UNIVERSITY OF RICHMOND
SECTION 125 CAFETERIA PLAN

Effective January 1, 2023

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INTRODUCTION

The Employer adopted this amended and restated University of Richmond Section 125 Cafeteria Plan effective January 1, 2023 (the "Plan"). The Plan includes Health Care Spending Accounts, Dependent Care Spending Accounts, and the opportunity to contribute to a Health Savings Account.

This Plan document is an amendment and restatement of the University of Richmond Flexible Spending Account Plan and the University of Richmond Section 125 Cafeteria Plan.

This Plan is intended to provide Eligible Employees an opportunity to select among the qualified benefits and taxable benefits (including cash compensation) made available by the Employer to its Employees. It is the intention of the Sponsor that this Plan qualify as a cafeteria plan pursuant to Code section 125. The Health Care Spending Account is intended to qualify as a Code section 105 medical expense reimbursement plan. The Dependent Care Spending Account is intended to qualify as a Code section 129 dependent care assistance program. The Health Care Spending Account and the Dependent Care Spending Account are intended to be "flexible spending arrangements" under Prop. Treasury Regulation section 1.125-5.

An Eligible Employee's elections and Salary Reduction Elections made under the University of Richmond Section 125 Cafeteria Plan and the University of Richmond Flexible Spending Account Plan with respect to Benefit Options available under this Plan during Enrollment Period for the Benefit Period commencing January 1, 2023, shall be deemed to be elections and Salary Reduction Election under this Plan effective January 1, 2023. Health Care Spending Accounts under this Plan document are a continuation of the Medical Reimbursement Accounts under the University of Richmond Flexible Spending Account Plan. Carry overs from the 2022 Plan Year from Medical Reimbursement Accounts under the Flexible Spending Account Plan shall be available and administered in accordance with the terms of the University of Richmond Flexible Spending Account Plan as amended by this Plan document.

ARTICLE I
GENERAL

1.01 **Establishment of the Plan**

The Plan governed by this document is the University of Richmond Section 125 Cafeteria Plan. The Plan is intended to be a cafeteria plan within the meaning of Code section 125 and shall be interpreted and administered in a manner consistent with Code section 125 and regulations thereunder.

1.02 **Nondiscrimination**

(a) Intent to be nondiscriminatory. 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 the group in whose favor discrimination may not occur under Code section 125.

(b) 25% Concentration Test. It is the intent of this Plan to not provide qualified benefits as defined under Code section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefit Options 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.

(c) 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, reject any Election and related Salary Reduction Election as provided in Plan section 3.04(c).

(d) Separate Plans. If and to the extent necessary to satisfy the nondiscrimination provisions of Code section 125, each coverage level, each group of employees covered by the Plan, and each class of benefits provided under the Plan, will constitute a separate Code section 125 cafeteria plan. The Health Care Spending Account is a separate "plan" for purposes of Code section 105(h).

ARTICLE II
PARTICIPATION

2.01 **Eligibility for Participation**

Only Eligible Employees may participate in this Plan.

2.02 **Participation and Coverage**

(a) Effective date of participation. An Eligible Employee who timely makes an Election and executes a Salary Reduction Election under Article III may participate in this Plan and in the elected Benefit Options for which he or she is an Eligible Employee as of the applicable Entry Date.

(b) Termination of participation. Termination of participation in this Plan automatically cancels any Election and Salary Reduction Election. A Participant's participation in this Plan shall end on the earlier of: (i) the termination of the Plan; or (ii) the last day of the month that includes the date on which the Participant ceases to be an Eligible Employee, subject to any applicable COBRA continuation coverage rights under Code section 4980B, and Plan sections 3.07(f) and 6.14.

ARTICLE III
BENEFITS AND BENEFIT ELECTIONS

3.01 **Benefit Options and Elections**

(a) Benefit Options. An Employee may elect one or more of the Plan's Benefit Options for which he or she is eligible under the terms of the Welfare Benefits Plan or the Cash Benefit. To the extent permitted by the applicable Benefits Document, an Eligible Employee may elect coverage for their Spouse and/or Dependents under a Benefits Option. Benefit Options are the benefit options identified in Appendix A. Benefit Options identified in Appendix A, other than the Health Care Spending Account, Dependent Care Spending Account and the Health Savings Account are described in the applicable Benefit Documents which are incorporated herein by reference. The terms of the Health Care Spending Account, the Dependent Care Spending Account, and the Health Savings Account, are set forth in this Plan. The period of coverage for Benefit Options shall be the Benefit Period.

(b) Election to Participate. If an Eligible Employee elects one or more Benefit Options under this Plan, he or she will be required to submit a Salary Reduction Election during the applicable Enrollment Period pursuant to which his or her cash Compensation will be reduced and an amount equal to the reduction will be contributed by the Employer to cover all or a portion of the cost of such Benefit Option(s) as set forth in Plan section 3.06. The timing of Elections and Salary Reduction Elections shall comply with Prop. Treas. Reg. section 1.125-2.

(i) Initial Election. An Employee who becomes an Eligible Employee during a Plan Year may prospectively elect to participate in Benefit Options for the applicable Benefit Period, provided that such Election is made during the applicable Enrollment Period which shall end prior to the earlier of (i) the date the Compensation (or other taxable benefit) subject to the Election is Currently Available; or (ii) the first day of the Benefit Period.

(ii) New Employees. Notwithstanding Plan section 3.01(b)(i), new Employees who are Eligible Employees shall be provided thirty (30) days after their hire date to make Elections under this Plan. Such Elections shall be effective as of the first day of the month coincident with or immediately following such new Eligible Employee's hire date. Salary Reduction Contributions used to pay for such an Election must be from Compensation not yet Currently Available on the date of the Election. Any employee who terminates employment and is rehired within thirty (30) days (or returns to employment following an unpaid leave of absence of less than thirty (30) days) is not a new employee eligible for the Election in this Plan section 3.01(b)(ii) and he or she shall return to his or her Elections in effect prior to the termination of employment (or return from unpaid leave) upon rehire, unless another event that would permit an Election change occurs.

(iii) Annual Elections. During the annual Enrollment Period prior to each Plan Year, each Eligible Employee may elect to participate in one or more Benefit Options or not to participate in any Benefit Options for the Plan Year immediately following such annual Enrollment Period. Such Elections must be made before the end of such annual

Enrollment Period and shall be effective as of the first day of the Plan Year immediately following such annual Enrollment Period.

(iv) Automatic Elections. Except with respect to the Health Care Spending Account, under Plan section 3.07, the Dependent Care Spending Account under Plan section 3.08, and the Health Savings Account under Plan section 3.09, a Participant who fails to submit an Election during an annual Enrollment Period shall be deemed to have made the same Benefit Elections as in effect for the current Plan Year, as well as the necessary Salary Reduction Contributions, as increased or decreased to the extent required by changes in Benefit Option costs and Employer Benefit contributions, if any, under the Plan. In order to participate in the Health Care Spending Account and/or the Dependent Care Spending Account, a Participant must submit an Election during the applicable Enrollment Period. To contribute to a Health Savings Account, a Participant must submit an Election during an annual Enrollment Period.

3.02 **Election Procedures**

(a) Administrator procedures. The Administrator may establish procedures regarding Elections and Salary Reduction Elections as it deems necessary or desirable to enable Eligible Employees to elect Benefit Options for which they are eligible. The Administrator may also establish procedures allowing Eligible Employees to change or revise their Benefit Elections and Salary Reduction Elections during a Benefit Period or for a subsequent Benefit Period to the extent consistent with Plan section 3.04. The Administrator may revise such procedures whenever it deems appropriate.

