Execution Version

TEAM, INC.

CAFETERIA BENEFIT PLAN

(Amended and Restated Effective as of January 1, 2020)

TABLE OF CONTENTS

Page No.

TEAM, INC.
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(Amended and Restated Effective as of January 1, 2020)

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PREAMBLE

The purpose of this document is to set forth the "Team, Inc. Cafeteria Benefit Plan" (the "**Plan**"). The Plan is hereby amended and restated effective as of January 1, 2020 (the "**Effective Date**").

The Plan is a flexible arrangement with optional welfare benefits available for selection by Participants. The purpose of the Plan is to permit Participants to elect to reduce their compensation and to choose among cash or coverages available under the welfare benefit options provided by the Employer. The Plan is maintained for the exclusive benefit of Eligible Employees, and the terms and provisions of the Plan are intended to be legally enforceable by Eligible Employees.

The Plan is intended to qualify as a "cafeteria plan", as described in Section 125 of the Internal Revenue Code of 1986, as amended (the "**Code**"). The Plan also contains a dependent care assistance program as described in Section 129 of the Code, a health flexible spending arrangement as described in Section 105(h) of the Code and Proposed Treasury Regulation Section 1.125-5. The Plan also provides for the funding of (i) pre-tax salary reduction contributions and (ii) employer non-elective contributions to Participants' individual "health savings accounts", as described in Code Section 223. The Plan is to be interpreted in a manner consistent with the requirements of applicable sections of the Code and the regulations and other authority issued thereunder.

It is intended that this Plan meet all applicable requirements of the Code and the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**") and the regulations and other authority issued thereunder. ERISA does not apply to the Dependent Care Flexible Spending Account (Article III) or the Health Savings Account Funding portion of the Plan (Article V). The Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any term or provision of this Plan and the Code and/or ERISA, as applicable, the term or provision of the Code or ERISA shall be deemed controlling, and the conflicting term or provision of this Plan shall be deemed superseded only to the extent of such conflict as determined by the Plan Administrator.

The capitalized terms used in this Plan document shall have the meaning set forth herein; provided, however, the definitions of certain capitalized terms contained in this preamble are provided solely for convenience of reference within this preamble.

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TEAM, INC.
CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2020)

W I T N E S S E T H:

WHEREAS, Team, Inc. (the "**Plan Sponsor**") maintains the Plan for the benefit of the Eligible Employees of the Plan Sponsor and the other adopting Employers; and

WHEREAS, the Plan Sponsor now desires to amend and restate the Plan, effective as of January 1, 2020 (unless otherwise specifically stated herein), under the form of this Plan document, to make such changes as deemed necessary or advisable; and

WHEREAS, it is intended that the benefits offered under the Plan will help retain and attract highly qualified employees by providing health and other welfare benefits on a tax-advantageous basis;

NOW, THEREFORE, RESOLVED, the Plan Sponsor hereby amends and restates the Plan, without a gap or lapse in coverage, effective as of January 1, 2020 (unless otherwise specifically stated herein), under the form of this document, which Plan is intended to continue to meet the requirements for a cafeteria plan under Section 125 of the Code and regulations issued thereunder; and

FURTHER RESOLVED, the Plan Sponsor enters into this amended and restated Plan, as follows:

ARTICLE I.
DEFINITIONS AND CONSTRUCTION

***Note:** As used in this Plan, the following words and phrases have the meanings set forth below unless the context clearly indicates otherwise and, wherever appropriate, the singular includes the plural and vice-versa, and the use of either gender shall include the other gender.*

1.1 Active Service means, as to any Employee, a period of service with an Employer beginning on the Employee's employment commencement date or reemployment commencement date, whichever is applicable, and ending on his severance from service date as determined by the Plan Sponsor. "Employment commencement date" and "reemployment commencement date" shall mean, respectively, the dates on which the Employee first performs an hour of service as an Employee initially and following a severance of service with an Employer.

1.2 Affiliated Employer means (a) an employer which is a member of the same controlled group of corporations (within the meaning of Code Section 414(b)), or which is a trade or business (whether or not incorporated) which is under common control (within the meaning of Code Section 414(c)), or which is a member of an affiliated service group of employers (within the meaning of Code Section 414(m)), which related group of corporations, businesses or employers includes the Employer, and (b) any other entity required to be aggregated with the Employer pursuant to regulations under Section 414(o) of the Code.

