DAYTONA STATE COLLEGE’S
FLEXIBLE BENEFITS PLAN

Restated Effective January 1, 2014

Plan Sponsored By: Daytona State College
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INTRODUCTION

This is the Plan Document. It also represents what is referred to as a Summary Plan Description. The purpose of the Plan is to allow you to choose among different types of Benefits, and pay your share of the cost of those Benefits on a tax-favored basis. You may choose Benefits based on your own particular goals, desires and needs. These plans are often called “cafeteria plans” because they offer a “menu” of benefit choices. This Plan, as reflected on the following pages, is restated January 1, 2014 through December 31, 2014.

Once you are eligible to participate in this Plan, you must complete the Benefit Solver online enrollment.

You must agree to reduce your Compensation in an amount equal to the Benefits you want to receive under the Plan. The Employer then converts each dollar (by which you agree to have your Compensation reduced) into a Flexible Benefits Plan Dollar, and contributes it to the appropriate account under the Plan, where it is used to provide your Benefits under the Plan.

Example: Here’s an example that shows how you enroll under the Plan, and explains why participating in this Plan is a good idea. Assume you and your family are covered under your Employer’s health care plan, and that you pay $200 per month for this coverage. Also assume that your monthly pay is $2,000, and that 25% ($500) goes to pay state and federal income taxes and Social Security taxes. You have $1,300 left after paying your health care premiums and taxes.

But now let’s assume you complete the enrollment indicating that you want to pay your health care premiums under this Plan. You also agree to a salary reduction that instructs your Employer to reduce your Compensation in an amount equal to the Premiums you owe. In this way, you don’t pay tax on the amount by which your pay is reduced in order to pay your Premium. Your $2,000 pay is reduced by $200 to pay your health care Premiums, leaving you $1,800. You pay 25% tax on $1,800 instead of $2,000, so your tax bill is $450 instead of $500, leaving you with $1,350 and saving you $50 in taxes. However, see Article IX, wherein the Employer does not guarantee any particular tax result.

Here’s an important point. If you agree to participate in this Plan, once you complete your enrollment and agree to the salary reduction you cannot make a change for the remainder of the Coverage Period, unless you meet certain requirements (these requirements are described in Article IV).
ARTICLE I
BENEFITS AVAILABLE TO YOU

Benefit Options. You might recall from the Introduction that when your Employer reduces your Compensation the Employer takes each dollar it withholds from your Compensation and converts it to a Flexible Benefits Plan Dollar. These Flexible Benefits Plan Dollars are then credited to various accounts under this Plan, and used to provide the Benefits you chose during your enrollment.

You may choose, during your enrollment, to receive any or all of the following Benefits:

- **Pre-Tax Health and Welfare Plan Premium Payment.** You may choose to have Flexible Benefits Plan Dollars used to pay Premiums for coverage (on behalf of yourself, your Spouse and/or other Dependents, depending on whether they’re eligible for the coverage) under the Employer’s health and welfare benefit plan(s) listed below:
  - Medical Plan
  - Dental Plan
  - Vision Plan

The rules concerning eligibility under, and the benefits available from, the plans listed above, are contained in the documents and contracts that comprise the plans.

- **Health Care Reimbursement Program.** You may elect coverage under the Health Care Reimbursement Program option. Appendix A describes the rules that apply to that Program.

- **Dependent Care Reimbursement Program.** You may elect coverage under the Dependent Care Reimbursement Program option. Appendix B describes the rules that apply to that Program.

Non-discrimination Requirements. The following paragraphs describe technical requirements of the Code that apply to plans like this Flexible Benefits Plan.

This Plan is intended to provide Benefits that do not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate, or Highly Compensated Participants, with respect to contributions and Benefits. In addition, it is the intent of this Plan not to provide “qualified benefits” (as defined under Code Section 125(e)) to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan.

If the Administrator or its designee deems it necessary to avoid discrimination or possible taxation to Key Employees or Highly Compensated Individuals or Highly Compensated Participants, it may, but is not required to, reject any election or reduce contributions or non-taxable Benefits in order to assure that the rules in these paragraphs are not violated. Any act taken by the Administrator or its designee under these paragraphs will be carried out in a uniform and non-discriminatory manner.

If the Administrator or its designee decides to reject any election or reduce contributions or non-taxable Benefits, it will be done in the following manner: the non-taxable Benefits of the affected Participant (either a Highly Compensated Individual or Participant, or a Key Employee, whichever is applicable) who has elected the highest amount of non-taxable Benefits for the Coverage Period will have his or her non-taxable Benefits reduced until:

- the discrimination tests set forth in these paragraphs are satisfied, or
the amount of his or her non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has elected the second highest amount of non-taxable Benefits.

This process will continue until the non-discrimination tests described in these paragraphs are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to these paragraphs, the reduction will first be made proportionately among non-insured Benefits, and once all non-insured Benefits are expended, proportionately among insured Benefits.
ARTICLE II
PARTICIPATION

Becoming Eligible to Participate, and Beginning Your Participation. Generally you will be eligible to participate in this Plan at 12:01 a.m. on the first day of the month following one month of employment. For example, if you are hired on April 16th, coverage begins on June 1st.

Although you might be eligible to participate in the Plan, you must actually complete the online enrollment and agree to the salary reduction in order to actually begin your participation, and obtain the benefits of the Plan. As noted earlier, as a general rule the enrollment you complete cannot be changed until the end of the Coverage Period for which you completed the enrollment, unless you are permitted to make changes under the special rules described in Article III.

Terminating Your Participation. Your participation in the Plan will end when one of the events listed below occurs (although in some cases described elsewhere in this Plan you and/or your Dependents might be eligible to continue your participation, at least for a while). The events are:

• termination of your employment;
• the date you cease to be an eligible Employee;
• your death;
• the termination of this Plan itself; or
• the date you validly revoke your enrollment.

Special Rules Concerning Termination of Employment. If your employment terminates (for any reason other than your death), you may continue to file claims for reimbursement, but only for expenses Incurred through the end of the month in which your employment terminated. Whether or not your (and your Dependents’) coverage under the Employer’s benefit plans terminates at the same time depends on the terms of those plans.

COBRA Coverage. If you or one of your covered Dependents lose coverage under one or more of the Employer’s health care plans (including dental and vision plans) under circumstances where you or the Dependent are entitled to continue coverage under the federal law known as COBRA, and you or the Dependent would also lose coverage under the Health Care Reimbursement Program due to those same circumstances, you or the Dependent also have a right under COBRA to continue coverage for a short while under the Health Care Reimbursement Program. In this way, you or the Dependent may be able to obtain reimbursement for claims Incurred after coverage would otherwise have ended but for the continued coverage under COBRA. See the Health Care Reimbursement Program (Appendix A) for more information.

1 This right to continue coverage applies, for example, where your coverage ends due to termination of your employment (for reasons other than gross misconduct) or reduction in work hours, or your death. Your Dependents have the right to continue coverage where their coverage ends due to termination of your employment (for reasons other than gross misconduct) or reduction in work hours; your death; your divorce; your entitlement to Medicare; or a Dependent Child’s ceasing to meet the definition of “Dependent” under the plan. These events are known as “qualifying events” because they “qualify” you or the dependent for COBRA coverage.
Participants in the Dependent Care Reimbursement Program are not eligible to continue such coverage under COBRA.

**Family and Medical Leave Act.** For any leave, and solely to the extent the provisions of the Family and Medical Leave Act of 1993 (“FMLA”) apply and such leave qualifies as a FMLA leave, the Participant may remain a Participant if you have worked for the Employer for at least one year, and for 1,250 hours during the previous 12 months and shall be entitled to receive the same Benefits as before the start of the FMLA leave, subject to the continued payment of any required contributions under the Plan. Solely to the extent required under FMLA, a Participant whose Benefits have been suspended or terminated while on a FMLA leave (whether due to revocation, non-payment of premiums or otherwise) may have such Benefits reinstated on return from the FMLA leave on the same terms as prior to taking the FMLA leave, subject to any changes in Benefit levels that may have taken place during the period of FMLA leave.

**Special Rules Concerning Reemploysments.** If you participate in the Plan during a Coverage Period, then terminate employment but are rehired during that same Coverage Period, you may be able to complete a new enrollment and agree to a new salary reduction for the remaining portion of the Coverage Period. You may do so if the termination of employment and the reemployment are *bona fide*. The termination and reemployment are deemed to be *bona fide* if there is at least a 30-day break in employment between the date of your termination and the date of your reemployment. If the break is for fewer than 30 days, you are considered to have resumed, upon your reemployment, the elections you had in effect at the time of your termination. See also the special rules described in Article III, in the section titled, *Mid-Year Changes to Elections*.

**Special Rules Concerning Death.** If you die your participation in the Plan will cease. Your beneficiaries or the representative of your estate, however, may submit claims for expenses that you Incurred through the end of the month in which you die. You may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Administrator or its designee may designate your Spouse, one of your other Dependents, or a representative of your estate. Claims Incurred by your Spouse or other of your covered Dependents prior to the end of the month in which you die may also be submitted for reimbursement.

Under the COBRA rules discussed above, your Spouse and Dependents may be able to continue to participate under the Health Care Reimbursement Program through the end of the Coverage Period in which you die. Your Spouse and Dependents may be required to make contributions in order to continue their participation.
ARTICLE III
BENEFIT ELECTIONS

Initial Benefit Elections. Once you meet the eligibility requirements described in Article II you can choose to participate in this Plan for the remainder of the Coverage Period, but to do so you must complete the Benefit Solver on-line enrollment within 30 days after you first become hired.

Your initial enrollment will apply to expenses that are reimbursable or payable by this Plan and that are Incurred after the Administrator or its designee receives your completed enrollment. As a general rule, that enrollment will continue in effect for the remainder of the Coverage Period.

For example, assume that you first become eligible to participate in this Plan on March 1 of a given Coverage Period. Your initial enrollment must be completed within this Period, in order for you to receive any Benefits under this Plan for the remainder of that Coverage Period. If you fail to complete your online enrollment on time you must wait until the annual Election Period (described below) to enroll. However, you might be permitted to enroll earlier than the next annual Election Period if you meet the requirements for changing Benefit Elections described below, in the section titled, Mid-Year Changes to Elections.

Subsequent Annual Elections. During the annual Election Period (defined in Article VIII), you may choose, by completing a new online enrollment, which Benefits you wish to purchase for the next Coverage Period. Any election you make must be completed before the end of the annual Election Period and will apply for the following Coverage Period. For example, assume that the annual Election Period is the month of December. If you complete a new online enrollment during the month of December of a given year (“Year 1”), for the ensuing Coverage Period (beginning, say, January 1 of the following year (“Year 2”), the election will apply to the Coverage Period beginning that January 1).

