Genuine Financial Holdings LLC

Genuine Financial Holdings LLC
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Genuine Financial Holdings LLC FSA Plan

Plan Document

Amended and Restated January 01, 2022

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INTRODUCTION

The company amends and restates this Plan as of January 01, 2022 with an original effective date of January 01, 2011. Its purpose is to provide benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to elect between cash compensation or certain nontaxable benefit options as they desire. The Plan shall be known as the Genuine Financial Holdings LLC FSA Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

I. ARTICLE - PLAN DEFINITIONS

01. **"Administrator"** means the Employer, unless another person or entity has been designated by the Employer pursuant to the Article titled: "Administration" 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.

02. **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in the Article titled: "Benefit Information".

03. **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under the Article titled: "Benefit Information". Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

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

05. **"Compensation"** means the amounts received as compensation by the Participant from the Employer during a Plan Year.

06. **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

    "Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

    For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his or her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

    The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

07. **"Effective Date"** means January 01, 2011.

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

09. **"Eligible Employee"** means any Employee who has satisfied the provisions of the Section titled: "Eligibility".

    An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll

records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

10. **"Employee"** means any person who is currently or hereafter employed by the Employer.

    The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

11. **"Employer"** means Genuine Financial Holdings LLC and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, or Adopting Employer.

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

13. **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit, or any self-funded arrangement providing any Benefit offered for health and welfare coverage to Eligible Employees of the Employer.

14. **"Insurance Premium Payment Plan"** means the plan of benefits contained in the "Benefit Options" section of this Plan, which provides for the payment of Premium Expenses.

15. **"Insurer"** means any insurance company that underwrites a Benefit or any self-funded arrangement under this Plan.

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

17. **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to the Section titled: "Application to Participate" and has not for any reason become ineligible to participate further in the Plan.

18. **"Plan"** means the flexible benefits plan described in this instrument, including all amendments thereto.

19. **"Plan Year"** means the 12-month period beginning January 01 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

20. **"Premium Expenses"** or **"Premiums"** means the Participant's cost for the Benefits described in the Section titled: "Benefit Options".

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

22. **"Run-out Period"** means the set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the Plan Year.

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

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

25. **"Spouse"** means "spouse" as defined in an Insurance Contract, then, for purposes of coverage under that Insurance Contract only, "spouse" shall have the meaning stated in the Insurance Contract. In all other cases, "spouse" shall have the meaning stated under applicable federal or state law.

II. ARTICLE - PARTICIPATION

01. **ELIGIBILITY**

An individual is eligible to participate in this Plan if the individual:

a. is an Eligible Employee as defined in the Article titled: "Definitions"
b. is working an average of 30 hours or more per week or at least 130 hours per month; and
c. is eligible for the group medical plan

02. **EFFECTIVE DATE OF PARTICIPATION**

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan.

03. **APPLICATION TO PARTICIPATE**

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his or her Benefit elections pursuant to the Section titled: "Change in Status".

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance, unless the Employee elects, during the Election Period, not to participate in the Plan.

04. **TERMINATION OF PARTICIPATION**

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

a. **Termination of employment.** The termination of Participant's employment, subject to the provisions of the Section titled: "Termination of Employment"

b. **Death.** The Participant's death, subject to the provisions of the Section titled: "Death" or

c. **Termination of the plan.** The termination of this Plan, subject to the provisions of the Section titled: "Termination".

05. **TERMINATION OF EMPLOYMENT**

If a Participant's employment with the Employer is terminated for any reason other than death, his or her participation in the Benefit Options provided under the Section titled: "Benefit Options" shall be governed in accordance with the following:

a. **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

b. **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related Dependent Care Expense reimbursements for expenses within 0 days after the date of termination, limited by the balance in the Participant's Dependent Care Flexible Spending Account as of the date of termination.

c. **Health FSA, COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year for which contributions to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account, shall be applied and administered consistent with such further rights that a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B and the Section titled: "Continuation of Coverage" of the Plan.

06. **REINSTATEMENT OF A FORMER PARTICIPANT**

An Employee whose participation terminates and returns to an eligible status less than thirty days

later may re-enroll within thirty days of returning to an eligible status with a commencement date of the first of the month following the adjusted eligibility date. An Employee who re-enrolls in a Health Flexible Spending Account or Dependent Care Account after such time must re-enter the Plan and reinstate their original elections for that Plan Year with adjustments to the annual election amount as the Administrator deems necessary to prorate the annual election amount over the remainder of the Plan Year. Expenses incurred by the employee during the time that the employee was not a Participant will not be covered expenses unless COBRA was elected pursuant to the Article titled: "Continuation of Coverage (COBRA)".