1.3 Affordable Care Act means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and the authoritative guidance issued thereunder by the appropriate governmental entities.

1.4 Benefit Cost means the Participant's portion of the premium or other cost, as determined by the Plan Sponsor, for coverage under a Covered Benefit.

1.5 Benefits Appendix means the "Covered Benefits Appendix" attached hereto and made a part of the Plan, as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Plan.

1.6 Board means the Board of Directors (or equivalent governing authority) of the Plan Sponsor.

1.7 Carryover Balance means any positive balance, not in excess of $550, remaining in a Participant's Cash Account following final payment of all proper claims for Medical Care Expenses incurred during a Plan Year (*i.e.*, the "**original year**"). The Carryover Balance shall be available to reimburse or pay claims for Medical Care Expenses incurred by the Participant or his Spouse or Dependent during the immediately following Plan Year (*i.e.*, the "**carryover year**").

A Participant's Carryover Balance attributable to the original year will be applied to a Health Care Flexible Spending Account in the carryover year as follows:

(a) If the Participant is an HSA-Covered Employee as of the first day of the carryover year, his Carryover Balance will automatically be forfeited; or

(b) If the Participant is not an HSA-Covered Employee as of the first day of the carryover year, his Carryover Balance will automatically be applied to a Health Care Flexible Spending Account (and the Participant will be deemed to have elected a Health Care Flexible Spending Account) for the carryover year.

1.8 Cash Account means the separate subaccount of a Health Care Flexible Spending Account that is credited with contributions made to the Plan on behalf of the Participant pursuant to his Medical Conversion Agreement during the Period of Coverage or, in the case of a former Employee who elects COBRA coverage pursuant to Section 4.13 (to the extent the Health Care Flexible Spending Account portion of the Plan is subject to COBRA), with other contributions made to the Plan by such former Employee during the Period of Coverage. The Cash Account shall also include the amount, if any, of the Participant's Carryover Balance from the prior Plan Year.

1.9 CEO means the then current Chief Executive Officer of the Plan Sponsor.

1.10 Claims Administrator means the person or entity that has been retained by the Plan Administrator to provide claims processing and other administrative services as the Plan Sponsor or Plan Administrator may from time to time deem necessary or appropriate for the operation of the Plan. The Claims Administrator shall accept, hold, account for, and disburse contributions in a fiduciary capacity in accordance with the terms and provisions of the Plan.

1.11 COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, as codified in Section 4980B of the Code and Title I, Part 6 of ERISA.

1.12 Code means the Internal Revenue Code of 1986, as amended, and regulations and other authority issued thereunder by the appropriate governmental authority. References to any section of the Code or the Income Tax Regulations shall include reference to any successor section or provision of the Code or Income Tax Regulations, as applicable.

1.13 Compensation means remuneration received during the Plan Year by the Employee from the Employer which is required to be reported as wages on the Employee's form W-2 (or its successor) for federal income tax withholding purposes. Compensation shall be determined without taking into account pre-tax contributions made by the Participant under the Plan (or another cafeteria plan described in Section 125 of the Code), or any compensation deferral agreement under a plan described in Section 401(k) or 403(b) of the Code.

1.14 Coverage Account means the separate subaccount of a Health Care Flexible Spending Account that is credited as of the beginning of each Period of Coverage with the maximum amount of coverage that the Participant has elected for such Period of Coverage pursuant to his Medical Conversion Agreement, plus the amount, if any, of the Participant's Carryover Balance from the prior Plan Year.

1.15 Covered Benefits Agreement means (a) an agreement, (b) in a written or electronic form satisfactory to the Plan Sponsor, (c) by and between the Employer and an Eligible Employee, (d) entered into prior to an applicable Period of Coverage, and (e) pursuant to which the Eligible Employee agrees (i) to participate in the Covered Benefits portion of the Plan under the terms and conditions thereof and (ii) to a pre-tax reduction in Compensation to be applied towards the

Employee's Benefit Cost for the Covered Benefits selected by the Eligible Employee. To the extent that applicable law requires the Eligible Employee to authorize in writing any such reduction in Compensation, the Eligible Employee's posting of the Covered Benefits Agreement in electronic form to the Plan's online enrollment system in accordance with the Plan's procedures shall serve as the requisite written authorization. The Covered Benefits Agreement and Covered Benefits election form shall be a part of the Plan's written or electronic application form.