(b) Transmission of elections. To elect Benefit Options for a Benefit Period, an Eligible Employee must transmit a completed Benefit Election and Salary Reduction Election to the Administrator on or before the last day of the Enrollment Period for that Benefit Period (except as provided in Plan section 3.01(b)(iv) with respect to automatic elections). An Enrollment Period for a Benefit Period must end, and Benefit Elections and Salary Reduction Elections must be submitted (or deemed to be submitted under Plan section 3.01(b)(iv)) before the earlier of (i) the date Compensation (or other taxable benefit) to which the Election and Salary Reduction Election apply is Currently Available; or (ii) the first day of the Benefit Period, except as permitted under Plan sections 3.01(b)(ii) and 3.04. If an Eligible Employee does not meet the deadline for submission of the Benefit Election and Salary Reduction Election, the Employee is denied the ability to elect any Benefit Options under this Plan until the next annual Enrollment Period immediately preceding the next Plan Year, unless an event occurs that would permit a mid-year election change as described in Plan section 3.04. An Employee who would be an Eligible Employee but for completion of a waiting period may submit a Benefit Election and Salary Reduction Election prior to becoming an Eligible Employee only to the extent an Election will not be effective until the Employee becomes an Eligible Employee. Such Elections by an Employee are subject to the procedures set forth by the Administrator.

(c) Irrevocability of elections. Except as permitted under Plan section 3.04, an Eligible Employee's Benefit Election and Salary Reduction Election for a Plan Year is irrevocable for the entire Plan Year.

3.03 **Salary Reduction Election**

If an Eligible Employee wishes to elect Benefits hereunder which require a contribution from the Employee, such Employee shall also be required to execute a Salary Reduction Election during the applicable Enrollment Period.

3.04 **Revised Elections**

(a) General rules on revised elections. If the Administrator receives an Election and/or Salary Reduction Election after the end of the applicable Enrollment Period for such Election and Salary Reduction Election, that Election and Salary Reduction Election is not effective except as authorized by the Administrator according to this Plan section.

(b) Changing elections. Unless otherwise allowed under Plan section 3.04(d), a Benefit Election and Salary Reduction Election remain in effect for the entire Plan Year (or remainder of the Plan Year) to which it relates, and a Participant may not change his Elections with respect to Benefit Options during that Plan Year. Retroactive Elections shall be permitted only to the extent consistent with Code section 125.

(c) Modification and rejection of elections. The Administrator may modify or reject any Election and related Salary Reduction Election to the extent the Administrator deems it necessary to assure that the Plan does not discriminate in favor of highly compensated employees in violation of Code section 125 or to prevent taxation of key employees under the provisions of Code section 125(b)(2). Any such modification or rejection of shall be made by the Administrator on a reasonable and nondiscriminatory basis.

(d) Permitted election changes. An Eligible Employee may revoke an Election during a Plan Year and make a new Election for the remainder of the Plan Year if both the revocation and/or the new Election are permitted under the Plan and are consistent with Code section 125, applicable Treasury Regulations, and other Internal Revenue Service guidance. An Election change under this Plan section may only be made with respect to Compensation or other taxable benefits that are not yet Currently Available at the time of the Election change. Election change elections must be made within 31 days of the event described in this subsection. Election changes are permitted in accordance with the following subsections.

(i) HIPAA Special Enrollment Rights. An Eligible Employee may change an election for group health plan coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP). Such change shall take place on a prospective basis, unless otherwise required by Code section 9801(f) to be retroactive.

(ii) Change in Status Event.

(A) General Rule. An Eligible Employee who has a Change in Status Event may revoke an Election and/or make a new Election during a Plan Year if

such revocation and/or new Election satisfies the consistency requirement of paragraph (B) below.

(B) Consistency Rule. An Election change is subject to the consistency rule of Treas. Reg. §1.125-4(c)(3). An Election change satisfies such consistency rule with respect to accident or health coverage only if the Election change is on account of and corresponds with the Change in Status Event that affects eligibility for coverage under the Plan. A Change in Status Event that affects eligibility under the Plan includes a Change in Status Event that results in an increase or decrease in the number of an Employee's family members or Dependents who may benefit from coverage under the Plan. An Election change satisfies such consistency rule with respect to other Benefits if the Election change is on account of and corresponds with a Change in Status Event that affects eligibility for coverage under the Plan.

(C) Exception for COBRA: If the Eligible Employee, Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan, as provided in Code section 4980B or any similar state law, the Plan may permit the Eligible Employee to elect to increase payments under the Plan in order to pay for the continuation coverage.

(iii) Judgment, decree, or order. In the event of a judgment, decree or 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) that requires accident or health coverage for an Eligible Employee's child who is a Dependent of the Eligible Employee:

(A) The Plan may change the Eligible Employee's Election to provide accident or health coverage for the child; or

(B) The Eligible Employee may make an Election to cancel accident or health coverage for the child if:

1. the order requires the Spouse, former Spouse, or other individual to provide coverage for the child, and

2. that coverage is, in fact, provided.

(iv) Entitlement to Medicare or Medicaid. If an Eligible Employee, or their Spouse or Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to coverage (i.e. becomes enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Eligible Employee may make a prospective Election change to cancel or reduce the accident or health coverage of such individual under the Plan. In addition, if such an Eligible Employee, or his Spouse or

Dependent loses eligibility for the Social Security Act benefits described above, the Eligible Employee may make a prospective Election to commence or increase the accident or health coverage of such individual under the Plan.

(v) Significant cost or coverage changes. This subsection does not apply to an election change with respect to the Health Care Spending Account.

(A) Cost changes.

1. Automatic election changes. If the cost of a Benefit Option increases or decreases during a Plan Year requiring Eligible Employees to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the Salary Reduction Elections of affected Eligible Employees.

2. Voluntary election changes due to significant cost changes. If the cost charged for a Benefit Package Option significantly increases or significantly decreases during a Plan Year, an Eligible Employee may make a corresponding change in his Salary Reduction Election. Such changes may include commencing participation in the Plan for the option with a decrease in cost, revoking an election for such coverage due to an increase in cost and in lieu thereof either receiving on a prospective basis coverage under another Benefit Package Option providing Similar Coverage, or ending coverage if no other Benefit Package Option providing Similar Coverage is available.

3. Application of Cost Changes. For purposes of paragraphs (1) and (2) of this subsection, a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the Plan, whether that increase or decrease results from an action taken by the Employee (such as switching between full-time and part-time) or from an action taken by the Employer (such as reducing the amount of employer contributions for a class of employees).

4. Application to Dependent Care Spending Account. This subsection applies in the case of the Dependent Care Spending Account only if the cost change is imposed by a dependent care provider who is not a relative of the Employee. For this purpose, a relative is an individual who is related as described in Code section 152(a)(1) through (8), incorporating the rules of Code section 152(b)(1) and (2).

(B) Coverage changes.

1. Significant curtailment without loss of coverage. If an Eligible Employee (or the Eligible Employee's Spouse or Dependent) has a

significant curtailment of coverage under any Benefit Option, that is not a loss of coverage (as described in paragraph (2) below) the Eligible Employee may revoke his Election for that coverage and may elect to receive, on a prospective basis, coverage under another Benefit Package Option providing Similar Coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage so as to constitute reduced coverage generally.

2. Significant curtailment with loss of coverage. If an Eligible Employee (or the Eligible Employee's Spouse or Dependent) has a significant curtailment of coverage under any Plan Benefit Option that is a loss of coverage, the Eligible Employee may revoke his Election and elect in lieu thereof to elect to receive, on a prospective basis, either coverage under another Benefit Package Option providing Similar Coverage or to drop coverage if no Benefit Package Option providing Similar Coverage is available. A loss of coverage is a complete loss of coverage under the Benefit Package Option or other coverage option (including the elimination of a Benefit Package Option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). Additionally, a "loss of coverage" shall Include the following:

a) a substantial decrease in the medical care providers available under the option;

b) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Eligible Employee, his Spouse or Dependent is currently in a course of treatment; or

c) any similar fundamental loss of coverage.

3. Addition or improvement of Benefit Package Option. If a new Benefit Package Option or other coverage option is added during a Benefit Period, or if coverage under an existing Benefit Package Option is significantly improved during a Benefit Period, an Eligible Employee may revoke his Election under the Plan, regardless of whether the Eligible Employee previously made an Election under the Plan, and make a new Election on a prospective basis under the new or improved Benefit Package Option.