Choosing to Participate After Initially Declining to Participate. In addition, if you fail to complete your initial enrollment on time (or simply chose not to complete it) you can choose during an ensuing annual Election Period to participate in the Plan, and complete a new enrollment, effective for the ensuing Coverage Period. Of course, in order to be able to do this you must still be eligible to participate in the Plan.

Terminating Participation in the Plan. If you want to terminate your participation in the Plan, you can do that by notifying the Administrator or its designee, in writing (on a form the Employer will supply) during the annual Election Period that you do not want to participate in the Plan for the next Coverage Period. Note this important point: if you’re participating in the Plan, and during the annual Election Period you either fail to affirmatively terminate your participation for the next Coverage Period, or fail to make a new election for the next Coverage Period, then your prior election might automatically continue for the next Coverage Period. See the rules below titled, Failure to Make a New Election.

If during the annual Election Period you choose not to participate for the next Coverage Period you will have to wait until the next annual Election Period before you will again have an opportunity to participate in the Plan. However, you might be permitted to complete a new enrollment earlier than the next annual Election Period if you meet the requirements for changing Benefit Elections described below, in the section titled, Mid-Year Changes to Elections.

Failure to Make a New Election. If you’re participating in the Plan, but fail to complete a new enrollment during the annual Election Period, what happens then depends on the Benefits you were receiving under the Plan.
With regard to coverage for which you must pay Premiums (such as coverage under a health care plan or disability insurance policy, etc.), if you fail to complete a new enrollment you will be deemed to have made, for the ensuing Coverage Period, the same Benefit Elections that are then in effect for the current Coverage Period. You will also be deemed to have elected to have your Compensation reduced for the next Coverage Period in an amount necessary to purchase those Benefits.

With regard to Benefits for which you pay no Premiums, but do make contributions (such as the Medical or Dependent Care Reimbursement Programs), you will be deemed to have elected not to receive any of those Benefits for the upcoming Coverage Period. No further reductions from your Compensation will be made for the next Coverage Period in order to provide such Benefits to you. As a result, with respect to the Medical and Dependent Care Reimbursement Programs, filing no enrollment is the same as choosing not to participate for the next Coverage Period.

Example: Assume that the Plan’s annual Election Period is the month of December. Assume also that in December of a given year (“Year 1”) you choose to have your Compensation in the following year (“Year 2”) reduced in an amount sufficient to pay for coverage under the Employer’s group health care plan. You also choose to have your Compensation reduced by $100 per month and to have that amount contributed to the Health Care Reimbursement Program or Dependent Care Reimbursement Program (the $100 per month allows you to receive up to $1,200 in Benefits from the Program for the Coverage Period).

If during the annual Election Period in December of Year 2 you make no election for the following year (“Year 3”), then for Year 3 you will be deemed to have elected to:

- contribute nothing to the Health Care Reimbursement Program (or Dependent Care Reimbursement Program, as the case may be) for Year 3 (meaning you’ll be entitled to no Benefits under that Program for that Coverage Period), but
- continue to have your Compensation reduced in Year 3 in an amount sufficient to pay your Premiums due under the Employer’s group health care plan.

Mid-Year Changes to Elections. As a general rule the Code does not allow you to change an enrollment after the start of a Coverage Period and complete a new enrollment for the remainder of the Coverage Period. However, there are exceptions to this rule. The exceptions are described below, and the exception that applies to you depends on the Benefits that will be affected by your change. If an exception applies to you, the change in your enrollment and salary reduction must be completed (received by the Plan Administrator within 30 days after the date of the event that gives rise to your right to make the change).

These rules are complex; if you have questions about them; see your Employee Benefits Department. In this section, the term “mid-year” means “mid-Coverage Period.”

Events Entitling You to Change Elections Concerning Payment of Health Insurance Premiums. For purposes of this section, the term “health insurance” includes medical, dental, vision and accidental death and dismemberment insurance, whether insured or self-insured by the Employer.

- HIPAA Special Enrollment. You may cancel your enrollment and salary reduction (and complete a new enrollment for the remainder of the Coverage Period) with respect to coverage under a group health care plan where the cancellation of the old, and the completing of the new,
enrollment correspond with a “special enrollment” right under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). If the “special enrollment event” is the birth, adoption or placement for adoption of a Dependent child, and the health plan allows you to enroll the child retroactively (to the date of birth, adoption or placement for adoption), your election change may also be given retroactive effect.

- **Court Decree.** You may cancel your enrollment and salary reduction (and complete a new enrollment for the remainder of the Coverage Period) where a judgment, decree or order resulting from a divorce, annulment or change in legal custody requires either you or your Spouse, former Spouse or other individual to provide health insurance coverage for your Dependent child. You may add coverage for the child if the court order requires you or the Employer’s health care plan(s) to provide coverage for the child. You may drop coverage for the child if the court order requires your Spouse, former Spouse or other individual (or their employer’s health care plan(s)) to provide coverage for the child, and your Spouse, former Spouse or other individual actually acquires coverage for the child. The Plan may make a unilateral change in your enrollment under these circumstances, to provide for coverage of your Dependent child under the Employer’s health care plan(s), where the order is a qualified medical child support order and the order requires the plan(s) to provide coverage.

- **Entitlement to Medicare or Medicaid.** You may cancel your enrollment and salary reduction (and complete a new enrollment for the remainder of the Coverage Period) where you, your Spouse, or other Dependent becomes entitled to, or ceases to be entitled to, benefits under either Medicare or Medicaid. Where the individual becomes entitled to Medicare or Medicaid benefits you may modify your enrollment to drop coverage of the individual under your Employer’s health care plan(s). Similarly, where the individual ceases to be entitled to Medicare or Medicaid benefits you may modify your enrollment to add coverage of the individual under your Employer’s health care plan(s).

- **Changes in Status.** You may cancel your enrollment and salary reduction (and complete a new enrollment for the remainder of the Coverage Period) where you experience a “change in status” and the change to your enrollment is “consistent with” that change in status. A “change in status” is:
  
  > a change in your legal marital status, including your marriage, the death of your Spouse, the annulment of your marriage, or your divorce;
  
  > a change in the number of your Dependents, including the birth, adoption, placement for adoption, or death of a Dependent;
  
  > a change in the employment status of you, your Spouse or other Dependent; a “change in employment status” includes:
  
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  • termination or commencement of employment (if commencement of employment follows a termination of employment with the same employer, no new election is permitted unless the commencement follows at least 30 days after the termination);
  • strike or lockout;
  • commencement of, or the return from, an unpaid leave of absence;
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• change in work site;
• satisfying, or ceasing to satisfy, eligibility conditions due to a change in employment status (a switch between part-time and full-time employment, salaried and hourly positions, etc.);

• change from full-time to part-time or vice-versa;

- an event that causes your Dependent to satisfy or cease to satisfy the eligibility requirements for coverage whether due to the attainment of a specified age, student status, or any similar circumstance described in such plan(s); or

- a change in the place of residence or work of you, your Spouse, or your other Dependent.

Your change in your enrollment is “consistent with” a change in status if and only if the change in status affects eligibility for coverage under an employer’s plan, and the election change is on account of and corresponds with the change in status.

A change in status that affects eligibility for coverage includes a change in status that causes an increase or decrease in the number of your family members who may benefit from coverage under the plan. For example, let’s say you wish to change your election to drop coverage under this Plan for you or your Spouse because, due to a marital status change or a change in your Spouse’s employment status, you or your Spouse now qualify for coverage under a plan provided by your Spouse’s employer. You can make the election change so long as the person you wish to disenroll under this Plan acquires the newly available coverage under your Spouse’s plan. We will allow the election change upon your certification that coverage has been or will be obtained under the other plan.

Notwithstanding this consistency rule, if you, your Spouse or other Dependent become eligible (under a health care plan maintained by the Employer) for COBRA Continuation Coverage or continuation coverage under any similar state health coverage continuation law, you may modify your enrollment and salary reduction in order to pay for that continuation coverage.

• Family and Medical Leave and Military Leave. You may cancel your enrollment and salary reduction (and complete a new enrollment for the remainder of the Coverage Period) if you take a leave of absence pursuant to the Family and Medical Leave Act (“FMLA”) or the Uniformed Services Employment and Reemployment Rights Act (USERRA). In addition:

- if you continue your participation during the period of FMLA or USERRA leave, you will be entitled to change your enrollment, in accordance with the rules described above, to the same extent as any other Participant who is not on FMLA or USERRA leave;

- if you continue your participation during the period of FMLA or USERRA leave the Employer may permit you, under procedures applied in a non-discriminatory manner, to pay your share of the cost of coverage under one or more of the following methods (note, however, that where the period of FMLA or USERRA leave is substituted paid leave, your method of paying your required contributions must be the same method normally used by Participants during paid leave):
• **Pre-pay option.** You may, prior to beginning your FMLA or USERRA leave, pre-pay on a pre-tax basis (from taxable Compensation payable to you, including the cashing out of unused sick days or vacation days) the contributions required on your behalf for the period of FMLA or USERRA leave. But if the period of FMLA or USERRA leave begins in one Coverage Period and ends in another Coverage Period, you may not pre-pay, on a pre-tax basis, for coverage during the period of FMLA or USERRA leave that extends into the next Coverage Period. The cost of coverage for periods of FMLA or USERRA leave in the next Coverage Period must be paid under the method described below.

• **Pay-as-you-go option.** You may pay (on a pre-tax basis, from taxable Compensation otherwise payable to you, or on an after-tax basis) the contributions required on your behalf for the period of FMLA or USERRA leave on the same schedule under which payments would be made if you were not on FMLA leave. For example, if while not on FMLA or USERRA leave your contributions to the Plan were made semi-monthly, you may make your contributions semi-monthly while on FMLA or USERRA leave. Alternatively, you may pay the required contributions on the same payment schedule that applies to payment for COBRA Continuation Coverage under the Employer’s group health care plan or dental plan (i.e., typically monthly, with a 30-day grace period for each monthly payment).

• **Catch-up option.** To the extent you and the Employer agree in advance, the Employer may continue your coverage(s) during a period of unpaid FMLA or USERRA leave, and that you will not pay your share of the premiums until you return from leave. You and the Employer must agree in advance of the period of continued coverage that (i) you elect to continue your coverage while on unpaid leave; (ii) the Employer assumes responsibility for advancing premium payments on your behalf during the FMLA or USERRA leave; and (iii) these advance amounts are repaid by you after your return from FMLA or USERRA leave. However, the Employer has the option of using this “catch up” feature unilaterally, where you intend but fail to make premium payments while on leave (that is, you utilize the pay-as-you-go option but fail to make premium payments). In that case, the Employer may unilaterally pay your share of the premium while you’re on FMLA or USERRA leave, and then recoup its advance from you after your return. No advance agreement is required in this latter case.