Any Employee who terminates employment and is rehired into an eligible status after thirty days from the date of termination will be treated as a new enrollee under the Plan. If such Employee returns within the same Plan Year, prior contributions made to the Health Flexible Spending Account and/or the Dependent Care Account will be taken into consideration so as not to exceed Plan or IRS maximums.

07. **DEATH**

If a Participant dies, his or her participation in the Plan shall immediately cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to a particular specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

III. ARTICLE - CONTRIBUTIONS TO THE PLAN

01. **SALARY REDIRECTION**

Subject to the provisions of the section titled "Employer Contributions," benefits under the Plan shall be financed by Salary Redirections sufficient to support the benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his or her pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participant's elections made under the Section titled: "Initial Elections".

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to the Section titled: "Initial Elections") and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under the Article titled: "Participant Elections" and are consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

02. **APPLICATION OF CONTRIBUTIONS**

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

03. **PERIODIC CONTRIBUTIONS**

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

04. **EMPLOYER CONTRIBUTIONS**

The Employer may provide non-elective contributions in the form of Employer Funding into the Health Flexible Spending Account and Dependent Care Spending Account to the extent as described in the Section Titled: "Limitation on Allocations". Such contributions may be prorated for Participants who begin participating in the middle of the Plan Year. Contributions or matching contributions made to the Health Flexible Spending Account and Dependent Care Spending Account generally do not count toward the annual contribution limit as described in the Section Titled: "Limitation on Allocations".

IV. ARTICLE - BENEFITS

01. **BENEFIT OPTIONS**

Each Participant may elect any one or more of the following optional Benefits:

- Health Flexible Spending Account
- Dependent Care Flexible Spending Account

In addition, each Participant shall have a sufficient portion of his or her Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

- Group Medical Plan
- Group Dental Plan
- Group Vision Plan
- Accidental Death & Dismemberment

02. **HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case the Article titled: "Health Flexible Spending Account" shall apply.

03. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case the Article titled: "Dependent Care Flexible Spending Account" shall apply.

04. **HEALTH INSURANCE BENEFIT**

a. **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

b. **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

05. **DENTAL INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

06. **VISION INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

b. **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

07. **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT**

a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's accidental death and dismemberment Insurance Contract.

b. **Employer selects contracts.** The Employer may select suitable accidental death and dismemberment Insurance Contracts for use in providing this accidental death and dismemberment insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such accidental death and dismemberment Insurance Contract shall be determined therefrom, and such accidental death and dismemberment Insurance Contract shall be incorporated herein by reference.

08. **HEALTH SAVINGS ACCOUNT CONTRIBUTIONS**

a. Participants may elect to make contributions on a pre-tax basis to a Health Savings Account ("HSA"). The HSA is not an employer-sponsored benefit plan. It is an individual trust or custodial account that Participants open and which may be used to reimburse Participants for eligible medical expenses as set forth in Code Section 223.

09. **NONDISCRIMINATION REQUIREMENTS**

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

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 is prohibited by Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his or her non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his or her non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

10. **NON-TAX DEPENDENT COVERAGE**

a. If (i) Employee Salary Redirections are made to fund Benefits under the Plan, and (ii) the Employer allows a Participant to elect to cover a Non-Tax Dependent through the Participant's coverage under group Medical, Dental or Vision benefit(s), a Participant who elects to participate in the Salary Redirection program may pay on a pre-tax basis through salary reduction contributions the Participant's portion of the premium cost of coverage under the Employer's Medical, Dental or Vision Benefits, provided that the full fair market value of such Medical, Dental or Vision coverage for any such Non-Tax Dependent shall be includible in the Participant's gross income as a taxable benefit in accordance with applicable federal income tax rules. For purposes of this Plan, the Participant electing coverage for Non-Tax Dependent(s) shall be treated as receiving, at the time that coverage is received, cash compensation equal to the full fair market value of such coverage and then as having purchased the coverage with after-tax employee contributions.

b. Notwithstanding the foregoing, no medical care or dependent care expenses incurred by or with respect to a Non-Tax Dependent of a Participant shall be eligible for reimbursement as eligible expenses under the Health Flexible Spending Account or Dependent Care Flexible Spending Account.