(C) Change in coverage under another employer plan. An Eligible Employee may make a prospective Election change that is on account of and corresponds with a change made under another employer plan, including a plan of the Employer, if the other cafeteria plan or health benefit plan permits participants to make a mid-year election that would be permitted under Code section 125 and

the regulations thereunder, or the Plan's Plan Year is different from the period of coverage under the other cafeteria plan or health benefit plan.

(D) Loss of coverage under other group health coverage. An Eligible Employee may elect, on a prospective basis, coverage under the Plan if the Eligible Employee, his Spouse, or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including a medical care program of an Indian Tribal government, a state health benefits risk pool, or a foreign government group health plan.

(vi) FMLA Leave. An Eligible Employee who is on FMLA Leave may revoke an existing election of group health plan coverage (as defined in Plan section 3.06) and make such other election for the remaining portion of the Benefit Period as may be provided under the FMLA and Plan section 3.12. A Participant who revokes his election in accordance with the prior sentence must be permitted to reinstate his Salary Reduction Election upon his return to active work immediately following the end of his FMLA Leave.

(vii) Revocation of medical care coverage due to reduction in hours. If the medical care coverage under the Plan offer "minimum essential coverage" within the meaning of Code section 5000A(f)(1), an Eligible Employee may revoke an election of medical care coverage (other than the Health Care Spending Account) provided that the following conditions are met:

(A) The Eligible Employee has been in an employment status under which the Eligible Employee was reasonably expected to average at least 30 hours of service per week and there is a change in the Eligible Employee's status so that the Eligible Employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Eligible Employee ceasing to be eligible for medical care coverage; and

(B) The revocation of the election of medical care coverage corresponds to the intended enrollment of the Eligible Employee, and any related individuals who cease medical care coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the medical care coverage is revoked.

(viii) Revocation of medical care coverage due to enrollment in a Qualified Health Plan. If the medical care coverage under the Plan offers "minimum essential coverage" within the meaning of Code section 5000A(f)(1), an Eligible Employee may revoke an election of medical care coverage (other than the Health Care Spending Account) provided that the following conditions are met:

(A) The Eligible Employee is eligible for a special enrollment period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable

guidance, or the Eligible Employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(B) The revocation of the election of medical care coverage corresponds to the intended enrollment of the Eligible Employee and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the medical care coverage.

(ix) Health Savings Account. Notwithstanding any provision of the Plan to the contrary, (A) an Eligible Employee may change his or her Election for Health Saving Account contributions at any time; and (B) an Eligible Employee who becomes ineligible to make Health Savings Account contributions may prospectively revoke his or her Election for Health Savings Account contributions.

For purposes of this subsection, the term "Qualified Health Plan through a Marketplace" means a qualified health plan offered through a marketplace established under section 1311 of the Patient Protection and Affordable Care Act.

3.05 **Effect of Elections**

(a) Administrator's approval. An Election shall not be effective until the Administrator determines it is permitted under the Plan's terms. An Eligible Employee whose Election or Salary Reduction Election is wholly or partially invalid shall receive his regular Compensation during the Plan Year for the portion of the election that is invalid.

(b) Effective date of elections. The valid portion of an Eligible Employee's Election and Salary Reduction Election is effective on the date set by the Administrator, subject to Plan section 3.02(b).

(c) Cessation. An Eligible Employee's Salary Reduction Election terminates as of the date on which he or she loses his or her status as an Eligible Employee.

3.06 **Contributions and Salary Reduction Elections**

(a) Salary Reduction Election. A Salary Reduction Election is not valid unless the Eligible Employee indicates the amount, subject to the Administrator's adjustments as allowed by this Plan, by which his or her Compensation will be reduced and used by the Employer to purchase or pay for the elected Benefit Options. The amount specified on a Salary Reduction Election must be equal to the amount of the contribution required to be made by an Employee for the Benefit Options elected by the Eligible Employee. The Administrator may adopt and announce rules indicating maximum and minimum reduction allowances for all Benefit Options or for individual Benefit Options. Salary Reduction Contributions shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Reduction Elections are deemed to be part of this Plan and incorporated by reference hereunder.

(b) Eligible Employee status. A Salary Reduction Election is not effective for any Plan Year that ends before an Employee is an Eligible Employee, and it cannot be effective for any pay period during which the Employee is not an Eligible Employee except as provided in Plan section 3.12.

(c) No transfer of elected amounts. A Salary Reduction Election must indicate the specific dollar amount that is to be applied to each Benefit Option elected. The amount directed for one Benefit Option may not be applied to purchase any other Benefit Option.

(d) Application of Contributions. As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Reduction Contributions to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Care Spending Account, the Dependent Care Spending Account, and/or the Health Savings Account shall be credited to such fund or account.

(e) Periodic Contributions. Notwithstanding Plan section 3.06(a) and any other provision of the Plan, and to the extent consistent with Code section 125 and the regulations thereunder, the Employer and Administrator may implement a procedure in which Salary Reduction Contributions are contributed throughout the Plan Year on a period basis that is not pro rata for each payroll period. However, with regard to the Health Care Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

(f) Maximum contribution. The cost of providing the elected Benefit Options may vary for each Eligible Employee, based on the required contributions or premium costs for the Benefit Option and level of coverage. The maximum contribution as to any Eligible Employee also may vary, based on the Eligible Employee's family status. The maximum contribution available to any Eligible Employee for a Plan Year will be determined by the Sponsor in advance of the annual Enrollment Period. It will be adjusted as necessary, due to changes in the cost of available Benefit Options. The maximum allowable Salary Reduction Election dollar amount may not exceed the Employee cost of the most expensive Benefit Options available to any Eligible Employee. The maximum contribution will not exceed the cost of the most expensive Benefit options available to any Participant (including the maximum permitted Health Care Spending Account, Dependent Care Spending Account, and Health Savings Account contributions).

3.07 **Health Care Spending Account**

(a) Establishment of Plan. The Administrator shall establish a Health Care Spending Account for each Participant who elects to apply Salary Reduction Contributions to Health Care Spending Account Benefits. This Health Care Spending Account is intended to qualify as a medical reimbursement plan under Code section 105 and shall be interpreted in a manner consistent with such Code section and the Treasury regulations thereunder. A Participant who elects to participate in this Health Care Spending Account may submit claims for the reimbursement of Medical Expenses incurred by the Participant, the Participant's Spouse, and/or the Participant's Dependents. All amounts reimbursed shall be periodically paid from amounts

allocated to the Health Care Spending Account. Periodic payments reimbursing Participants from the Health Care Spending Account shall in no event occur less frequently than monthly.

(b) Limitations on Allocations.

(i) Statutory Limit**.** The maximum amount that may be allocated to the Health Care Spending Account by a Participant in or on account of any Plan Year is $3,050 (for the Plan Year beginning January 1, 2023,). Such amount shall be adjusted for increases in the cost-of-living in accordance with Code section 125(i)(2) and as announced by the Plan Administrator. The cost-of-living adjustment in effect for a calendar year applies to any Plan Year beginning with or within such calendar year. The dollar increase in effect on January 1 of any calendar year shall be effective for the Plan Year beginning with or within such calendar year. For any short Plan Year, the limit shall be an amount equal to the limit for the calendar year in which the Plan Year begins multiplied by the ratio obtained by dividing the number of full months in the short Plan Year by twelve (12).

(ii) Participation in Other Plans**.** All employers that are treated as a single employer under Code sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the limit described in subsection (a). If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Care Spending Account contributions under all of the cafeteria plans are limited to $3,050 (as adjusted under Code section 125(i)(2)). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up each Plan's limit for each Employer's Health Care Spending Account.

(c) Nondiscrimination Requirements.