Upon your return from FMLA or USERRA leave, your “catch-up” contributions may be made on a pre-tax basis from any taxable compensation to which you’re entitled (including unused sick leave and vacation days). Premiums may also be paid from salary reductions on a pre-tax basis if the premiums were not paid under any other method while you were on leave. You may also make “catch-up” contributions on an after-tax basis.

➢ If your coverage under the Plan terminated while you were on FMLA or USERRA leave (either because you cancelled your enrollment and salary reduction, or because you failed to pay the required Premiums or other contributions), you may recommence participation after you return from FMLA or USERRA leave. You do that by completing a new enrollment within 30 days of your return.
• **Distribution under Heroes Earnings Assistance & Tax Relief Act ("HEART Act").** A Participant who is ordered or called to active duty for a period of 180 days or more, or for an indefinite period may request a distribution to himself of the amount contributed to the Plan as of the date of the request minus any reimbursements for Qualified Expenses received as of the date of the request. The distribution to the Participant will be made within 60 days of the request for a distribution.

A Participant should contact the Plan Administrator for procedures in making such a request. A request must be made on or after the date of the order or call to active duty and before the last day of the Plan Year during which the order or call to active duty occurred. A request may not be made based on an order or call to active duty of any individual other than the Employee, including the Spouse of the Employee. Distributions are taxable as wages and will be reported on the Participant’s W-2.

A Participant may continue to submit claims for reimbursement of Qualified Expenses Incurred before the date the distribution is requested. A Participant’s right to submit claims for reimbursement terminates as of the date of the request for distribution.

• **Significant Changes in the Cost of Coverage.** You may cancel your enrollment and salary reduction where during a Coverage Period there is a significant increase or significant decrease in the cost of a benefit package option under the Employer’s plan(s). (A “benefit package option” is a qualified benefit under Section 125(f) of the Code or an option for coverage under an underlying health care plan, such as an indemnity, HMO or PPO option.) In that case you may then complete a new enrollment to either (i) receive coverage under the option with the decrease in cost, (ii) revoke coverage under the option with an increase in cost and elect similar coverage under another benefit package option providing similar coverage or, (iii) if there is no other option with similar coverage available, drop coverage entirely. No automatic adjustment in your salary reduction, as described in Article IV, will be made under these circumstances.

For purposes of this rule, a “cost increase” or “cost decrease” refers to an increase or decrease in the amount of contributions you make under this Plan, whether due to actions taken by you (switching between part-time and full-time employment, etc.) or from an action by your Employer (such as decreasing the cost of coverage for a classification of Employees of which you’re a member).

• **Significant Changes in Coverage.** You may cancel your enrollment and salary reduction where during a Coverage Period your, your Spouse’s or other Dependent’s coverage under a plan of the Employer is significantly curtailed or ceases. Coverage is considered significantly “curtailed” if, among other things, there is a significant increase in the deductible, the co-pay, or out-of-pocket maximum amount under a health plan. In that event, you must then complete a new enrollment to elect coverage on a prospective basis for such person under another benefit package option providing similar coverage. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally.

If there is a “loss” of coverage, you may elect coverage on a prospective basis for such person under another benefit package option providing similar coverage, or drop coverage if there is no other option providing similar coverage. A “loss” of coverage includes a complete loss of coverage (including the elimination of a benefit package option, an HMO ceasing to be available in the area where the person resides, the individual’s attainment of an overall annual or lifetime benefit maximum under a plan, a substantial decrease in the number of medical providers
available under the option (such as a major hospital ceasing to be a member of a managed care network, or a substantial decrease in the number of physicians participating in the network), a reduction in the benefits for a specific type of medical condition or treatment (where you, your Spouse or other Dependent is currently in a course of such treatment), or any other similar fundamental loss of coverage.

- **Addition (or Improvement) of Benefit Package Option.** You may cancel your enrollment and salary reduction where during a Coverage Period a plan of the Employer adds a new benefit package option or other coverage option (or significantly improves an existing benefit package option or other coverage option). In that case you may then complete a new enrollment to elect the newly-added or improved option prospectively.

- **Loss of Coverage Under Certain Governmental or Educational Institution Plans.** You may cancel your enrollment and salary reduction where during a Coverage Period you, your Spouse or other Dependent lose coverage under any group health plan sponsored by a governmental or educational institution, including a State children’s health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government, the Indian Health Service or a tribal organization; a State health benefits pool; or a foreign government group health plan. You may then complete a new enrollment to provide coverage for such person on a prospective basis under a plan of the Employer.

- **Change in Coverage Under Other Plan.** You may cancel your enrollment and salary reduction, and complete a new enrollment for the remainder of the Coverage Period, where the change is on account of and corresponds with a change made under another plan maintained by your Employer or another employer if:

  - that other plan permits participants to make an election change that would be permitted under the rules of this Article (disregarding this section concerning changes in coverage under another plan); or

  - this Plan permits you to make an election for a period of coverage that is different from the period of coverage under the other plan.

**Events Entitling You to Change Elections Concerning Contributions to the Health Care Reimbursement Program.** The events and requirements under which you may make a mid-year change to your enrollment and salary reduction with respect to contributions to the Health Care Reimbursement Program are the same events and requirements described above (with respect to payment of health insurance premiums, with the following exceptions:

- The events described in the heading titled, **HIPAA Special Enrollment Events** are applicable only if the Health Care Reimbursement Program is subject to HIPAA. In most cases a Health Care Reimbursement program is not subject to HIPAA. Ask the Administrator.

- The events described in the headings titled, **Significant Changes in the Cost of Coverage, Significant Changes in Coverage, Addition (or Improvement) of Benefit Package Option, Loss of Coverage Under Certain Governmental or Educational Institution Plans, and Change in Coverage Under Other Plan** do not authorize changes to enrollments concerning the Health Care Reimbursement Program.
Note also that if you change your enrollment and salary reduction as to the Health Care Reimbursement Program, you may not reduce the amount you elect to contribute to the Program for the Coverage Period below a certain amount. That amount is equal to the amount of Benefits paid to you by the Program during the Coverage Period and prior to the event justifying your change in enrollment.

**Events Entitling You to Change Elections Concerning Contributions to the Dependent Care Reimbursement Program.** The events and requirements under which you may make a mid-year change to your enrollment and salary reduction with respect to contributions to the Dependent Care Reimbursement Program are the same events and requirements described above (with respect to payment of health insurance premiums), with the following exceptions:

- The events described in the headings titled, HIPAA Special Enrollment Events, Court Decree, Family and Medical Leave and Military Leave, Loss of Coverage Under Certain Governmental or Educational Institution Plans, and Entitlement to Medicare or Medicaid do not apply.

- The Change in Status rules described above (with respect to payment of health insurance premiums) apply; in order for an election change to be considered “consistent with” the change in status, the election change must affect eligibility for coverage under an employer’s plan, and the election change must be on account of and correspond with the change in status. An election change meets this consistency requirement if the election change is on account of and corresponds with a change in status that affects Employment-Related Dependent Care Expenses described in Appendix B. For purposes of the “change in status” rules as they apply to the Dependent Care Reimbursement Program, the term “Dependent” means your Qualifying Dependent as described in Appendix B. Thus, for example, a “change in status” occurs when your Dependent child attains age 13 and is therefore no longer a “Dependent” for purposes of the Dependent Care Reimbursement Program.

- The events described in the headings titled, Significant Changes in the Cost of Coverage, Significant Changes in Coverage, Addition (or Improvement) of Benefit Package Option, and Change in Coverage Under Other Plan apply; however:
  - the term “Dependent” means your Qualifying Dependent as described in Appendix B; and
  - the rules concerning Changes in Cost of Coverage apply only if the cost change is imposed by a dependent care provider who is not your relative. For this purpose, a “relative” is a child (including a step-child) or grandchild, a brother or sister (or step-brother or step-sister), parent (including a step-parent), grandparent or great-grandparent, a niece or nephew, uncle or aunt, mother- or father-in-law, brother- or sister-in-law, or son- or daughter-in-law. A child includes a foster child and a child adopted by or placed for adoption with you. A sister or brother includes a sister or brother by half-blood.
ARTICLE IV
YOUR CONTRIBUTIONS TO THE PLAN

Salary Reduction – General Rules. Recall that, in order to participate in this Flexible Benefits Plan, you must complete the online enrollment and agree to the salary reduction. Your Benefits under the Plan are financed by reductions from your Compensation, as authorized by your enrollment; that is, the amount by which your Compensation is reduced must be sufficient to pay for the Benefits you chose. These elections may be made on the same online enrollment system, to be provided by the Employer.

Your Employer will administer its payroll program to allow you to agree, with your enrollment, to reduce your Compensation during a Coverage Period by the amount necessary to purchase the Benefits you choose (note, however, that the Code might impose limits on your selections). You indicate on your enrollment how much you will contribute under the Plan for the year. The enrollment will apply for the entire Coverage Period and can’t be changed except as provided under the special rules in Article III concerning, Mid-Year Changes to Elections.

As a general rule, the amounts you agree to contribute to the Plan will be contributed on a pro rata basis for each pay period during the Coverage Period (that is, the same amount will be subtracted from your Compensation each pay period). However, the Employer may also allow you to make your contributions to the Plan in advance (for example, in a single sum at the beginning of the Coverage Period). Each dollar contributed to the Plan with your salary reduction will be “converted” into what the Plan calls a “Flexible Benefits Plan Dollar” and allocated to the appropriate funds or accounts under the Plan, to pay for the Benefits you chose when you enrolled.

Initial Salary Reduction. Your initial salary reduction will apply to pay periods that end during the Coverage Period to which the initial enrollment applies. For example, if you first become eligible to participate and agree to the salary reduction effective March 1 of a given year, that enrollment generally will apply for the remainder of the Coverage Period that includes that March 1.

Subsequent Salary Reductions. Subsequent salary reductions (that is, salary reductions you agree to after the initial enrollment) can be made during the annual Election Periods that occur shortly before each new Coverage Period. You’ll agree to these new salary reductions at the same time that you complete your new enrollment for the ensuing Coverage Period, as described in Article III. There are special rules in Article III that describe what happens if you don’t complete a new enrollment during the annual Election Period. Those same rules apply to your failure to agree to a new salary reduction during the annual Election Period.

Changing Your Salary Reductions. Generally, you may not change your salary reduction during the Coverage Period. However, there are two exceptions to this rule:

First, you may cancel, change or (if you don’t have one in effect) agree to salary reduction during a Coverage Period if the circumstances under which you intend to cancel, change or make your salary reduction meet the requirements described in Article III in the section there titled, Mid-Year Changes to Elections.