When used in reference to all Covered Benefits under the Plan (including the Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Health Savings Account Funding portions of the Plan), the term "Covered Benefits Agreement" shall also mean the Medical Conversion Agreement, the Dependent Conversion Agreement, and the HSA Funding Agreement, as applicable in context.

1.16 Covered Benefit means a Qualified Benefit that is available under the Plan during a Period of Coverage, as set forth in the Benefits Appendix.

1.17 Dependent means an individual who qualifies as a federal income tax dependent of the Participant, as defined in Section 152 of the Code, with the following exceptions:

(a) For purposes of accident or health coverage (as described in Code Sections 105(b) or 106) under a Covered Benefit, the term "Dependent" means an individual who qualifies as a dependent of the Participant under Code Sections 105(b) and 106, as amended by the Affordable Care Act; and

(b) For purposes of the Dependent Care Flexible Spending Account portion of the Plan, the term "Dependent" means a Qualifying Individual.

The Plan Administrator and/or Claims Administrator each reserve the right to require evidence from a Participant of an individual's status as a "Dependent". If the Plan Administrator and/or Claims Administrator so requires, the Participant must provide such evidence to the Plan Administrator and/or the Claims Administrator (or the delegate of either) in the form and manner, and within the timeframe, specified by the Plan Administrator and/or the Claims Administrator (or the delegate of either). Such evidence may include, but is not limited to, certifications, affidavits or other written or electronic documentation. The Plan Administrator and/or the Claims Administrator (or the delegate of either) shall determine, in its or their discretion, whether such evidence reasonably substantiates such individual's status as a "Dependent" under the Plan.

Nothing in this Section 1.17 is intended to restrict or enlarge the definition of "Dependent" established by any Qualified Benefit offered under the Plan.

1.18 Dependent Care Assistance means, in accordance with Section 129(e)(1) of the Code, the payment or reimbursement for, or provision of, those services which are considered Employment-Related Expenses.

1.19 Dependent Care Center means, in accordance with Section 21(b)(2)(D) of the Code, any facility which (a) provides care for more than six (6) individuals (other than individuals who reside at the facility), and (b) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

1.20 Dependent Care Flexible Spending Account means the bookkeeping account maintained by the Claims Administrator for each Period of Coverage, in the name of each Participant who has elected to participate in the Dependent Care Flexible Spending Account portion of the Plan, for the purpose of accounting for (a) the amounts periodically contributed by such Participant pursuant to a Dependent Conversion Agreement, and (b) amounts reimbursed to, or paid on behalf of, the Participant for Employment-Related Expenses.

1.21 Dependent Care Service Provider means a person, Dependent Care Center, or other entity which provides Dependent Care Assistance; provided, however, in accordance with Section 129(c) of the Code, such term (for the taxable year of the Participant) shall not include an individual (a) with respect to whom a deduction is allowable for such taxable year under Section 151(c) of the Code (relating to personal exemptions for dependents) to such Participant or to his Spouse, or (b) who is a child of such Participant (within the meaning of Section 152(f)(1) of the Code) under the age of 19 at the close of such taxable year.

1.22 Dependent Conversion Agreement means (a) an agreement, (b) in a written or electronic form satisfactory to the Plan Sponsor, (c) by and between the Employer and an Eligible Employee, (d) entered into prior to the applicable Period of Coverage, and (e) pursuant to which such Eligible Employee agrees (i) to participate in the Dependent Care Flexible Spending Account portion of the Plan under the terms and conditions thereof and (ii) to a pre-tax reduction in Compensation to be credited to his Dependent Care Flexible Spending Account for purposes of reimbursement of Employment-Related Expenses. To the extent that applicable law requires the Eligible Employee to authorize in writing any such reduction in Compensation, the Eligible Employee's posting of the Dependent Conversion Agreement in electronic form to the Plan's online enrollment system in accordance with the Plan's procedures shall serve as the requisite written authorization. The Dependent Conversion Agreement may be part of the enrollment form.