(i) Intent to be nondiscriminatory**.** It is the intent of this Health Care Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(ii) Adjustment to avoid test failure**.** If the Administrator deems it necessary to avoid discrimination under this Health Care Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or benefits in order to assure compliance with this Plan section. Any act taken by the Administrator under this Plan section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or benefits, it shall be done in the following manner. First, the benefits designated for the Health Care Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Plan section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code section 105 who has elected the second highest contribution to the Health

Care Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Plan section or the Code 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 and credited to the benefit plan surplus.

(d) Health Care Flexible Spending Account Claims.

(i) Expenses must be incurred during Plan Year**.**

(A) General Rule. A Medical Expense of Participant, the Participant's Spouse and/or the Participant's Dependents may be reimbursed from the Participant's Health Care Spending Account for a Plan Year if the Medical Expense is incurred during such Plan Year and while the Participant is enrolled in the Health Care Spending Account. Medical Expenses are treated as having been incurred when the Participant (or the Participant's Spouse or Dependents) is provided with the medical care that gives rise to the Medical Expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(B) Advance Payment for Orthodontia. Notwithstanding Pan section 3.07(d)(i) and to the extent consistent with Prop. Treas. Reg. section 1.125-5(k), a Participant may be reimbursed for orthodontia services before the services are provided but only to the extent that the Participant has actually made payments in advance of the orthodontia services in order to receive the services. Such orthodontia services are deemed to be incurred when the Participant makes the advance payment.

(ii) Reimbursement available throughout Plan Year**.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Spending Account for the Plan Year, less any reimbursements already disbursed for the Plan Year. Reimbursements shall be made available to the Participant throughout the Plan Year without regard to the level of Salary Reduction Contribution that has been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(iii) Substantiation and Payments**.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. To be reimbursed from the Health Care Spending Account, a Medical Expense must be substantiated by information from a third-party that is independent of the Participant, the Participant's Spouse, and the Participant's Dependents. The independent third party must provide information describing the service or product, the date of the service or sale, and the amount. If the Administrator is provided with information from an independent third party (such as an "explanation of benefits" (EOB) from an insurance company) indicating the date of the Medical Expense and the Participant's responsibility for payment for that Medical Expense (that is,

coinsurance payments and amounts below the plan's deductible), and the Participant certifies that any expense paid through the Health Care Spending Account has not been reimbursed and that the Participant will not seek reimbursement from any other plan covering health benefits, the claim is fully substantiated without the need for submission of a receipt by the employee or further review. The Administrator shall retain a file of all such applications.

(iv) 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 practicable; provided however, that if a Participant fails to submit a claim by the ninetieth (90^{th}) day after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. 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.

(v) Carry-Over. A Participant may roll over up to the "Carryover Amount" of unused amounts in his or her Health Care Spending Account remaining at the end of one Plan Year to the immediately following Plan year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over under this subsection do not affect the maximum Health Care Spending Account election permitted under Section 5.1. Unused amounts are those remaining after expenses have been reimbursed during the Runout Period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of the Carryover Amount will be forfeited. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the Carryover Amount. The Carryover Amount is the maximum amount permitted under Notice 2020-33 (and any related Internal Revenue Service guidance) applicable for a Plan Year. Notwithstanding the preceding sentence, a Participant my roll over their entire unused Health Care Spending Account balance as of the end of the Plan Year commencing January 1, 2021 to reimburse Medical Expenses incurred in the Plan Year commencing January 1, 2022.

(vi) Forfeitures. The amount in the Health Care Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Plan section 3.07(d)(v) and except as provided in Plan section 3.07(d)(vi) (Carry-Over) above) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 4.02.

(vii) Terminated Participants. The Plan shall comply with Prop. Treas. Reg. section 1.125-5(d)(3) with respect to terminated Health Care Spending Account Participants. Specifically, when an employee ceases to be a participant with respect to the Health Care Spending Account, the Plan shall pay the former participant any amount the former participant previously paid for coverage or benefits to the extent the previously paid amount relates to the period from the date the employee ceases to be a participant through the end of that Plan Year. See Plan section 3.07(f) regarding COBRA continuation coverage.

(e) Separate Plans. Although described in this Plan document, Health Care Spending Account is a separate plan for purposes of administration, the nondiscrimination requirements of Code section 105, HIPAA, and COBRA.

(f) COBRA. If a Participant participating in the Health Flexible Spending Arrangement ceases to be an Employee, the Participant may submit claims for Medical Expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Arrangement have already been made. COBRA continuation coverage will be available to COBRA "qualified beneficiaries" with respect to the Health Flexible Spending Arrangement through the end of the Plan Year in which the COBRA "qualifying event" occurred if such qualified beneficiaries are entitled to receive a benefit under the Health Flexible Spending Arrangement that exceeds the maximum amount that the law permits as payment for COBRA continuation coverage for the remainder of the Plan Year. This subsection shall be interpreted and administered in accordance with Code section 4980B, ERISA sections 601 through 607, and the regulations issued under such section of the Code and ERISA.

(g) Debit and Credit Cards. Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

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

(ii) Card issuance**.** Such card shall be issued upon the Participant's Entry Date and reissued for each Plan Year the Participant remains a Participant in the Health Care Spending Account. Such card shall 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 Health Care Spending Account.

(iii) Maximum dollar amount available**.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Plan section 3.07(b).

(iv) Only available for use with certain service providers**.** Use of the cards shall be limited to (A) physicians, dentists, vision care offices, hospitals, other medical care providers (as identified by the merchant category code); (B) stores with the merchant category code for Drugstores and Pharmacies if, on a location by location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care described in Code section 213(d); and (C) Stores that have implemented the inventory information approval system under paragraph (f) of Prop. Treas. Reg. section 1.125-6.

(v) Card use. The cards shall only be used for Medical Expense purchases at the providers described in Plan section 3.07(g)(iv), including, but not limited to, the following:

(A) Co-payments for doctor and other medical care;

(B) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the- counter medications as allowed under IRS regulations;

(C) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(vi) Substantiation. Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Prop. Treas. Reg. section 1.125-6. Specifically, the Employer shall substantiate claims based on payments to medical care providers and stores described in Plan sections 3.07(g)(iv)(A) and (B) in accordance with either paragraph (e) or paragraph (f) of Prop. Treas. Reg. section 1.125-6. All charges shall be conditional pending confirmation and substantiation.

(vii) Correction methods**.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Employer shall use the following correction methods to make the Plan whole. Until the amount is repaid, the card shall be deactivated and the Participant may request payments or reimbursements of Medical Expenses through other methods.

(A) The Employer shall demand repayment of the improper amount by the Participant;

(B) If after the demand for repayment of the improper payment, the Participant fails to repay the amount of the improper charge, the Employer shall withhold the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(C) If any portion of the improper payment remains outstanding after subsections (A) and (B), above, the Employer shall apply a claims substitution or offset of future claims until the amount is repaid; and

(D) if subsections (A) through (B) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

3.08 **Dependent Care Spending Accounts**

(a) Establishment of Account. The Administrator shall establish a Dependent Care Spending Account for each Participant who elects to apply Salary Reduction Contributions to Dependent Care Spending Account benefits. The Dependent Care Spending Account is intended to qualify as a program under Code section 129 and shall be interpreted in a manner consistent with such Code section and the Treasury regulations thereunder.

(b) Definitions. For the purposes of this Plan section, the terms below shall have the following meaning:

(i) "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.

(ii) "Employment-Related Dependent Care Expenses" means the amounts paid for expenses of a Participant 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 Participant. 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. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(A) 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 as defined in Plan section 3.08(b)(iii)(A) (or deemed to be, as described in Plan section 3.08(b)(iii)(A) pursuant to Plan section 3.08(b)(iii)(C) or for a Qualifying Dependent as defined in Plan section 3.08(b)(iii)(B) (or deemed to be, as described in Plan section 3.08(b)(iii)(B) pursuant to Plan section 3.08(b)(iii)(C)) who regularly spends at least 8 hours per day in the Participant's household;

(B) 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 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

(C) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent (as defined in Code section 152) of such Participant or such Participant's Spouse.