Second, your salary reduction will automatically change to the extent necessary to conform to any increase or decrease in the cost of coverage of any of the Employer’s health and welfare plans under which you are enrolled.
For example, assume that you choose coverage under the Employer’s group health care plan, and choose to have your cost of coverage paid under this Plan. Assume your monthly cost of coverage under the health care plan, at the beginning of the year, is $100.

If your cost of coverage increases or decreases during the course of the year, then as a general rule your salary reduction will automatically change to correspond to the adjusted Premium amount. The rules in Article III concerning mid-year changes to Benefit Elections describe situations where, due to a change in the cost of some coverage, you might be entitled to cancel your enrollment and complete a new enrollment and agree to a new salary reduction.

**What Your Employer Does with the Reductions From Your Compensation.** As soon as practicable after each pay period your Employer will take the amount by which you agreed, with your enrollment in your salary reduction, to have your Compensation reduced and convert those dollars into Flexible Benefits Plan Dollars. It will then apply those Flexible Benefits Plan Dollars to provide the Benefits you chose when you enrolled.
ARTICLE V
CLAIMS FILING PROCEDURES

Submitting Your Claims for Benefits. Any claim for Benefits provided under an Insurance Contract issued by an insurance company must be filed with that Insurer. If the Insurer denies any claim, you or your beneficiary must follow the Insurer’s claims review procedure. A claim for Benefits under any self-insured Benefit program sponsored by the Employer should be submitted to the Claims Administrator for that program. Any other claim for Benefits must be filed with the Claims Administrator. See the following paragraphs below, and Appendix A, for rules concerning claims under the Health Care Reimbursement Program. See the following paragraphs below, and the Appendix B for rules concerning claims under the Dependent Care Reimbursement Program.

Review of Reimbursement Claims. The Claims Administrator will review and decide a claim (appropriately filed with it) for reimbursement within 90 days after it is timely filed. If the Claims Administrator denies a claim, the Claims Administrator will provide notice to you or your beneficiary, in writing, within 90 days after the claim is filed, unless special circumstances require an extension of time for processing the claim. No extension will be for more than 90 days after the end of the initial 90-day period.

If an extension of time for processing is required, written notice of the extension will be furnished to you or your beneficiary before the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which a final decision will be rendered. You will be informed in writing of the time limits set forth in this paragraph. If the Claims Administrator does not notify you of the denial of the claim within the period specified above, then the claim will be deemed denied.

If a claim appropriately filed with the Claim Administrator is wholly or partially denied, you or your beneficiary will be furnished a written notice setting forth in a manner calculated to be understood:

- the specific reason or reasons for the denial;
- specific references to the pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you or your beneficiary to perfect the claim and an explanation as to why such information is necessary; and
- an explanation of the Plan's claim procedure, including the steps to be taken if you or your beneficiary wishes to appeal the claim, the period within which the appeal must be filed, and the period within which it will be decided.

Appealing a Denied Claim. Within 60 days after receipt of the above material, you or your beneficiary will have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. You or your beneficiary or your (or the beneficiary’s) duly authorized representative may:

- request a review upon written notice to the Administrator;
- review pertinent documents; and
- submit issues and comments in writing.

Decision on Review. A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing). In that case a decision will be rendered as soon as possible, but not later than 120 days after receipt. If such an extension of time for deciding the appeal is required, written notice of the extension will be furnished to you or your beneficiary prior to the
commencement of the extension. The decision of the Administrator will be written and will include specific reasons for the decision, written in a manner calculated to be understood by you or your beneficiary, with specific references to the pertinent Plan provisions on which the decision is based.

The Status of Your Plan Accounts Pending Appeal. Any balance remaining in a Reimbursement Account described in one or more Appendices (as applicable) at the end of a Coverage Period will be forfeited and credited to the Employer’s Benefit Plan Surplus as described in the appropriate Appendices, as applicable. However, if you had made a claim for such Coverage Period, in writing, which was denied or is pending, the amount of the claim will be held in your Account until the claim appeal procedures described above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Coverage Period will be forfeited and credited to the Benefit Plan Surplus.

Benefit Plan Surplus. Any forfeited amounts credited to the Benefit Plan Surplus (because you did not Incurred a reimbursable expense or did not timely make a claim for reimbursement) may be separately accounted for after the end of the Coverage Period (or after a later time specified in this Plan for the filing of claims) in which the forfeitures arose. But due to Code rules, such forfeited amounts will not be carried over to the next Coverage Period, to reimburse you for expenses Incurred during such next Coverage Period, nor will amounts you forfeited be made available to you in any other form or manner, except as may be permitted by Treasury regulations and this Plan. Forfeited amounts credited to the Benefit Plan Surplus will be used to defray any administrative costs and experience losses.

Nonassignability of Rights. Your right to receive any reimbursement under the Plan cannot be assigned by you, and will not be made subject to the rights of your creditors. Any attempt to cause such right to be subjected to your creditors will not be recognized, except to such extent Required By Law.
ARTICLE VI
ADMINISTRATION

Plan Administration. The operation of the Plan will be conducted by the Claims Administrator under the supervision of the Administrator. It will 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 will have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code.

The Administrator has the greatest permissible discretion to construe the terms of the Plan and to determine all questions concerning eligibility, participation and benefits. Any such decision made by the Administrator will be binding on all Employees, Participants and beneficiaries, and is intended to be subject to the most deferential standard of judicial review. Such standard of review is not to be affected by any real or alleged conflict of interest on the part of the Administrator. The Administrator’s powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

• to make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

• to interpret the Plan, the Administrator’s interpretations thereof to be final and conclusive on all persons claiming Benefits under the Plan;

• to decide all questions (including questions of fact) concerning or related to the Plan and the eligibility of any person to participate in the Plan and to receive Benefits provided under the Plan;

• to reject enrollments or to limit contributions or Benefits for certain Highly Compensated Employees, Individuals or Participants, or Key Employees, if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

• to provide Employees with a reasonable notification of their Benefits available under the Plan;

• to approve reimbursement requests and to authorize the payment of Benefits;

• to appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan;

• to develop appellate and review procedures for any Participant, Spouse, Dependent or designated beneficiary with regard to denied Benefits under the Plan; and

• to report to the Employer, or any party designated by the Employer, after the end of each Coverage Period, regarding the administration of the Plan; and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and Benefits, or any other change which might ensure the efficient administration of the Plan.

Any procedure, discretionary act, interpretation, or construction taken by the Administrator will be done in a non-discriminatory manner based upon uniform principles consistently applied, and will be consistent with the intent that the Plan comply with Section 125 of the Code and the regulations issued under that Section.
Information to be Provided to Plan Administrator. The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of an Employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant, Spouse or Dependent entitled to Benefits under the Plan shall furnish to the Plan Administrator his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the Plan Administrator might reasonably request to ensure the proper and efficient administration of the Plan.

Examination of Records. The Administrator will make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, any records that pertain to his or her interest under the Plan.

Payment of Expenses. The Employer will pay any reasonable administrative expenses, unless the Employer decides that administrative costs will be paid by Participants under the Plan or by any Trust Fund that may be established in connection with the Plan. The Administrator and/or its designee may impose reasonable conditions for payments, but such conditions will not discriminate in favor of Highly Compensated Employees.

Insurance Contracts May Control Over Terms of this Plan. If there is a conflict between the terms of this Plan and the terms of an Insurance Contract of a particular Insurer whose product is being used in conjunction with this Plan, the terms of the Insurance Contract will control with respect to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract will 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.

Indemnification of Claims Administrator and Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law the Claims Administrator and 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 the following: all liabilities, damages, costs and expenses (including reasonable attorneys’ fees and amounts paid in settlement of any claims approved by the Employer) caused by or resulting from any act of, or omission to act by, the Claims Administrator or any such Employee) in connection with the Plan, if such act or omission is in good faith.
ARTICLE VII
AMENDMENT OR TERMINATION OF PLAN

Amendment. The Employer may at any time amend any provisions of the Plan without the consent of any other participating employer, Employee, or Participant. No amendment will have the effect of modifying any enrollment of any Participant in effect at the time of the amendment, unless the amendment is made to comply with Federal, state or local laws, statutes or regulations.

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

Upon termination, no further additions will be made to your Reimbursement Accounts described in the Appendices. However, all payments from your Reimbursement Accounts will continue to be made, according to the enrollments in effect, until the earlier of two dates. The two dates are (1) the end of the Coverage Period in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims), and (2) the date on which the balances of all Reimbursement Accounts have been reduced to zero. Any amounts remaining in any such Reimbursement Accounts as of the end of the Coverage Period in which Plan termination occurs will be forfeited and deposited in the Benefit Plan Surplus after the expiration of the claim filing period.
ARTICLE VIII
DEFINITIONS

The following terms have special meanings and when used in this Plan will be capitalized.

“Administrator” means the individual(s) or corporation responsible for carrying out or overseeing the administration of the Plan. The Administrator is Daytona State College. If the Administrator is not the Employer, and resigns from a prior appointment and no successor Administrator is appointed, the Employer will be the Administrator.

“Benefit” means any of the benefits available under the Plan. These benefits are described in Article I.

“Benefit Plan Surplus” means amounts you forfeit and that are credited to such surplus as described in Appendices A and B, as applicable.

Benefit Solvers Online Enrollment System” means the online enrollment program, described in Article III, by which you elect to receive one or more Benefits available to you under the Plan. Your completed enrollment signifies your agreement to have your salary reduced to pay for the Benefits available under the Flexible Benefits Plan that you chose to enroll in.

“Claims Administrator” means CoreSource.

“Code” means the Internal Revenue Code of 1986, as amended from time to time.

“Compensation” means the total cash compensation you receive from the Employer during a Coverage Period, prior to any reductions authorized by your enrollment under this Plan. “Compensation” includes overtime, commissions and bonuses.

“Coverage Period” means the period for which certain Benefits are provided to you under the Plan. The Coverage Period will be no less than 12 months, except that the Plan’s first Coverage Period may, if it is commensurate with the Plan’s fiscal year, be a short Coverage Period, and except where the Plan changes its fiscal year. In the event your participation begins during a Coverage Period, your initial Coverage Period is the portion of the Coverage Period remaining, beginning on the date your participation begins, and ending on the last day of that Coverage Period. The Plan may have different Coverage Periods for different Benefits, and a Coverage Period may be different than the Plan’s fiscal year.

There is a single Coverage Period for all Benefits under the Plan. The Plan’s fiscal year is January 1 through December 31.