1.23 Earned Income means, in accordance with Section 129(e)(2) of the Code, "earned income" as defined in Section 32(c)(2) of the Code to generally mean the Participant's wages, salaries, tips and other employee compensation, plus any net earnings from self-employment, but excluding any amounts paid or reimbursed, or incurred, by an Employer for Dependent Care Assistance provided on behalf of a Participant.

1.24 Effective Date means January 1, 2020, the effective date of the Plan as amended and restated.

1.25 Electronic Protected Health Information or EPHI means individually identifiable health information that is created or received by the Health Care Flexible Spending Account portion of the Plan and transmitted by or maintained in electronic media.

1.26 Eligible Employee means an Employee who has satisfied the conditions for eligibility to participate in the Covered Benefits, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, or Health Savings Account Funding portions of the Plan in accordance with Sections 2.1, 3.1, 4.1, or 5.1, as applicable.

1.27 Employee means any individual who is considered to be in an employer-employee relationship with the Employer on the payroll records of the Employer for purposes of federal income tax withholding. The term "Employee" shall not include any person during any period

that such person was classified on the Employer's records as other than an Employee. For example, "Employee" shall not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee, temporary employee or similar classification, regardless of a determination by a governmental agency that any such person is or was a common law employee of an Employer.

For purposes of this definition, (i) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Code Section 414(n)(2), whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party, (ii) an "independent contractor" means any person rendering service directly or indirectly to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on IRS Form 1099 (or its successor), and (iii) a "contract employee" means a person who is employed by a third-party entity which is retained by the Employer through a contract for services, pursuant to which such person indirectly renders services to, or for the benefit of, the Employer.

Furthermore, employees who are non-resident aliens and who receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) shall not be considered Employees for purposes of the Plan.

1.28 Employer means the Plan Sponsor and any other entity that adopts the Plan pursuant to applicable provisions of the Plan, or any successor organization of an Employer that assumes the obligations of a prior Employer under the Plan. The adopting Employers of the Plan shall be listed in the Adopting Employers Appendix (attached hereto), as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Plan.

1.29 Employment-Related Expenses means amounts paid or payable to a Dependent Care Service Provider for (a) household services or (b) the care of a Qualifying Individual, but only if such expenses were incurred to enable the Participant to be gainfully employed for any period for which there is at least one Qualifying Individual with respect to the Participant.

Notwithstanding the immediately preceding paragraph, Employment-Related Expenses that are incurred for services outside of the Participant's household shall be taken into account only if incurred for the care of (a) a Qualifying Individual who is a "qualifying child" dependent of the Participant, as defined in Section 152(a)(1) of the Code, under the age of thirteen (13), or (b) another Qualifying Individual of the Participant (other than a child described in clause (a) above) who regularly spends at least eight (8) hours each day in the Participant's household; provided, however, (i) Employment-Related Expenses that are incurred for services provided outside of the Participant's household by a Dependent Care Center shall be taken into account only if such center complies with all applicable laws and regulations of a State or unit of local government, and (ii) the term Employment-Related Expenses shall not include any amount paid for services outside of the Participant's household at a camp where the Qualifying Individual stays overnight.

The above definition is intended to comply with the requirements of Section 21(b)(2) of the Code. To the extent that any portion of the above definition is inconsistent with the preceding sentence, such provision shall be deemed to be inoperative and the Plan shall be operated in a

manner which complies with the requirements of the preceding sentence.

1.30 Entry Date means the first day of the Plan Year or, for an Employee who first satisfies the requirements for eligibility during a Plan Year, the Entry Date shall be the date on which the Employee's participation in the respective Covered Benefit commences.

1.31 ERISA means the Employee Retirement Income Security Act of 1974, as amended, and regulations and other authority issued hereunder by the appropriate governmental authority. References to any section of ERISA shall include reference to any successor section or provision of ERISA.

1.32 FMLA means the federal Family and Medical Leave Act of 1993, as amended from time to time.

1.33 Grace Period means the period that begins immediately following the close of the Plan Year and ends on the end of the day that is two (2) months and fifteen (15) days after the close of that Plan Year (March 15 for a calendar year Plan Year), during which a Participant may incur eligible Employment-Related Expenses pursuant to Section 3.10.