(iii) "Qualifying Dependent" means, for Dependent Care Spending Account purposes,

(A) a Participant's Dependent (as defined in Code section 152(a)(1)) who has not attained age 13;

(B) a Dependent (as defined in Code section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B)) 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

(C) a child that is deemed to be a Qualifying Dependent described in paragraph (A) or (B) above, whichever is appropriate, pursuant to Code section 21(e)(5).

(c) Dependent Care Spending Accounts. The Administrator shall establish a Dependent Care Spending Account for each Participant who elects to apply Salary Reduction to Dependent Care Spending Account benefits.

(d) Increases in Dependent Care Spending Accounts. A Participant's Dependent Care Spending Account shall be increased each pay period by the portion of Salary Reduction Contribution that he or she has elected to apply toward his Dependent Care Spending Account pursuant to elections made under Article III hereof.

(e) Decreases in Dependent Care Spending Accounts. A Participant's Dependent Care Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid to or on behalf of a Participant pursuant to Plan section 3.08(l) hereof.

(f) Allowable Dependent Care Reimbursement. Subject to limitations contained in Plan section 3.08(j), and to the extent of the amount contained in the Participant's Dependent Care Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant covered by the Dependent Care Spending Account.

(g) Grace Period. During the period ending on the fifteenth (15th) day of the third month following the end of each Plan Year (the "Grace Period"), a Participant with unused contributions in his or her Dependent Care Spending Account from the preceding Plan Year who incurs Employment-Related Dependent Care Expenses may be reimbursed for such expenses (up to the amount of unused contributions remaining in the Dependent Care Spending Account) as if the expenses had been incurred in the immediately preceding Plan Year. During the Grace Period, unused contributions in a Participant's Dependent Care Spending Account cannot be cashed out or converted to any other taxable or nontaxable benefit. Unused contributions in a Participant's

Dependent Care Spending Account at the end of a Plan Year may only be used to reimburse Employment-Related Dependent Care Expenses incurred in the Grace Period (or the preceding Plan Year). To the extent any unused contributions in a Participant's Dependent Care Spending Account from the immediately preceding Plan Year exceed expenses incurred during the Grace Period (or the preceding Plan Year), those remaining unused contributions may not be carried forward to the current Plan Year or any subsequent Plan Year and shall be forfeited. Participants who were Participants as of the last day of the Plan Year but terminate during the Grace Period are Participants for purposes of the Grace Period. Any claims for reimbursement paid during a Grace Period for Employment-Related Dependent Care Expenses incurred during the Grace Period shall be applied first against any unused Dependent Care Spending Account benefits remaining for the Plan Year to which the Grace Period relates, and then Dependent Care Spending Account benefits, if any elected by the Eligible Employee for the subsequent Plan Year.

(h) Annual Statement of Benefits. The Employer shall furnish to each Employee who was a Participant and received benefits under this Plan section during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

(i) Forfeitures. Except as provided in subsection 3.08(g), the amount in a Participant's Dependent Care Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Plan section 3.08(k)) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason. Notwithstanding the preceding sentence, a Participant my roll over their entire unused Dependent Care Spending Account balance as of the end of the Plan Year commencing January 1, 2021 to reimburse Medical Expenses incurred in the Plan Year commencing January 1, 2022. Such amounts carried over from the 2021 Plan Year to the 2022 Plan Year shall not be taken into account for purposes of the limitations in subsection 3.08(j).

(j) Statutory Limitation. Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code section 21(e)). Notwithstanding any provision contained in this Article to the contrary, the maximum amount that may be allocated to a Dependent Care Spending Account by a Participant during any taxable year of the Participant also may not exceed the lesser of the Earned Income limitation described in Code section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code section 21(e)).

(k) Nondiscrimination Requirements

(i) Intent to be nondiscriminatory. It is the intent of this Dependent Care 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).

(ii) 25% test for shareholders. It is the intent of this Dependent Care 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.

(iii) 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. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Spending 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 Spending 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.

(l) Dependent Care Spending Account Claims. The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party that includes a description of the service, the date of the service, and the cost of the service. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Plan for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(i) The Qualifying Dependent or Qualifying 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 by 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 Qualifying Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(vii) If the services were being performed in a day care center, a statement:

(A) that the day care center complies with all applicable laws and regulations of the state of residence,

(B) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(C) of the amount of fee paid to the provider.

(viii) If the Participant is married, a statement containing the following:

(A) the Spouse's salary or wages if he or she is employed, or

(B) if the Participant's Spouse is not employed, that

1. 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.

(ix) If a Participant fails to submit a claim by the ninetieth (90^{th}) day after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

3.09 **Health Savings Accounts**

(a) General**.** A Health Savings Account ("HSA") is a personal savings account established with a Custodian or Trustee to be used primarily for reimbursement of eligible medical expenses of the Account Beneficiary and the Account Beneficiary's eligible tax dependents (as defined in Code section 152) as set forth in Code section 223. The HSA is administered by the

HSA Custodian/Trustee or its designee. The HSA is not an Employer-sponsored employee benefit plan. The Employer's role with respect to the HSA is limited to making contributions to the HSA under this Plan. The fact that the HSA is offered under this Plan should not be construed as endorsement of the HSA by the Employer. The Employer has no authority or control over the funds deposited in the Account Beneficiary's HSA. As such, the HSA is not subject to ERISA.

(b) Eligibility for Health Savings Accounts**.** Only Eligible Employees who satisfy the following conditions are eligible for contributions to an HSA under this Plan ("Eligible Individual"):

(i) The Employee is enrolled in a qualifying "High Deductible Health Plan" (as defined in Code section 223);

(ii) The Employee has opened an HSA with the Custodian chosen by the Plan Sponsor. Although the Custodian may be chosen by the Plan Sponsor, the Account Beneficiary may rollover funds from the HSA offered under this Plan to another HSA at any time (subject to the terms of the Custodial Agreement);

(iii) The Employee is not covered (as a dependent or otherwise) under any other non-high deductible health plan maintained by the Plan Sponsor that is determined by the Plan Sponsor to offer disqualifying health coverage;

(iv) The Employee has certified he/she is otherwise eligible to participate in the HSA (i.e., the Employee: (i) cannot be claimed as a tax dependent; (ii) is not enrolled in Medicare coverage; (iii) has qualifying High Deductible Health Plan coverage; and (iv) has no disqualifying coverage from any other source); and

(v) The Employee is eligible for this Plan.

An Employee who first becomes an Eligible Individual anytime on or before the first day of December of any year is treated as though they are an Eligible Individual for the entire year so long as they continue to be an Eligible Individual (as defined in Code section 223) for twelve (12) months beginning with the last month in the year in which the individual became an Eligible Individual. If the individual fails to be an Eligible Individual during that twelve (12) month period, all contributions attributable to months for which the individual was not an Eligible Individual during the year are included in gross income for the year in which the individual ceases to be an Eligible Individual, other than disability or death, and such amounts are subject to a ten percent (10%) excise tax.

(c) Definition of Account Beneficiary**.** An Account Beneficiary is an eligible Participant in this Plan who has properly enrolled in an HSA in accordance with the terms of the applicable Custodian Agreement.

(d) Definition of Custodian or Trustee. The Custodian or Trustee (for purposes of this Plan, use of the term "Custodian" includes a reference to both Custodian and Trustee) is the entity with whom the Account Beneficiary's HSA is established. The HSA is not sponsored by or

maintained by the Plan Sponsor. The Custodian will provide each Account Beneficiary with a Custodial Agreement as well as other information that describes how to enroll in the HSA and the Account Beneficiary's rights and obligations under the HSA.

(e) Health Savings Account Contributions**.** Contributions made under this Plan to HSAs may consist of both Employee Salary Reduction Contributions made pursuant to a Salary Reduction Election and/or Employer contributions, if any.

