the Plan and has completed all of the required administrative steps to finalize participation, and has not for any reason become ineligible to participate further in the Plan.

"Premium Expenses" or "Premiums" mean the Participant's cost for the Benefits described in Article IV.

"Premium Expense Reimbursement Account" means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

"Salary Redirection" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

"Salary Redirection Agreement" means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

"Spouse" means "spouse" as defined in an Insurance Contract for purposes of that Contract or the legally married husband or wife of a Participant, unless legally separated by court decree.

ADOPTION AND EXECUTION

Adoption and Execution. This Plan is hereby adopted and approved by the Employer, and is effective as stated herein.

NSM Insurance Group

By: _____

Its: _____