V. ARTICLE - PARTICIPANT ELECTIONS

01. **INITIAL ELECTIONS**

An Employee who meets the eligibility requirements of the Section titled: "Eligibility" on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his or her effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

02. **SUBSEQUENT ANNUAL ELECTIONS**

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form or electronically, as provided by the Administrator, which spending account Benefit options he wishes to participate in. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which immediately follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

a. A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

b. A Participant may terminate his or her participation in the Plan by notifying the Administrator in writing or by electronic notification, as determined by the Employer, during the Election Period that he does not want to participate in the Plan for the next Plan Year;

c. An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in the Section titled: "Change of Status".

03. **FAILURE TO ELECT**

With regard to Benefits available under the Plan for which no Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits, subject to the provisions of the Section titled: "Change in Status" below.

With regard to Benefits available under the Plan for which Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

04. **CHANGE IN STATUS**

a. **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict with any of the provisions of this Plan, then such rules and regulations shall control. See below in this Section for other situations in which changes in Benefit elections are permitted.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains eligibility for coverage under any other plan, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan is consistent with that change in status only if coverage for that individual becomes applicable or is increased under said other plan. Also, if the Participant, Spouse or Dependent loses eligibility for coverage under any other plan, then a Participant's election under the Plan to start or increase coverage for that individual under the Plan is consistent with that change in

status only if coverage for that individual ceases or is decreased under said other plan.

Regardless of the consistency requirement, if the individual, or the individual's 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, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

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

1. Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

2. Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

3. Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

4. Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

5. Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or 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.

b. **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health 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 (CHIP), provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

c. **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) (collectively, an "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 a Participant's child (including a foster child who is a Dependent of the Participant):

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

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

d. **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of 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). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or

Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

e. **Cost increase or decrease.** Notwithstanding subsection (a), if the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

   A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

f. **Loss of coverage.** Notwithstanding subsection (a), if the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

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

h. **Loss of coverage under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

i. **Change of coverage due to change under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse, former Spouse's employer or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse, former Spouse's employer or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse, former Spouse's employer or Dependent's employer.

j. **Change in dependent care provider.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in a dependent care provider. The availability of dependent care services from a new dependent care provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

k. **Health Savings Account changes** Notwithstanding subsection (a), with regard to the Health Savings Account Benefit specified in the Article titled: "Benefits", a Participant who has elected to make elective contributions under such arrangement may modify or revoke the election prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder.

l. **Health Flexible Spending Account cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

VI. ARTICLE - HEALTH FLEXIBLE SPENDING ACCOUNT

01. **ESTABLISHMENT OF BENEFIT**

This Health Flexible 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. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of allowable Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Participant's Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

02. **DEFINITIONS**

For the purposes of this Article and the Plan, the terms below have the following meanings:

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

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

1. one of the 5 highest paid officers;

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

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

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

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his or her Spouse or Dependent.

d. A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

e. The definitions of the Article titled: "Plan Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

03. **FORFEITURES**

The amount in the Health Flexible Spending Account as of the end of the allowable 2.5 month Grace Period, as defined in the Article titled: "Definitions", of the normal Plan Year (including any applicable run-out period and the processing of all claims for such Plan Year pursuant to the Section titled: "Health Flexible Spending Account Claims" hereof) 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.

04. **LIMITATION ON ALLOCATIONS**

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary redirections that may be allocated to the Health Flexible Spending Account by a Participant in any Plan Year is $2,850.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code.

05. **NONDISCRIMINATION REQUIREMENTS**

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

b. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible 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 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 Health Flexible 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 Section and/or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the 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 Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this 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.

06. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Plan are eligible to receive Benefits under this Health Flexible Spending Account. Enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

07. **HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS**

a. **Expenses must be incurred during Plan Year.** All eligible Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed, subject to the Section titled: "Termination of Employment", even though the submission of such a claim occurs after his or her participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant 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. **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 Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have 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 or her Spouse or Dependents.

c. **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. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time after incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

d. **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 within the 2.5 month Grace Period, as defined in the Article titled: "Definitions" or within 90 days after the end of the Plan Year, that Medical Expense claim shall not be considered for reimbursement by the Administrator. Moreover, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 0 days after the end of the Plan Year.