(i) Statutory Contribution Limit. Notwithstanding any provision of this Plan to the contrary, Employee Salary Reduction Contributions and/or Employer contributions made to an HSA under this Plan cannot exceed the applicable statutory maximum set forth in Code section 223. If the Account Beneficiary is age fifty-five (55) or older and the Account Beneficiary properly certifies his or her age to the Employer, the maximum contribution amount described above may be increased by the "additional contribution amount" in accordance with Code section 223(b)(3)(B), but only to the extent permitted as set forth in the separate HSA communication material provided by the Employer and/or the Custodian. The Employer may adjust contributions made under this Plan as necessary to ensure the maximum contribution amount is not exceeded.

(ii) Salary Reduction Contributions to HSA. To the extent set forth in the Plan's enrollment material or the HSA communication material, the Employer may automatically withhold Salary Reduction Contributions from the Account Beneficiary's compensation to contribute to an HSA unless the Account Beneficiary affirmatively indicates that he or she does not wish to contribute to the HSA with Salary Reduction Contributions. The Employee's HSA election under this Plan will not be effective until the later of the date that the Employee makes his election or the date that the Employee establishes his HSA.

(iii) Employer Contributions to HSA. The Employer may, in its discretion, contribute to Participants' HSAs as announced by the Administrator from time to time.

(f) Excess Contributions. Any Salary Reduction Contributions that cannot be made to the HSA because the Employee is not eligible for such contribution will be paid to the Employee as taxable compensation or as otherwise set forth in the Plan enrollment material. Any Employer contributions that cannot be made to the HSA because the Employee is not eligible for such contribution will be returned to the Employer except as otherwise set forth in the applicable communication material. Any Employer contributions credited to the HSA of a Participant who fails to activate his or her account with the Custodian by the end of the calendar year in which the Employer contribution was made shall be forfeited.

3.10 **Cash Benefit**

The Plan's Cash Benefit for a Participant is portion of the Participant's Compensation that could have been reduced, but is not being reduced, under a Salary Reduction Election election available to the Participant. The Cash Benefit, if any, will be paid pro-rata over the Plan Year under regular payroll in equal payments.

3.11 **Contributions During FMLA Leave**

(a) A Participant who qualifies for an FMLA Leave shall have the opportunity to elect to continue group health plan coverage during the FMLA Leave, or to suspend coverage for the FMLA Leave. A Participant who chooses to continue coverage must make such contributions as may be required by the Employer as a condition of continuing coverage. The election procedures must comply with applicable regulations. In accordance with such regulations, a Participant may continue contributions in one of the following methods (or a combination of such methods) offered by the Administrator:

(1) Pre-pay. A Participant may pay the amount due for the FMLA Leave period prior to the commencement of an FMLA Leave to the extent that the FMLA Leave period occurs during the Plan Year in which the FMLA Leave period commences. Such amounts may come from any taxable compensation, including cashing out unused sick days or vacation days. Contributions also may be made on a pre-tax basis.

(2) Pay-as-you-go. A Participant may pay the amount due on the same schedule as if he was not on leave. Contributions are usually made on an after-tax basis but may be made on a pre-tax basis, to the extent that contributions are made from taxable income due the Participant while he is on leave. A Participant may purchase benefits on a pre-tax basis from any taxable compensation (including the cashing out of unused sick days or vacation days) or on an after-tax basis.

(3) Catch-up. In accordance with the agreement between the Employer and a Participant, set out before FMLA Leave commences, the Employer may pay the amount of required Participant contributions on the Participant's behalf while the Participant is on FMLA Leave and the Participant must repay the amount on his return on an after-tax or pre-tax basis.

(b) For purposes of this Section, the term "group health plan" has the meaning set forth in Code Section 5000(b)(1) and 29 CFR§ 825.102, as modified by 29 CFR §825.209.

ARTICLE IV
ERISA PROVISIONS.

4.01 **Claim for Benefits**

(a) General claims procedures**.** The claims procedures set forth in the Benefits Documents shall apply to any claim for benefits under the Plan, other than Dependent Care Spending Account claims or Health Care Spending Account claims.

(b) Dependent Care Spending Account claims**.** Any claim for Dependent Care Spending Account Benefits shall be made to the Administrator (or its delegate). For the Dependent Care Spending Account, if a Participant fails to submit a claim by the deadline set forth in Plan section 3.08, those claims shall not be considered for reimbursement by the Administrator.

(i) Claims Denial**.** If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 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 shall be written in a manner calculated to be understood by the claimant and shall set forth:

(A) specific references to the pertinent Plan provisions on which the denial is based;

(B) 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

(C) an explanation of the Plan's claim procedure.

(ii) Appeal**.** Within 60 days after receipt of the above material, 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:

(A) request a review upon written notice to the Administrator;

(B) review pertinent documents; and

(C) submit issues and comments in writing.

(iii) Review of appeal**.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(c) Health Care Spending Account claims**.** Any claim for Health Care Spending Account Benefits shall be made to the Administrator (or its delegate). If a Participant fails to submit a claim under the Health Care Spending Account by the deadline set forth in Plan section 3.07, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 90 days after termination of employment. Once a claim is submitted, the following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

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

(2) Reference to the specific Plan provisions on which the denial was based.

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review.

(5) 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.

(6) 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.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant

requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

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.

(d) Statute of Limitations on Claims. No legal action to recover benefits under the Plan may be brought more than one year following the date of final decision on review by the Insurer or the Plan Administrator, as applicable.

(e) Forfeitures**.** Amounts forfeited pursuant to sections 3.07 or 3.08 shall be deposited in the benefit plan surplus of the Employer, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

4.02 **Application of Benefit Surplus**

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for

the same or any other Benefit Option available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan. No amounts attributable to the Health Savings Account shall be subject to the benefit plan surplus.

4.03 **Named Fiduciary**

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

4.04 **Nonassignability of Rights**

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to 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.

ARTICLE V
ADMINISTRATION

5.01 **Plan Administration**

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

An Administrator may resign by delivering a written resignation to the Employer or be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. 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 to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Act, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the 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 and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

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

(b) To interpret the provisions of 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;

(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 and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

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

(i) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code section 125 and the Treasury regulations thereunder.

5.02 **Examination of Records**

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

5.03 **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. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

5.04 **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.

5.05 **Indemnification of Administrator**

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.

5.06 **Errors and Omissions**

Individuals and entities charged with the administration of the Plan must see that it is administered in accordance with its terms as long as it is not in conflict with ERISA or any applicable provisions of the Code with which the Plan is intended to comply. If an innocent error or omission is discovered in the Plan's operation or administration, and if the Administrator determines that it would cost more to correct the error than is warranted, and if the Administrator determines that the error did not result in discrimination prohibited by this Plan or cause a qualification or excise-tax problem, then, to the extent that an adjustment will not, in the Administrator's judgment, result in discrimination prohibited by this Plan, the Administrator may authorize any equitable adjustment it deems necessary or desirable to correct the error or omission, including but not limited to the authorization of additional Employer contributions designed, in a manner consistent with the goodwill intended to be engendered by the Plan, to put Participants in the same relative position they would have enjoyed if there had been no error or omission.

ARTICLE VI
MISCELLANEOUS

6.01 Plan Interpretation

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 6.12.

6.02 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.

6.03 Written Document

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code section 125 and any Treasury regulations thereunder relating to cafeteria plans.

6.04 Exclusive Benefit

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

6.05 Participant's Rights

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.

6.06 Action by the Employer

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

6.07 Employer's Protective Clauses

(a) Insurance purchase**.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that

remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) Validity of insurance contract**.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

6.08 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.

6.09 Indemnification of Employer by Participants

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.

6.10 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.

6.11 Governing Law

This Plan is governed by the Code and the Treasury 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 Commonwealth of Virginia.

6.12 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.

6.13 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.

6.14 Continuation of Coverage (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code section 4980B, and related regulations.

6.15 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.