“Dependent” means any individual who, with respect to you, is a “qualifying child” or “qualifying relative” for the taxable year under Section 152 of the Code as determined without regard to subsections 152(b)(1), (b)(2) or (d)(1)(B). Generally, this requires the individual to (i) be your child, parent, or other relative described in that Section, and (ii) rely upon you for over half of his or her support during the taxable year (special support rules apply in the case of a child of divorced parents). In the case of a non-spouse Dependent who is not a child or relative described in Section 152, generally the individual must rely upon you for over half of his or her support, have the same principal place of abode as you, and reside with you as a member of your household in a manner that is not in violation of local law.
“Dependent Care Expenses” means the expenses Incurred by a Participant for the care of a Dependent or Spouse of the Participant or for related household services, which would be considered employment-related expenses under Section 21(b)(2) of the Code.

“Dependent Care Reimbursement Account” means your account under the Dependent Care Reimbursement Program, to which Flexible Benefits Plan Dollars may be credited on your behalf, in accordance with the salary reduction you agreed to when you enrolled, and from which this Plan will pay eligible Dependent Care Expenses Incurred by you, as described in Appendix B.

“Dependent Care Reimbursement Program” means the program, under this Flexible Benefits Plan, under which Flexible Benefits Plan Dollars, contributed to your Dependent Care Reimbursement Account pursuant to the salary reduction you agreed to when you enrolled are used to pay eligible Dependent Care Expenses Incurred by you. The Program is described in detail in the Appendix B.

“Effective Date” means the date this Plan was established: July 1, 2010 and restated January 1, 2014.

“Election Period” means the annual period that precedes the beginning of a Coverage Period, and during which you may elect the Benefits you want to receive under this Plan during that Coverage Period. The annual Election Period under this Plan is during open enrollment.

“Eligible Employee” means any Employee who has satisfied the following eligibility rules:

With respect to the Pre-Tax Health and Welfare Plan Premium Payment feature under the Plan, an Employee is eligible as follows: on the date he becomes eligible to participate in a health and welfare plan sponsored by the Employer. The eligibility rules of the health and welfare plan(s) are described in the plan(s), and are hereby incorporated into this Plan by reference.

With respect to the Health Care Reimbursement Program, an Employee is eligible when he becomes eligible to participate in the Employer’s other health and welfare plan.

With respect to the Dependent Care Reimbursement Program, an Employee is eligible at the same time he becomes eligible for the Health Care Reimbursement Program.

“Employee” means any person who is employed by an Employer, but excluding the following persons (if any):

- independent contractors, and any other person paid through accounts payable rather than payroll, even if such person is later determined to have been a common law employee
- leased employees within the meaning of Section 414(n) of the Code
- all temporary employees

“Employer” means Daytona State College and any successor that maintains this Plan, and any predecessor that has maintained this Plan.

“Flexible Benefits Plan Dollars” means the amount available to you, pursuant to the salary reduction you agreed to when you enrolled described in Article IV, to purchase Benefits. Each dollar contributed to this Plan pursuant to your salary reduction equals one Flexible Benefits Plan Dollar.
“Health Care Reimbursement Account” means your account under the Health Care Reimbursement Program of this Plan, to which Flexible Benefits Plan Dollars may be allocated on your behalf, pursuant to the salary reduction you agreed to when you enrolled, and from which this Plan will pay eligible Medical Expenses Incurred by you, your Spouse or other Dependents, as described in Appendix A.

“Health Care Reimbursement Program” means the program, under this Flexible Benefits Plan, under which Flexible Benefits Plan Dollars are contributed to your Health Care Reimbursement Account pursuant to the salary reduction you agreed to when you enrolled, and used to pay eligible Medical Expenses Incurred by you, your Spouse or other Dependents. The Program is described in detail in Appendix A.

“Highly Compensated Employee” means an Employee described in Code Section 414(q) and the Treasury regulations issued under that Section.

“Highly Compensated Individual” means a person described in Code Section 125(e)(2) and the Treasury regulations issued under that Section.

“Highly Compensated Participant” means a person described in Code Section 125(e)(1) and the Treasury regulations issued under that Section.

“Insurance Contract” means any contract issued by an Insurer.

“Insurer” means any insurance company that underwrites a Benefit.

“Key Employee” means an Employee described in Code Section 416(i)(1) and the Treasury regulations issued under that Section.

Over-the-Counter Drugs” means items which are legally procured without a prescription and which are generally accepted as falling within the category of medicine and drugs. Over-the-Counter Drugs do not include toiletries or similar preparations (such as toothpaste, shaving lotion, shaving creams, etc.), cosmetics (such as face creams, deodorants, hand lotions, etc. or any similar preparation used for ordinary cosmetic purposes), or dietary supplements that are merely beneficial to the general health of the individual (such as vitamins, etc.). The Plan Administrator has the sole discretionary authority to implement additional restrictions on the type or amount of items that qualify as Over-the-Counter Drugs for purposes of this Plan.

“Participant” means any Eligible Employee who chooses to become a Participant under Article II and has not, for any reason, become ineligible to participate further in the Plan.

“Plan” means this document, including all amendments to this document.

“Plan Year” period of time from January 1 to December 31.

“Premiums” mean the cost of your (and, where applicable, your Dependents’) coverage under any or all of the health and welfare plans described in Article I under which you chose to be covered.

“Pre-Tax Health and Welfare Premium Account” means your account under this Plan to which Flexible Benefits Plan Dollars may be credited on your behalf, under the salary reduction you agreed to when you enrolled, and from which this Plan will pay Premiums for your (and, where applicable, your Spouse’s and/or your other Dependents’) coverage under one or more of the health and welfare benefit plans described in Article II. If you elect coverage under more than one benefit plan, a sub-account will be established for each such plan.
“Qualified Expenses” means the medical expenses Incurred during a Coverage Period by a Participant, the Participant’s Spouse or the Participant’s Dependents, and that qualify as expenses for “medical care” within the meaning of Section 213(d) of the Code. Qualified Expenses do not include premium expenses for other health coverage, including (i) premiums paid for health coverage under a plan maintained by the employer of the Employee’s Spouse or Dependent or (ii) premiums for an individual health insurance policy.

Expenses Incurred for the purchase of Over-the-Counter (OTC) medicines and drugs (i.e., Advil, ibuprofen, cough syrup), except Insulin, cannot be Qualified Expenses unless the Participant, the Participant’s Spouse or the Participant’s Dependents has a Note of Medical Necessity (NMN) or a written prescription from their doctor. Expenses for OTC items that are not considered a drug or medicine will be considered Qualified Expenses.

“Required By Law” means the same as the term “required by law” as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal Law.

“Spouse” means your legal husband or wife, as the case may be. Your spouse will cease to be considered your “spouse” upon the entry of a decree of divorce.

“You” means an Employee.
ARTICLE IX
GENERAL INFORMATION

Plan Interpretation. All provisions of this Plan will be interpreted and applied in a uniform, non-discriminatory manner by the Administrator, as described in Article VI. This Plan will be read in its entirety and not severed, except as described below, in the section titled, Severability.

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

Written Document. This Plan, in conjunction with any separate written document that may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any regulations promulgated thereunder relating to cafeteria plans.

Exclusive Benefit. This Plan will be maintained for the exclusive benefit of the Employees who participate in the Plan.

Participants’ Rights. This Plan is not an employment contract between the Employer and any Participant or Employee, nor is it consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan will 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 will have upon him as a Participant of this Plan.

Action by the Employer. Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act, it will be done and performed by a person duly authorized by the Employer.

Address, Notice and Waiver of Notice. Each Participant shall furnish the Employer with his correct post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under the Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

Employer’s Protective Clauses. Upon the failure of either you or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), your Benefits will be limited to the amounts described in the following sentence. The amounts described in this sentence are (1) the insurance premium, if any, that remained unpaid for the period in question; and (2) the actual insurance proceeds, if any, received by the Employer or you as a result of your claim.

The Employer’s liability to you will only extend, and be limited to, any payment actually received by the Employer from the Insurer. If the full insurance Benefit is not received by the Employer within a reasonable time after submission of a claim, the Employer will have no legal obligation whatsoever (except to execute any document called for by a settlement reached by you). You will be free to settle, compromise or refuse to pursue the claim as you, in your sole discretion, will see fit.

The Employer will not be responsible for the validity of any Insurance Contract issued under this Plan or with respect to which you purchase coverage under this Plan. Similarly, the Employer will not be responsible for the Insurer’s failure to make payments called for under any Insurance Contract, or for the
action of any person that might delay or render null and void or unenforceable, in whole or in part, an Insurance Contract. With regard to this paragraph, the following will apply:

• Once insurance is applied for or obtained, the Employer will not be liable for any loss that might result from the failure to pay Premiums, where the Employer does not receive Premium notices.

• Where the Employer receives Premium notices, its liability for the payment of such Premiums will be limited to the amount of such Premiums and will not include liability for any other loss that may result from failure to pay such Premiums.

• The Employer will not be liable for the payment of any insurance Premium, or any loss that may result from the failure to pay an insurance Premium, if the Benefits available under this Plan are insufficient to provide for the amount of such Premium cost at the time it is due. In these circumstances you will be responsible for and see to the payment of such Premiums. The Employer will attempt to notify you if available Benefits under this Plan are insufficient to provide for payment of an insurance Premium but will not be liable for any failure to make such notification.

No Guarantee of Tax Consequences. The Administrator and the Employer make no guarantee that any amounts paid to you or for your benefit under the Plan will be excludable from your gross income for federal or state income tax purposes. In addition, the Administrator and the Employer make no guarantee that any other federal or state tax treatment will apply to or be available to you. It will be your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes, and to notify the Employer if you have reason to believe that any such payment is not so excludable.

Indemnification of Employer by Participants. If you receive one or more payments or reimbursements under the Plan that are not for a permitted Benefit, you will 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 will not exceed the amount of additional federal and state income tax (plus any penalties) that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by you.

Funding. The Plan is funded through salary reductions made by Participants. Unless otherwise Required by Law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but will instead be considered general assets of the Employer. Furthermore, and unless otherwise Required By Law, nothing in this Plan will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for your benefit, and neither you nor any other person will 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.

Other Salary-Related Plans. It is intended that any other salary-related employee benefit plans that are maintained or sponsored by the Employer will not be affected by this Plan. Any contributions or benefits under the other plans with respect to you will be based on your total compensation from the Employer, including any amounts by which your salary or wages may be reduced under Article IV. However, this rule will not apply to the extent not permitted by law or not otherwise provided for in such other plans.
**Governing Law.** The Code and the Treasury regulations issued under the Code (as they might be amended from time to time) govern this Plan. The Employer does not guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan will be construed, enforced and administered according to the laws of the State of Florida.

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

**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 will affect the Plan or the construction of any provision thereof.

**Clerical Error.** Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, this Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a plan participant, if it is requested, the amount of overpayment will be deducted from future Benefits payable.