08. **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:

a. **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.

b. **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued or remain in effect for each Plan Year the Participant remains a Participant in the Health Flexible 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 Flexible Spending Account.

c. **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 the Section titled: "Limitation on Allocations".

d. **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

e. **Card use.** The cards shall only be used for Medical Expense purchases as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, including, but not limited to, the following:

   1. Co-payments for doctor and other medical care;

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

   3. Purchase of medical items such as eyeglasses, syringes, crutches, etc.

f. **Substantiation.** Such purchases by the cards shall be subject to confirmation by the Administrator, usually by requiring the Participant to submit a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation by the Administrator.

g. **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

   1. Repayment of the improper amount by the Participant;

   2. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law;

   3. Claims substitution or offset of future claims until the amount is repaid; and

   4. If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

VII. ARTICLE - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

01. **ESTABLISHMENT OF ACCOUNT**

This Dependent Care Flexible 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. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

02. **DEFINITIONS**

For the purposes of this Article and the Plan, the terms below shall have the following meaning:

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

b. **"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.

c. **"Employment-Related Dependent Care Expenses"** means the amounts paid for those expenses of a Participant that, if paid by the Participant, would be considered employment related expenses under Code Section 21(b)(2). Generally, they 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 during 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:

1. If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment Related Dependent Care Expenses only if incurred for a Qualifying Dependent (as defined in the "Definitions" Section of the Article titled: "Dependent Care Flexible Spending Account") who regularly spends at least eight (8) hours per day in the Participant's household;

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

3. Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid to or incurred by a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

d. **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

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

2. a Dependent or 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

3. a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

e. The definitions of the Article titled: "Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

03. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

04. **INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the amount of Cafeteria Plan Benefit Dollars that he has elected to apply toward his or her Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

05. **DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of the Participant pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof.

06. **ALLOWABLE DEPENDENT CARE REIMBURSEMENT**

Subject to limitations contained in the Section titled: "Limitation on Payments" below, and to the extent of the amount contained in the Participant's Dependent Care Flexible 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.

07. **ANNUAL STATEMENT OF BENEFITS**

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under the Section titled: "Definitions" 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.

08. **FORFEITURES**

The amount in the Participant's Dependent Care Flexible Spending Account as of the end of the allowable 2.5 month Grace Period, as defined in the Article titled: "Definitions", of the normal Plan Year (and after the applicable run-out period and processing of all claims for such Plan Year pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof) 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.

09. **LIMITATION ON PAYMENTS**

a. **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any tax year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000.00 (or cannot exceed $5,000 as provided under Code Section 129 or $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)).

10. **NONDISCRIMINATION REQUIREMENTS**

a. **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination is prohibited under Code Section 129(d).

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

c. **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 is prohibited by 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 Flexible 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 Flexible 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.

11. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

12. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS**

The Administrator shall direct the payment of all qualified 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 as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

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

b. The nature of the services performed for the Dependent, the cost of which the Participant wishes reimbursement;

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

d. If the services are being performed by a child of the Participant, the age of the child;

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

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

g. If the services were being performed in a day care center, a statement:

    1. that the day care center complies with all applicable laws and regulations of the state of residence,

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

    3. of the amount of fee paid to the provider.

h. If the Participant is married, a statement containing the following:

    1. the Spouse's salary or wages, if he or she is employed, or

    2. if the Participant's Spouse is not employed, that

        i. he or she is incapacitated, or

        ii. he or she is a full-time student attending an educational institution, and the months of the year during which he or she attends such institution.

i. **Claims for reimbursement.** If a Participant fails to submit a claim within 2.5 month Grace Period, as defined in the Article titled: "Definitions", or within 90 days after the end of the Plan Year, that Dependent Daycare claim shall not be considered for reimbursement by the Administrator.

VIII. ARTICLE - ERISA PROVISIONS

01. **CLAIM FOR BENEFITS**

a. **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

b. **Health FSA claims.** If a Participant fails to submit a claim under the Health Flexible Spending Account within 90 days after the end of the Plan Year, 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 0 days after the end of the Plan Year. Once a claim is submitted, the following timetable for claims and the 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 with the denial 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 decision 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.

c. **Forfeitures.** Any balance remaining in the Participant's Dependent Care Flexible Spending Account or Health Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to the Section titled: "Forfeitures", whichever is applicable. Provided, any provision of the Plan to the contrary notwithstanding, where a Participant has properly appealed the denial of a claim and the appeal has not been finally resolved or the appeal has been finally resolved in favor of the Participant, no forfeiture shall take place as to any such balance in dispute. 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. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited and returned to the Employer following a reasonable time after the date any such payment first became due.

02. **APPLICATION OF BENEFIT PLAN SURPLUS**

Any forfeited amounts credited to the benefit plan surplus 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 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.

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.

04. **GENERAL FIDUCIARY RESPONSIBILITIES**

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

a. for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

b. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

c. in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

05. **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 alienated or subjected shall not be recognized, except to such extent as may be required by law.

IX. ARTICLE - ADMINISTRATION

01. **PLAN ADMINISTRATION**

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person or persons, including, but not limited to, one or more 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. An Administrator may resign by delivering a written resignation to the Employer or may be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery if no date is specified. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor. 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 ERISA, 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 should be paid. 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.