6.16 Uniformed 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.

6.17 Health Insurance Portability and Accountability Act (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

6.18 Nonalienation of Benefits

No Participant or beneficiary may alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he or she may expect to receive under the Plan.

6.19 No Right to Employment

This Plan shall not be construed as an employment contract between the Employer and any Employee or as a right of any Employee to continue in the employment of the Employer, or as a limitation on the right of the Employer to discharge any of its Employees with or without cause.

6.20 Compliance with HIPAA Privacy Standards

(a) Application. If any benefits under this Plan are 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 genetic information and information about treatment or payment for treatment.

(c) PHI disclosed 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. Genetic information will not be used or disclosed for underwriting purposes.

(d) PHI disclosed to certain workforce members. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and 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 official. The privacy official 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.

(a) 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.

6.21 **Compliance with HIPAA Electronic Security Standards**

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

(a) 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.

(b) 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.

(c) 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 6.18.

ARTICLE VII
AMENDMENT AND TERMINATION

7.01 **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. The Employer's right to amend this Plan continues even if the amendment prospectively restricts or terminates the types or amounts of Benefits that a Participant or Beneficiary may receive under the Plan as long as the amendment does not result in any prohibited discrimination under Code section 125.

7.02 **Termination**

The Employer reserves the right to terminate the 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 Benefit Document shall be paid in accordance with the terms of the Benefit Document.

Following the termination of the Plan, no further additions shall be made to the Health Care Spending Account or Dependent Care Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE VIII
DEFINITIONS

8.01 **Administrator**

Administrator means the Employer unless another person or entity has been designated by the Employer pursuant to Plan section 5.01 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

8.02 **Affiliate**

Affiliate means:

(a) a member of a controlled group of corporations as defined in Code section 1563(a), determined without regard to Code section 1563(a)(4) and 1563(e)(3)(C), of which an Employer is a member according to Code section 414(b);

(b) an unincorporated trade or business that is under common control with an Employer as determined according to Code section 414(c);

(c) a member of an affiliated service group of which an Employer is a member according to Code section 414(m); or

(d) any entity required to be aggregated according to Code section 414(o).

8.03 **Beneficiary**

Beneficiary means a Dependent or Spouse who is enrolled for coverage under one or more Benefit Option.

8.04 **Benefit Document**

Benefit Document means the written instrument governing and describing benefits under this Plan, including any applicable insurance policies or contracts, "Certificates of Coverage," "Evidences of Coverage," and summary plan descriptions. Benefit Documents are incorporated herein by reference.

8.05 **Benefit** or **Benefit Option**

Benefit or Benefit Option means any benefit option identified in Appendix A.

8.06 **Benefit Package Option**

Benefit Package Option means a qualified benefit under Code section 125 that is offered under the Plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option) under an accident or health plan.

8.07 **Benefit Period**

Benefit Period means the period of time to which a Benefit Election applies. A Benefit Period is a Plan Year, except: (a) for Employees who become eligible to participate during the Plan Year, that part of the Plan Year after the applicable Entry Date; and (b) for Employees whose participation ends during the Plan Year, that part of the Plan Year preceding the date participation terminates.

8.08 **Cash Benefit**

Cash Benefit means the Cash Benefit described in Plan section 3.11.

8.09 **Change in Status Event**

Change in Status Event means a change in an Eligible Employee's status because of one of the following events, subject to Treasury Regulation section 1.125-4(c):

(a) Legal Marital Status: a change in an Eligible Employee's legal marital status (marriage, divorce, legal separation, annulment, or death of the Eligible Employee's spouse);

(b) Number of Dependents: an event that changes the Employee's number of Dependents including the birth, adoption, placement for adoption, or death of a child;

(c) Employment Status: any of the following events of an Eligible Employee, his Spouse or Dependent:

(i) a termination or commencement of employment;

(ii) a reduction or increase in hours of employment including a switch between part-time and full-time;

(iii) a strike or lockout or a commencement or return from an unpaid leave of absence;

(iv) a beginning or ending of an unpaid leave of absence;

(v) a change in worksite; or

(vi) any change in the Eligible Employee's, his Spouse's or his Dependent's employment status resulting in the individual becoming, or ceasing to be, eligible under

the Plan or other plan of the Employer or of the employer of the Eligible Employee's Spouse or Dependent.

(d) Change in Dependent Status: an event that causes an Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of a certain age, Student status, or other similar circumstance. For the Dependent Care Spending Account, an individual ceasing to be a "qualifying individual" (as defined in Code section 21(b)(1) is a Change in Status Event. Notwithstanding anything in this Section to the contrary, change in eligibility of a child, as allowed under Code sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a Change in Status Event.

(e) Residence: a change in the place of residence for the Eligible Employee, his Spouse or Dependent;

(f) Other: such other status change as the Administrator determines is consistent with the provisions of Code section 125 and applicable Treasury regulations.

8.10 **COBRA**

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended and in effect for the relevant time.

8.11 **Code**

Code means the Internal Revenue Code of 1986, as amended and in effect for the relevant time.

8.12 **Compensation**

Compensation means the cash wages paid by the Employer to the Participant during a Plan Year determined prior to:

(a) any Code section 401(k) salary deferral elections;

(b) any Salary Reduction Contribution under this Plan; and

(c) any salary reduction election under a nonqualified deferred compensation plan maintained by the Employer.

8.13 **Currently Available**

Compensation or another taxable benefit is Currently Available if it has been paid to the Employee, or if the Employee is able currently to receive the Compensation or other taxable benefit at the Employee's discretion. However, Compensation or other taxable benefit is not Currently Available to an Employee if there is a significant limitation or restriction on the Employee's right to receive the benefit currently. Similarly, a benefit is not Currently Available as of a date if the Employee may under no circumstances receive the benefit before a particular time in the future.

The determination of whether a benefit is Currently Available does not depend on whether it has been constructively received by the Employee for purposes of Code section 451. For purposes of this definition, "other taxable benefit" includes the Cash Benefit.

8.14 **Dependent**

Dependent means a dependent as defined in Code section 152 except that, for purposes of accident and health plan coverage, any child to whom section 152(e) applies is treated as a Dependent of both parents.

For purposes of the Health Care Spending Account, Benefit Options that are accident or health plans described in Code section 106, and, consistent with IRS Notice 2010-38, with respect to accident or health plan Benefit Election changes under Plan section 3.04, the definition of Dependent shall also include the child of an Eligible Employee who will not attain age 27 by the end of the calendar year. For purposes of this definition, "child" means an individual who is:

(a) the Eligible Employee's son, daughter, stepson, or stepdaughter;

(b) the Eligible Employee's eligible foster child;

(c) a child who the Eligible Employee has legally adopted;

(d) a child who has been lawfully placed with the Eligible Employee for legal adoption; or

(e) a child who is under legal guardianship, as long as the child is a tax dependent of the Eligible Employee.

8.15 **Dependent Care Spending Account**

Dependent Care Spending Account means the account established for a Participant under this Plan to which part of his or her Salary Reduction Contribution may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of Qualifying Dependents of the Participant.

8.16 **Effective Date**

The Effective Date of this Plan document is January 1, 2023.

8.17 **Election**

Election means the election described in Plan Article III. For purposes of Plan section 3.04(d), Election includes the related Salary Reduction Election.

8.18 **Eligible Employee**

Eligible Employee means an Employee who satisfies the eligibility requirements of the Welfare Benefits Plan.

For purposes of eligibility for Health Care Spending Accounts, an Employee must be an Eligible Employee for the Medical Benefit under the Welfare Benefits Plan.

8.19 **Employee**

Employee means a common law employee of the Employer who is reported on the payroll records of the Employer as a common law employee. This term does not include any other common law employee or any leased employee as defined in Code section 414(n). In particular, it is expressly intended that individuals not treated as common law employees by the Employer on their payroll records are to be excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

8.20 **Employer**

Employer means University of Richmond, or other Affiliate whose participation in the Plan is authorized by University of Richmond.