**Continuation of Coverage.** In the event any Benefit under this Plan is subject to the continuation coverage requirement of Code Section 4980B or 42 U.S.C. § 300bb-1 (Public Health Service Act) and becomes unavailable, each Participant will be entitled to continuation coverage but only to the extent required in Code Section 4980B or 42 U.S.C. § 300bb-1, and regulations issued under the appropriate Section.

**Fraud or Intentional Misrepresentation.** If you, or anyone acting on your behalf, makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the Covered Person, or from any other person responsible for misleading the Plan, and from the person for whom the Benefits were provided. Any fraud or intentional misrepresentation of a material fact on the part of you or an individual seeking coverage on behalf of the individual in making application for coverage, or any application for reclassifications thereof, or for service there under is prohibited and shall render the coverage under this Plan null and void.

**Medical Child Support Orders.** To the extent applicable, the Plan Administrator shall adhere to the terms of any judgment, decree or court order (including a court’s approval of a domestic relations settlement agreement which:

1. relates to the provision of child support related to health benefits for a child of a Participant or a group health plan;
2. is made pursuant to a state domestic relations law; and
3. creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.
The Plan Administrator shall promptly notify the Participant and each alternate recipient named in the medical child support order of the Plan’s procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order (QMCSO) as defined in Section 609 of ERISA or National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998 and shall notify the Participant and each alternate recipient of such determination. If the Participant or any affected alternate payee objects to the determination of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Any such QMCSO or NMSN must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Any such QMCSO or NMSN shall not require the Plan to provide any type or form of benefits, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1983 (OBRA ’93).

Upon determination that a medical child support order is a QMCSO or NMSN, the Plan must recognize the QMCSO or NMSN by providing benefits for the Participant’s child in accordance with such order.

**Plan Records.** Plan records are maintained on the basis of the Plan’s fiscal year.

**Plan’s Fiscal Year.** The Plan’s fiscal year is January 1 through December 31.

**Employer’s Information.** The Employer’s Tax Identification Number is: 59-1211226.

**Type of Plan.** Flexible spending arrangement under Section 125 of the Code offering medical and dependent expense reimbursement accounts.

**Type of Administration.** The processing of claims for Benefits under the terms of the Plan are provided through a company contracted by the Employer and shall therein be referred to as the Claims Administrator.

**Administrator’s Address and Telephone Number.** The Administrator’s address and telephone number are:

1200 West International Speedway Blvd.
Daytona Beach, FL 32120-2811
(386) 506-3083

**Agent for Service of Process.** The Employer is the agent for service of process for the Plan.

**Not in Place of Workers’ Compensation.** This Plan is not in place of and does not affect any requirement for coverage by Workers’ Compensation insurance.
APPENDIX A
HEALTH CARE REIMBURSEMENT PROGRAM

Establishment of Program. This Health Care Reimbursement Program is intended to qualify as a medical reimbursement plan under Code Section 125 (non-discriminatory flexible spending arrangement) and Code Section 105(e) (non-discriminatory accident and health plan). It will be interpreted in a manner consistent with these Code Sections and the Treasury regulations issued under the Sections. If you choose to participate in the Health Care Reimbursement Program you may submit claims for the reimbursement of “Medical Expenses” (as defined below). All amounts reimbursed under this Health Care Reimbursement Program will be paid from amounts credited to your Health Care Reimbursement Account in accordance with the salary reduction you agreed to when you enrolled.

Definitions. For the purposes of this Appendix and the Flexible Benefits Plan:

“Medical Expenses” means expenses for medical care that meet the following requirements. First, the expense must fall within the meaning of the term “medical care” or “medical expense” as defined in Code Section 213 (and the rulings and Treasury regulations issued under that Section). Second, you may not deduct the expense from your gross income for purposes of determining your income tax. This Program will not reimburse you for the cost of other health coverage, such as premiums paid under plans maintained by your Spouse’s or other Dependent’s employer or individual policies maintained by you or your Spouse or other Dependent.

Expenses Incurred for the purchase of Over-the-Counter (OTC) medicines and drugs (i.e., Advil, ibuprofen, cough syrup), except Insulin, cannot be Qualified Expenses unless the Participant, the Participant’s Spouse or the Participant’s Dependents has a Note of Medical Necessity (NMN) or a written prescription from their doctor. Expenses for OTC items that are not considered a drug or medicine will be considered Qualified Expenses.

“Incur” or “Incurred” with respect to an expense means the following: An expense is Incurred at the time the service giving rise to the expense is furnished, and not when the individual is formally billed for, is charged for, or pays for the service. Special rules may apply with respect to a course of treatment such as orthodontic care, where payment is required in advance.

The definitions of Article VIII are incorporated into this Appendix to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Program.

Forfeitures. The amount in your Health Care Reimbursement Account as of the end of any Coverage Period (and after the processing of all claims for that Coverage Period pursuant to rules described below) will be forfeited and credited to the Benefit Plan Surplus. In that case, you will have no further individual claim to such amount for any reason.

Limitation on Allocations. The maximum amount of Flexible Benefits Plan Dollars your Employer will credit to your Health Care Reimbursement Account for this Coverage Period is: $2,500.00.

Health Care Reimbursement Program Claims. Medical Expenses that you, your Spouse or other Dependents Incur may be reimbursed even though the submission of the claim occurs after your participation under the Plan ends. However, the Medical Expenses must have been Incurred while you were a Participant, and the claims must be filed with the Claims Administrator within the time described in below.
Generally, the claim will include a written statement (e.g., a receipt) from an independent third party (such as the health care provider that provided the service) stating that the Medical Expense has been Incurred and the amount of such expense. Furthermore, you must provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health care plan coverage and, if reimbursed from the Health Care Reimbursement Account, such amount will not be claimed as a tax deduction. However, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Health Care Reimbursement Program Claims Administrator. The Claims Administrator will retain a file of all such claim forms.

The Claims Administrator will direct the reimbursement to you of all allowable Medical Expenses, up to a maximum equal to the amount of Flexible Benefits Plan Dollars you chose, when you enrolled and agreed to the salary reduction, to have the Employer contribute to your Health Care Reimbursement Account for the Coverage Period. **Reimbursements will be made available to you throughout the Coverage Period without regard to the amount of Flexible Benefits Plan Dollars that have been credited to your Account at any given point in time.**

| Example: | Assume you choose during your enrollment to contribute $1,200 to the Health Care Reimbursement Program for the Coverage Period, in increments of $100 per month. The Coverage Period is the calendar year. During January, the Employer reduces your Compensation by $100, converts those dollars into Flexible Benefits Plan Dollars and credits them to your Health Care Reimbursement Account. In that same month, you Incur an expense of $500 that is reimbursable under the Program. The claim is properly payable, even though at the time the claim is submitted you have only $100 Flexible Benefits Plan Dollars credited to your Account. |

In addition, you will be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan that may be sponsored by the Employer, any governmental agency or any other plan covering you and/or your Spouse or other Dependents.

**Claim Filing Deadline.** A claim for the reimbursement of Medical Expenses Incurred in any Coverage Period will be decided within a reasonable time after it is received. However, if you fail to submit a properly executed claim before the end of the claim filing deadline, the claim will not be accepted. The claim filing deadline is: **within 90 days after the close of the Coverage Period for active Employees and 90 days from the last date of employment for terminated Employees.**

A claim will be deemed submitted when the Claims Administrator receives the completed claim form. However, if a claim form is filed by U.S. Postal Service, it will be deemed to have been submitted on the date of the United States postmark stamped on the envelope in which the claim form is mailed. Claims will be decided in accordance with Article V.

Notwithstanding the foregoing, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Health Care Reimbursement Program Claims Administrator.

However, if a Qualified Expense was Incurred due to any co-pay, deductible, maximum benefit amount or other dollar limitations under the group medical plan, the Plan Administrator will receive information regarding such expense directly from such plan’s records and the Participant shall not be required to file reimbursement forms or supporting evidence for such expense.
Claim Payments Are Made to You. Except where this Program provides for your use of a debit or credit card to obtain services and supplies that would otherwise have been reimbursable under the Program had you paid cash for them, reimbursements under this Program will be made directly to you.

Debit or Credit Card Usage for Obtaining Covered Services and Supplies. The Employer may contract with the Claims Administrator to allow you to use a debit or credit card to access your Health Care Reimbursement Account. This allows you, where you obtain a service or supply from a provider that is willing to accept such debit or credit card transactions, to avoid having to pay cash for the service or supply, and then seek reimbursement from the Claims Administrator. However, your use of a debit or credit card would be subject to specific and mandatory requirements imposed by the Claims Administrator, including (among other things), “after-the-fact” documentation or substantiation of the expense in some cases. Over-the-Counter medications or drugs that require a Note of Medical Necessity (NMN) or a written prescription from a doctor are not eligible to be obtained using the Debit or Credit Card and must be submitted manually to the Claims Administrator, along with a copy of the Note of Medical Necessity or the written prescription, for reimbursement.

Automatic Rollover. If a Qualified Expense was Incurred due to any co-pay, deductible, maximum benefit amount or other dollar limitations under the group medical plan, the Plan Administrator will receive information regarding such expense directly from such plan’s records and the Participant shall not be required to file reimbursement forms or supporting evidence for such expense.

COBRA Continuation Coverage. If you and/or your Dependents lose coverage under the Health Care Reimbursement Program due to a “qualifying event”, you and/or the Dependents, as the case may be, might be entitled to continue coverage for a period of time after the qualifying event, in accordance with the COBRA provisions of Article II and this Appendix.

“Qualifying events” include:

- termination of your employment for any reason (including death), except for gross misconduct;
- your termination of eligibility due to reduced work hours;
- your eligibility for Medicare;
- your divorce;
- a Dependent child’s ceasing to satisfy the definition of “Dependent”;
- the last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the Employee informs the Employer that he or she will not be returning to work; and
- the call-up of an Employee reservist to active duty.

Under the law, you or the affected Dependent has the responsibility to inform the Administrator of a qualifying event that is a divorce, or a child losing Dependent status under this Plan within 60 days of the date of the later of the event or the date on which coverage would end under the Plan because of the event. The notice must be sent, in writing, to the person indicated below, and the notice must describe the qualifying event and the date it occurred:
When the Administrator is notified that one of these events has happened, the Administrator will in turn notify the person entitled to COBRA coverage (“qualified beneficiary”) of his or her COBRA rights. Under the law, qualified beneficiaries have at least 60 days from the date coverage would be lost because of one of the events described above to inform the administrator that they want continuation coverage.

Special COBRA rights apply if you lose coverage as a result of termination or reduction of hours and you qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance” under a federal law called the Trade Act of 1974. You are entitled to a second opportunity to elect COBRA coverage for yourself and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which you begin receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begin receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after your group health plan coverage ended.