02. **EXAMINATION OF RECORDS**

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

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.

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 or other benefit program that is self-insured 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.

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.

X. ARTICLE - AMENDMENT OR TERMINATION OF PLAN

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 and local laws, statutes and regulations.

02. **TERMINATION**

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such accounts 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.

XI. ARTICLE - MISCELLANEOUS

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 the Section titled: "Severability".

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.

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.

04. **EXCLUSIVE BENEFIT**

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

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.

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 the Employer.

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.

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.

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 and Medicare tax that would have been paid on such compensation, less any such additional income tax, Social Security tax, and Medicare tax actually paid by the Participant.

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.

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 does 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 Tennessee.

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.

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.

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. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

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.

16. **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.

17. **UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

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

18. **COMPLIANCE WITH HIPAA PRIVACY STANDARDS**

a. **Application.** If any benefits under this Cafeteria 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 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 authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

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

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

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

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

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

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

e. **Certification.** The Employer must and hereby does provide certification to the Plan that it agrees to adopt all required provisions as mandated under HIPAA for all non-exempt group health plans, including the following:

    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.

19. **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 the Section titled: "Compliance with HIPAA Privacy Standards".

20. **MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT**

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

21. **GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

22. **WOMEN'S HEALTH AND CANCER RIGHTS ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

23. **NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

Execution Agreement

IN WITNESS WHEREOF, Genuine Financial Holdings LLC has caused its authorized officer to execute this amended and restated Plan document as of _____, the same to be effective **January 01, 2022**, unless otherwise indicated herein.

Genuine Financial Holdings LLC

By: _____

Name: _____

Title: _____

CERTIFICATE OF RESOLUTION

The undersigned authorized representative of **Genuine Financial Holdings LLC** (the Employer) hereby certifies that the following resolutions were duly adopted by the governing body of the Employer on _____, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of amended and restated Welfare Benefit Plan, effective January 01, 2022, presented to this meeting (and a copy of which is attached hereto) is hereby approved and adopted, and that the proper agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of said Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the Plan.

RESOLVED, that the proper agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Plan and to deliver to each employee a copy of the Summary Plan Description of the Plan, which Summary Plan Description is attached hereto and is hereby approved.

The undersigned further certifies that attached hereto as Exhibits, are true copies of Genuine Financial Holdings LLC's Benefit Plan Document and Summary Plan Description approved and adopted at this meeting.

Genuine Financial Holdings LLC

By: _____

Name: _____

Title: _____

Appendix A

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a Claim under the Plan is denied in whole or in part, you will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure.

A level one appeal must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of your appeal (for example, your original claim, denial, claim documentation, and other correspondence or records). You may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. If you disagree with the level one appeal decision you may submit a request for a level two appeal to be determined by the Employer. You must submit a request for a level two appeal within 60 days of receipt of the level one denial notice. You will be notified within 30 days after the Employer receives the level two appeal (extended by reasonable time if necessary). The Employer has the exclusive right to interpret the appropriate plan provisions. Decisions of the Employer are conclusive and binding.

In the case of a claim under the Plan, the following timetable for claims applies:

Notification of whether claim is accepted or denied: 30 days

Extension due to matters beyond the control of the Plan: 15 days

Denial or insufficient information on the claim:

Notification of: 15 days

Response by Participant: 45 days

Review of claim denial: 30 days

You must file your level one appeal by submitting a written request by email, fax, or mail. Indicate level one appeal on the email, fax, or letter. You must submit a level one appeal before you can submit a level two appeal. For the **level one appeal** submit to:

Email: claims@naviabenefits.com

Fax: 425-451-7002 or 866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

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

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

(b) Reference to the specific Plan provisions on which the denial was based;

(c) 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;

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

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(f) 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.

If your level one appeal is denied, you will have 60 days following receipt of the denial notification in which to appeal the decision in a level two appeal to your employer. You may submit written comments, documents, records, and other information relating to the claim (for example, your level one appeal, the original claim, denial, claim documentation, and other correspondence or records). If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

You must file your level two appeal by submitting a written request by email, fax, or mail. Indicate level two appeal on the email, fax, or letter. For the **level two appeal** submit to:

Email: claims@naviabenefits.com

Fax: 425-451-7002 or 866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

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:

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

(b) 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;

(c) 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

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

The level two appeal 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. If applicable to your plan, you may have a right to bring a civil action under ERISA § 502(a) if you file a level two appeal and your request for benefits is denied.