8.21 **Entry Date**

Entry Date means the date Benefits begin as provided under the terms of the Welfare Benefits Plan.

8.22 **Enrollment Period**

Enrollment Period means the period following an Eligible Employee's date of hire (or the date an Employee becomes an Eligible Employee) or such annual period preceding a Plan Year as may be announced by the Administrator during which an Eligible Employee may make an Election and submit a Salary Reduction Election. The Enrollment Period for a Benefit Period must end before the earlier of (a) the date when taxable benefits to which the Election applies (the Cash Benefit) are Currently Available; or (ii) the first day of the Plan Year (or other coverage period).

8.23 **ERISA**

ERISA means the Employee Retirement Income Security Act of 1974, as amended and in effect for the relevant time.

8.24 **FMLA**

FMLA means the Family and Medical Leave Act of 1993, as amended and in effect for the relevant time.

8.25 **FMLA Leave**

FMLA Leave means a leave of absence that an Employer is required to extend to an Employee under the provisions of the FMLA.

8.26 **Health Care Spending Account**

Health Care Spending Account means the account established for a participant under this Plan to which part of his Salary Reduction Contribution 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, as provided in Plan section 3.07.

8.27 **Health Savings Account or HSA**

Health Savings Account or HSA means an account established in accordance with Code section 223.

8.28 **HIPAA**

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended and in effect for the relevant time.

8.29 **Medical Expense**

Medical Expense means any otherwise unreimbursed or uninsured expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code section 213(d) and the rulings and Treasury Regulations issued thereunder, that is not otherwise used by the Participant in determining a deduction to his tax liability under the Code. Over the counter drugs purchased by the Participant or his/her Spouse or Dependents to alleviate or treat personal injuries or sickness shall be considered allowable Medical Expenses, regardless of whether obtained with a physician's prescription. Additionally, "menstrual care products," as defined in Code section 223(d)(2)(D) shall be considered allowable Medical Expenses. "Medical Expense" does not include any amounts paid or incurred as premiums for health coverage or long-term care insurance. Additionally, "Medical Expense" does not include long-term care services. A "Medical Expense" eligible for reimbursement under the Health Care Spending Account shall not include any Medical Expense that is not allowed to be paid or reimbursed under a Code section 125 plan.

8.30 **Participant**

Participant means an Eligible Employee who is enrolled in the Plan under Articles II and III and has not ceased to be eligible to participate in the Plan.

8.31 **Plan**

Plan means the University of Richmond Section 125 Cafeteria Plan, as described in this document.

8.32 **Plan Year**

Plan Year means the twelve (12) consecutive month period beginning January 1 and ending December 31.

8.33 **Salary Reduction Election**

Salary Reduction Election 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 on a pre-tax basis and to have such amounts applied to the purchase of Benefits on the Participant's behalf. The Salary Reduction Election 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. Such agreement may be in such form and medium (paper or electronic) as determined by the Administrator.

8.34 **Salary Reduction Contribution**

Salary Reduction Contribution means the amount of a Participant's Compensation reduced pursuant to a Salary Reduction Election and applied toward the cost of a Benefit and or allocated to the Participant's Health Care Spending Account, Dependent Care Spending Account, and Health Savings Account.

8.35 **Similar Coverage**

Similar Coverage means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single).

8.36 **Sponsor**

Sponsor means the University of Richmond.

8.37 **Spouse**

Spouse means a person who is legally married to an Employee.

8.38 **Student**

Student means an individual who during each of five calendar months during the Plan Year is a full-time student at an educational institution.

8.39 **Welfare Benefits Plan**

Welfare Benefits Plan means the University of Richmond Employee Welfare Benefits Plan, as amended for the applicable time.

ADOPTION OF PLAN

As evidence of the adoption of the University of Richmond Section 125 Cafeteria Plan as effective January 1, 2023, University of Richmond has caused this document to be signed by its duly authorized representative as of the date set forth below.

UNIVERSITY OF RICHMOND

By: 

Title: __Sr. AVP Human Resources

Date: 12/21/2022

APPENDIX A

University of Richmond Section 125 Cafeteria Plan
Benefit Options Available as of January 1, 2023

Medical Benefits **[See Welfare Benefits Plan Attachment #1]**	
Component Program:	**Cigna Traditional Plan**
Health Care Reform Status:	This Component Program is **not** a grandfathered group health plan for purposes of health care reform.
Insured by:	This Component Program is self-funded by the University.
Medical, Prescription Drug, and Mental Health and Substance Use Disorder Claims Administered by:	Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223
Vision Claims Administered by:	Cigna Vision Claims Department P.O. Box 385018 Birmingham, AL 35238-5018
COBRA Administered by:	Benefits Express P. O. Box 2798 Omaha, NE 68103 Telephone Number: (833) 695-8747
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be shared by the University and the employees.

Medical Benefits **[See Welfare Benefits Plan Attachment #2]**	
Component Program:	**Cigna High $1,750 Deductible Health Plan**
Health Care Reform Status:	This Component Program is **not** a grandfathered group health plan for purposes of health care reform.
Insured by:	This Component Program is self-funded by the University.
Medical and Prescription Drug Claims Administered by:	Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223
Vision Claims Administered by:	Cigna Vision Claims Department P.O. Box 385018 Birmingham, AL 35238-5018
COBRA Administered by:	Benefits Express P. O. Box 2798 Omaha, NE 68103 Telephone Number: (833) 695-8747
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be shared by the University and the employees.

Medical Benefits **[See Welfare Benefits Plan Attachment #3]**	
Component Program:	**Cigna High $4,000 Deductible Health Plan**
Health Care Reform Status:	This Component Program is **not** a grandfathered group health plan for purposes of health care reform.
Insured by:	This Component Program is self-funded by the University.
Medical and Prescription Drug Claims Administered by:	Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223
Vision Claims Administered by:	Cigna Vision Claims Department P.O. Box 385018 Birmingham, AL 35238-5018
COBRA Administered by:	Benefits Express P. O. Box 2798 Omaha, NE 68103 Telephone Number: (833) 695-8747
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be shared by the University and the employees.

Voluntary Dental Benefits **[See Welfare Benefits Plan Attachment #4]**	
Component Program:	**University of Richmond Voluntary Dental Insurance Program**
Health Care Reform Status:	Not applicable. Even though the Dental Plan voluntarily complies with certain HIPAA mandates, the Dental Plan is intended to be a HIPAA-excepted benefit, particularly for the purposes of health care reform.
Insured by:	Anthem Blue Cross and Blue Shield
Claims Administered by:	Anthem Dental P.O. Box 9274 Oxnard, CA 93031 Telephone Number: (800) 453-3622
COBRA Administered by:	Benefits Express P. O. Box 2798 Omaha, NE 68103 Telephone Number: (833) 695-8747
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Vision Benefits **[See Welfare Benefits Plan Attachment #14]**	
Component Program:	**University of Richmond Voluntary Vision Insurance Program**
Health Care Reform Status:	Not applicable.
Insured by:	UniCare Life & Health Insurance Company
Claims Administered by:	UniView Vision Attn: Out of Network Claims P.O. Box 8504 Mason, OH 45040-7111 Phone (888) 884-8428 Phone (888)-884-8428
COBRA Claims Administered by:	Benefits Express P. O. Box 2798 Omaha, NE 68103 Telephone Number: (833) 695-8747
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Health Care Spending Account	
Component Program:	**Health Care Spending Account**
Health Care Reform Status:	Not applicable.
Insured by:	This option is self-funded by the University.
Claims and COBRA Administered by:	Benefits Express P. O. Box 2798 Omaha, NE 68103 Telephone Number: (833) 695-8747
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Dependent Care Spending Account	
Component Program:	**Dependent Care Spending Account**
Health Care Reform Status:	Not applicable.
Insured by:	This option is self-funded by the University.
Claims Administered by:	Benefits Express P. O. Box 2798 Omaha, NE 68103 Telephone Number: (833) 695-8747
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

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