The duration for which a qualified beneficiary may purchase COBRA coverage depends on a number of factors. If the maximum amount of Benefits available to you under the Health Care Reimbursement Program does not exceed two times your salary reduction contribution for the year or, if greater, your salary reduction contribution plus $500, COBRA coverage is not available beyond the end of the Coverage Period in which the qualifying event occurred; in addition, if at the time of the qualifying event the amount available for reimbursement for the remainder of the Coverage Period is less than the amount of contributions the COBRA qualified beneficiary would be required to pay for the remainder of that Coverage Period, then the qualified beneficiary is not eligible for COBRA coverage under the Health Care Reimbursement Program. These rules are described in additional detail in Article II.

However, if the maximum amount of Benefits available to you under the Health Care Reimbursement Program exceeds two times your salary reduction contribution for the year or, if greater, your salary reduction contribution plus $500, COBRA coverage can continue for 18 months (for qualifying events that are a termination of employment (for reasons other than death) or reduction in work hours) or 36 months (for other qualifying events). If a qualified beneficiary is disabled (within the meaning of the Social Security Act) at the time of a qualifying event that is a termination of employment (for reasons other than death) or reduction in hours, or is so disabled during the first 60 days of COBRA coverage following such a qualifying event, COBRA coverage for that beneficiary, and any other qualified beneficiary affected by the same qualifying event, can continue for up to 29 months. Where there are multiple qualifying events the 18- or 29-month limit may be extended to 36 months.

If a qualified beneficiary is eligible for and chooses COBRA coverage he or she is eligible for reimbursement, for covered claims Incurred after the qualifying event but during the same Coverage Period in which the qualifying event occurred, in an amount up to the maximum amount of reimbursement selected by you on your completed enrollment for that Coverage Period, minus the amount of reimbursements made to you for the Coverage Period up to the date of the qualifying event. If COBRA coverage can continue into subsequent Coverage Periods, the qualified beneficiary will make an election, prior to the beginning of the Coverage Period, concerning the Benefits he or she wants to have available for that Coverage Period.
Example: Here’s an example of how COBRA coverage works under the Health Care Reimbursement Program. Assume that all contributions to the Health Care Reimbursement Program are made by employees pursuant to the salary reduction you agreed to when you enrolled. At the beginning of a Coverage Period you elect to participate in the Program, select a maximum benefit for the Coverage Period of $1,200, and choose to contribute (with your completed enrollment) $100 per month to the Program in order to pay for that Benefit. You have one Dependent, who is your Spouse. You receive $200 in reimbursements during the first four months of the Coverage Period, and then your employment terminates (for reasons other than gross misconduct).

You have $1,000 in reimbursements available for the remainder of the Coverage Period, and are scheduled to contribute an additional $800. You may choose to continue your coverage under COBRA for the remainder of the Coverage Period by paying to the Plan $100 per month, on an after-tax basis, for the remainder of the Coverage Period. In this way, you are permitted to submit to the Program covered claims Incurred after the end of the month in which your termination of your employment occurs. For example, let’s say that three months after your termination, but still within the same Coverage Period, you Incure your first eligible claim since your termination, and that it’s for $500. The Program will pay the claim, so long as your COBRA coverage is still in effect when the claim is Incurred.

Your Spouse also has his or her own independent right to continue coverage under COBRA. For example, your Spouse can also agree to continue to make payments to the Program of $100 per month for the remainder of the Coverage Period, and if he or she makes that choice, he or she will also have $1,000 in reimbursements available under the Program, for claims Incurred by the Spouse during the remainder of the Coverage Period, so long as the COBRA coverage is still in force at the time the claims are Incurred.

Note that if at the time your employment terminated you had already received, say, $600 in reimbursements, so that you had only another $600 in reimbursements available for the remainder of the Coverage Period, but your COBRA premium for the remainder of the Coverage Period would be more than that (it would be $800; $100 per month for the eight months remaining in the Coverage Period), there would be no right to continue coverage under COBRA.

Each COBRA qualified beneficiary must pay for the coverage he or she elects, typically on an after-tax basis, in monthly amounts. For the remainder of the Coverage Period in which the qualifying event occurs the monthly amount is equal to the monthly amount you chose (when you enrolled) to pay during the Coverage Period, plus two percent. If COBRA coverage can be continued into a subsequent Coverage Period the monthly amount is equal to the 1/12th of the total Benefits the qualified beneficiary elected to have available under the Program for that Coverage Period, plus two percent. Where a disabled qualified beneficiary continues COBRA coverage for the additional 11-month period described above, the surcharge per month is fifty percent rather than two percent during the 11-month extension. This larger surcharge also applies to a non-disabled beneficiary who, along with the disabled beneficiary, continues coverage in the 11-month extended coverage period.

A qualified beneficiary’s continuation coverage may be cut short for any of the following three reasons:

• the Employer no longer provides group health coverage to any of its Employees;
• the premium for continuation coverage is not paid on time; or
• the beneficiary becomes covered, after the date of the election of COBRA coverage, under Medicare or under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have.

Payments are due monthly. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

For additional questions about continuation coverage, please contact the Administrator.

**Military Mobilization.** If an Employee is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the Employee and Employee’s Dependents may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the Employee and Employee’s Dependent may not be required to pay more than the Employee’s share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the Plan Administrator (or its designee) may require the Employee and Employee’s Dependent to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. twenty-four (24) months beginning on the day that the leave commences; or

2. a period beginning on the day that the leave began and ending on the day after the Employee fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty and subject to premium contribution requirement and other applicable requirements as described in the Participation section, coverage for the Employee and the Employee’s Dependent will be reinstated without pre-existing conditions exclusions or a waiting period, regardless of their election of COBRA Continuation Coverage.

**Address Changes.** In order to help ensure the appropriate protection of rights and Benefits under this Plan, Participants should keep the Plan Administrator (or its designee) informed of any changes to their current addresses.
APPENDIX B
DEPENDENT CARE REIMBURSEMENT PROGRAM

Establishment of Program. This Dependent Care Reimbursement Program is intended to qualify as a program under Code Section 125 (non-discriminatory flexible spending arrangement) and Code Section 129 (non-discriminatory dependent care assistance program). It will be interpreted in a manner consistent with these Code Sections and the Treasury regulations issued under the Sections. If you choose to participate in this Program you may submit claims for the reimbursement of Employment-Related Dependent Care Expenses (defined below). All amounts reimbursed under this Dependent Care Reimbursement Program will be paid from amounts credited to your Account under this Program. See the section at the end of this Appendix titled, What You Should Know — Comparison of the Dependent Care Reimbursement Program and the Dependent Care Tax Credit, for information about whether the Dependent Care Reimbursement Program is more beneficial to you than the tax credit for Dependent Care Expenses available to you under the Code.

Definitions. For the purposes of this Appendix and the Flexible Benefits Plan, the terms below will have the following meaning:

“Earned Income” means earned income as defined under Code Section 32(c)(2) (generally wages and salaries, plus net earnings from self-employment) but excluding amounts paid or Incurred by the Employer for dependent care assistance to you or on your behalf.

“Employment-Related Dependent Care Expenses” means expenses Incurred by you for those services that, if paid by you, would be considered employment-related expenses under Code Section 21(b)(2). Generally, they include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are Incurred to enable you to be gainfully employed for any period for which you have at least one Qualifying Dependent. Whether an amount qualifies as an Employment-Related Dependent Care Expense will be decided under the following rules:

• if the amounts are paid for expenses Incurred outside your household, they will constitute Employment-Related Dependent Care Expenses only if Incurred for a Qualifying Dependent as defined below (if the Qualifying Dependent is not a Dependent child under the age of 13, the Qualifying Dependent must also regularly spend at least 8 hours each day in your household);

• if the expense is Incurred outside your home at a facility that provides care for a fee, payment or grant for more than six 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

• your Employment-Related Dependent Care Expenses will not include amounts paid or Incurred for service performed by a person who is your child (as defined in Code Section 151(c)(3)) and who is under the age of 19, or to an individual who is claimed as a Dependent by you or your Spouse (that is, an individual with respect to whom a personal exemption is claimed on your or your Spouse’s federal income tax return).

• expenses for “household services” means expenses paid for the performance in your home of ordinary and usual services necessary to the maintenance of your household. The expenses must also be attributable to the care of a Qualifying Dependent.
“Incur” or “Incurred” with respect to an expense means the following: An expense is Incurred at the time the service giving rise to the expense is furnished, and not when the individual is formally billed for, is charged for, or pays for the service. Thus, with respect to Employment-Related Dependent Care Expenses, for example, services rendered for the month of June are not fully Incurred until June 30th and cannot be reimbursed in full until then.

“Qualifying Dependent” means, for purposes of this Dependent Care Reimbursement Program:

- your Dependent (as defined in Section 152(a)(1) of the Code (e.g. a “qualifying child”) who is under the age of 13;
- your Spouse or other Dependent who is physically or mentally incapable of caring for himself or herself, and who has the same principal place of abode as you, for over half the taxable year, and whose relationship with you is not in violation of local law at any time during the year; or
- any other Dependent who is deemed to be a Qualifying Dependent described in one of the preceding two paragraphs, whichever is appropriate, pursuant to Code Section 21(e)(5) (dealing with special rules for establishing dependency in the case of divorced parents).

The definitions of Article VIII are incorporated into this Appendix to the extent necessary to interpret and apply the provisions of this Dependent Care Reimbursement Program.

Your Account under this Program. The Claims Administrator will establish an account under this Program for you when you choose to apply Flexible Benefits Plan Dollars to Dependent Care Reimbursement Program Benefits.

Increases and Decreases in Dependent Care Reimbursement Accounts. Your account under this Program will be increased each pay period by the portion of Flexible Benefits Plan Dollars that you chose to apply toward your account under this Program pursuant to the salary reduction you agreed to when you enrolled.

Your account under this Program will be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or Incurred on your behalf, as described below in the section titled, Dependent Care Reimbursement Program Claims.

Allowable Dependent Care Reimbursement. Subject to (1) limitations reflected below, in the section titled, Limitations on Payments, and (2) the extent of the amount credited to your account under this Program, if you Incure Employment-Related Dependent Care Expenses you will be entitled to receive from the Program full reimbursement for the entire amount of such expenses Incurred during the Coverage Period (or portion of the Coverage Period) during which you are a Participant.

Annual Statement of Benefits. If you participate in this Program during a Coverage Period, then on or before June 30th of the ensuing Coverage Period the Employer will furnish to you a statement of all Benefits paid to you or on your behalf under this Program during the preceding Coverage Period.

Forfeitures. The amount credited to your account under this Program as of the end of any Coverage Period (and after the processing of all claims for such Coverage Period pursuant to the section below
titled, *Coordination with Flexible Benefits Plan*) will be forfeited and credited to the Benefit Plan Surplus. In that case, you will have no further claim to such amount for any reason.

**Limitation on Payments.** Amounts paid from your account under this Program, in or on account of any single taxable year, will not exceed:

- the Earned Income limitation described in Code Section 129(b), or
- $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)),

whichever is less.

**Dependent Care Reimbursement Program Claims.** You are required to file a claim with the Claims Administrator in order to receive Benefits from this Program. The claim must be in a form satisfactory to the Claims Administrator, and must include a statement from an independent third party (for example, the caregiver) as proof that the expense has been Incurred, and the amount of such expense. In addition, the Claims Administrator may require that the claim include a statement containing the following information:

- the name and age of each Dependent for whom the services were performed;
- the nature and dates of the services that were performed;
- your acknowledgment that you will include on your federal income tax return the name, address, and (except in the case of a tax-exempt provider) the taxpayer identification number of the provider (or will exercise due diligence in attempting to obtain such information);
- the relationship, if any, of the person performing the services for you;
- if another of your Dependents performed the services, the age of the other Dependent;
- where the services were performed;
- if any of the services were performed outside your home, whether the Dependent for whom such services were performed regularly spends at least 8 hours each day in your household;
- if the services were performed in a day care center that provides care for more than six individuals (other than individuals residing at the center) and receives a fee, payment or grant for providing any of such care:
  - whether the day care center complies with all applicable state and local laws and regulations of the state of residence, and
  - the amount of the fee, payment or grant paid to the provider.

- If you are married:
  - whether you and your Spouse plan to file a joint return or separate returns of federal income taxes; and
  - the amount, if any, of non-taxable dependent care assistance benefits received from any other employer by you or your Spouse for the Coverage Period.

The Claims Administrator will pay Benefits under this Program directly to you or, in the Claims Administrator’s discretion, directly to the service provider. *However, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Dependent Care Reimbursement Program Claims Administrator.*
A claim for the reimbursement of Employment-Related Dependent Care Expenses Incurred in any Coverage Period will be decided within a reasonable time after it is received. However, if a Participant fails to submit a properly executed claim form within the claim filing deadline, the Claims Administrator will not consider the claim. The claim filing deadline is: within 90 days after the close of the Coverage Period for active Employees and 90 days from the last date of employment for terminated Employees.

The Claims Administrator will deem a claim to have been submitted when the Claims Administrator receives the claim form. However, if a claim form is filed by U.S. Postal Service, the Claims Administrator will deem it to have been submitted on the date of the United States postmark stamped on the envelope in which the claim form is mailed. Claims will be decided in accordance with the rules in Article V.

Notwithstanding the foregoing, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Dependent Care Reimbursement Program Claims Administrator.

Debit or Credit Card Usage for Obtaining Covered Services. The Employer may contract with the Claims Administrator to allow you to use a debit or credit card to access your Dependent Care Reimbursement Account. This allows you, where you obtain a service from a provider that is willing to accept such debit or credit card transactions, to avoid having to pay cash for the service, and then seek reimbursement from the Claims Administrator. However, your use of a debit or credit card would be subject to specific and mandatory requirements imposed by the Claims Administrator, including (among other things), “after-the-fact” documentation or substantiation of the expense in some cases.

Non-discrimination Requirements. It is the intent of this Dependent Care Reimbursement Program that:

- contributions or Benefits not discriminate in favor of Highly Compensated Employees or their Dependents, as prohibited by Code Section 129(d), and

- not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Coverage Period 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 Coverage Period) owns more than 5 percent of the stock or the capital or profits interest in the Employer.

If the Claims Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Employees (as defined under Article VIII) or to principal shareholders or owners as described above, it may reject any completed enrollment or reduce contributions or non-taxable benefits in order to assure compliance with these rules. Any act taken by the Claims Administrator under these rules will be carried out in a uniform and non-discriminatory manner. If the Claims Administrator decides to reject any completed enrollment or reduce contributions or Benefits, it will be done in the following manner. First, the Benefits designated for the account under this Program of the Highly Compensated Employee that elected to contribute the highest amount to such account for the Coverage Period will be reduced until the non-discrimination tests set forth in these rules are satisfied, or until the amount designated for the account equals the amount designated for the account of the Highly Compensated Employee who has elected the second highest contribution to an account under this Program for the Coverage Period. This process will continue until the non-discrimination tests described above are satisfied.
Coordination with Flexible Benefits Plan. All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Dependent Care Reimbursement Program. The enrollment and termination of participation under the Flexible Benefits Plan will constitute enrollment and termination of participation under this Dependent Care Reimbursement Program. In addition, other matters concerning contributions, enrollments and the like will be governed by the general provisions of the Flexible Benefits Plan.

What You Should Know — Comparison of the Dependent Care Reimbursement Program and the Dependent Care Tax Credit. Many people find it necessary to pay for the care of their children or other Dependents so that they can work outside of the home. If that is your situation, you may be eligible for certain tax benefits provided in the Code. This subsection describes two of those benefits, so that you can judge which would be best suited to your own circumstances.

The Code helps you to pay for Dependent care Expenses in two different ways. First, it may be possible to exclude from your taxable income a portion of the Dependent Care Expenses you Incurred. Second, you may receive a credit against your taxes equal to a portion of such expenses. Although the exclusion and credit are calculated in entirely different ways, they are both subject to essentially the same eligibility requirements. Moreover, the Dependent Care Expenses to which each applies are limited to the Earned Income of you or your Spouse, whichever is smaller. These requirements and limitations are described in earlier sections of this Appendix. The remainder of this discussion will assume that you are eligible for at least a certain level of both such benefits.

Dependent Care Exclusion. You will note that the dependent care exclusion is described in earlier sections of this Appendix. The exclusion works like this. You elect to have the Employer withhold a portion of your Compensation each month and contribute that amount to your account under this Plan’s Dependent Care Reimbursement Program. Those amounts, up to the maximum set forth in this Appendix, may be used to pay for the expenses of Dependent Care, and are then excluded from the amount of compensation reported on your Form W-2. In other words, this would not be a deduction (which you would have to itemize on your income tax return), but would simply never be considered a part of your income.

The actual benefit of such a dependent care exclusion would depend on your income tax bracket. For example, if you were in a 15% tax bracket, the monetary benefit of a $5,000 dependent care exclusion would be 15% of that amount, or $750. If you were in a 28% bracket you would receive a $1,400 benefit from the full $5,000 exclusion.

Dependent Care Credit. The dependent care credit is entirely different from the exclusion described above. A credit is applied directly against the amount of taxes you would otherwise pay at the end of the year. To calculate the estimated credit, you must know your tax bracket, your adjusted gross income, how much you spend on daycare and how many Qualified Dependents you have.

For additional assistance in deciding whether to elect to participate in the Plan’s Dependent Care Assistance Benefit, to claim the Dependent Care Credit, or both, please consult your tax advisor.
APPENDIX C
HEALTH INSURANCE PORTABILITY
AND ACCOUNTABILITY ACT OF 1996
PRIVACY & SECURITY REQUIREMENTS

INTRODUCTION
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to Covered Persons remains confidential, subject to limited exceptions in which PHI may be disclosed. “Protected Health Information” means health information (including oral information) that:

- is created or received by health care providers, health plans or health care clearinghouses;
- relates to an individual’s past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and
- identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

HIPAA also imposes special requirements upon the Plan and the Employer with respect to electronic PHI ("ePHI"). Electronic PHI is PHI, as defined above, that is transmitted by or maintained in “electronic media”, as that term is defined in federal regulations, specifically 45 C.F.R. § 160.103.

EFFECTIVE DATE
The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy and Security regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan.

DISCLOSURES OF PHI/ePHI BY THE PLAN TO THE EMPLOYER
The Plan (or the Employer on behalf of the Plan) provides to Covered Persons a HIPAA Privacy Notice that, among other things, the Plan may disclose PHI/ePHI (relating to a Covered Person) to the Employer, as further described below, without the consent or authorization of the Covered Person. In no event may the Plan disclose PHI/ePHI to the Employer, without the consent or authorization of the Covered Person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (although the Plan may disclose summary ePHI or enrollment-related ePHI to the Employer, without authorization, as further described below).

The Plan may disclose PHI/ePHI to the Employer, without the consent or authorization of the Covered Person, subject to the Employer’s obligations described below (in the sections titled, Employer Obligations with Respect to PHI Obtained from the Plan and Additional Employer Obligations with Respect to ePHI Obtained from the Plan) for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, accounting, auditing and monitoring. However, only the minimum amount of PHI/ePHI necessary to accomplish a particular Plan administrative function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI/ePHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information, including electronic summary health information, to the Employer, without the consent or authorization of the Covered Person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. “Summary health information” is health information that
summarizes claims history, expenses or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information, including electronic enrollment and disenrollment information, to the Employer without the consent or authorization of the Covered Person.

**EMPLOYER OBLIGATIONS WITH RESPECT TO PHI OBTAINED FROM THE PLAN**

As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Person to whom the PHI relates;
- ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;
- not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the Covered Person to whom the PHI relates;
- report to the Plan any improper uses or disclosures of the PHI;
- provide Covered Persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);
- make available to appropriate federal authorities the Employer’s internal practices, books and records relating to the use and disclosure of PHI received from the Plan; and
- return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer’s need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

**ADDITIONAL EMPLOYER OBLIGATIONS WITH RESPECT TO ePHI OBTAINED FROM THE PLAN**

As a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan;
- ensure that the adequate separation (as required by 45 C.F.R. § 164.504(f)(2)(iii)), between the ePHI and persons who have no legitimate need to access such ePHI, is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- report to the Plan any security incident of which it becomes aware.

**USE AND DISCLOSURE OF PHI BY THE EMPLOYER; DISPUTE RESOLUTION**

When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to the Employee Benefits Department of the Employer, and may also be provided to the Employer’s payroll department (for purposes of processing payroll deductions for payment of premium) and chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the Covered Person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.
The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in the section above titled, *Disclosures of PHI by the Plan to the Employer*. The Employer may also disclose PHI relating to a Covered Person, without the consent or authorization of the Covered Person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the Covered Person, to law enforcement, public health, and judicial agencies in certain circumstances. PHI pertaining to a minor Covered Person may, to the extent permitted by local law, be disclosed to the Covered Person’s parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the Covered Person’s consent. For more information please review the Plan’s Privacy Notice or see the Plan’s Privacy Official.

In the event a Covered Person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer’s Privacy Official (contact the Employee Benefits Department for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan’s Privacy Notice, a copy of which you should have already received (an additional copy is available from the Employee Benefits Department). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer’s Privacy Policy and Procedure.