1.34 Health Care Flexible Spending Account means the health care flexible spending account which is a bookkeeping account maintained by the Claims Administrator for each Period of Coverage, in the name of each Participant who has elected to participate in the Health Care Flexible Spending Account portion of the Plan (set forth in Article IV hereof), for the purpose of accounting for the (a) amount of coverage elected by such Participant, (b) the amounts periodically contributed by the Participant pursuant to a Medical Conversion Agreement, and (c) the amounts reimbursed to, or paid on behalf of, the Participant for Medical Care Expenses. In accordance with Section 4.7, the Health Care Flexible Spending Account shall be segregated into two subaccounts, the Coverage Account and the Cash Account.

1.35 Health Savings Account or HSA means a health savings account established under Code Section 223 by a Participant. The funding of contributions to an HSA is offered as a Covered Benefit under the Plan. No HSA itself is a Covered Benefit under the Plan.

1.36 Health Savings Account Funding means making a contribution to an HSA as a Covered Benefit under the Plan.

1.37 High Deductible Health Plan means the "high deductible health plan", as defined in Code Section 223(c)(2), that is sponsored by the Employer and is a Covered Benefit.

1.38 Highly Compensated Employee means an Employee who:

(a) was at any time a 5-percent owner (as defined in Section 416(i)(1) of the Code) during the Plan Year for which the determination is being made (the "determination year") or during the 12-month period immediately preceding the Plan Year (the "look-back year"); or

(b) received compensation (described below) from the Employer in excess of $125,000 (as adjusted at such time and in such manner as prescribed under Sections 414(q)

and 415(d) of the Code) during the look-back year.

If the Plan Sponsor so elects for a Plan Year, the group described in clause (b) shall be limited to the top-paid group of Employees consisting of the top 20-percent of the Employees when ranked on the basis of compensation paid during the look-back year.

For purposes of this Section 1.37, "compensation" shall mean wages (as defined in Section 3401(a) of the Code for purposes of income tax withholding at the source) that are paid (within the meaning of Section 1.415-2(d)(3) and (4) of the Income Tax Regulations) to the Employee by the Employer during the Plan Year for services performed and reportable on the Employee's form W-2, but determined without regard to any rules that limit the remuneration included in wages based on the nature and location of the employment or the services performed (such as the exception for agricultural labor in Section 3401(a)(2) of the Code), but including elective or salary reduction contributions to (a) cafeteria plans under Section 125 of the Code, (b) cash or deferred arrangements under Section 402(g)(3) of the Code, including "401(k) plans", "403(b) plans", "SIMPLE plans", "SIMPLE IRAs", and "SARSEPs", (c) qualified transportation fringe benefit plans under Section 132(f)(4) of the Code, and (d) deferred compensation plan of a state or local government or tax-exempt organization under Section 457 of the Code.

The rules of Section 414(b), (c), (m), (n) and (o) of the Code, relating to aggregation of entities under common ownership or control, shall be applied before the above provisions of this definition are applied. The rules described in the immediately preceding sentence do not apply for purposes of determining who is a 5-percent owner.

Notwithstanding any other provision of this Section, the determination of who is a Highly Compensated Employee shall be made in accordance with Section 414(q) of the Code for all Plan Years. Moreover, to the extent that the Employer participates in a 401(k) plan maintained by the Employer, the determination under this Plan as to whether any Employee is a Highly Compensated Employee shall be made in accordance with the terms of the 401(k) Plan.

1.39 Highly Compensated Individual means an individual who is:

(a) one of the five highest paid officers of the Employer;

(b) a shareholder of the Employer who owns (with the application of the constructive ownership rules of Section 318 of the Code) more than ten percent (10%) in value of the stock of the Employer; or

(c) among the highest paid twenty-five percent (25%) of all Employees (other than those Employees who are excluded from participation in the Plan pursuant to Section 2.1).

The above definition is intended to comply with the requirements of Section 105(h)(5) of the Code. To the extent that any portion of the above definition is inconsistent with the preceding sentence, such portion shall be deemed to be inoperative and the Plan shall be operated in a manner which complies with Section 105(h)(5) of the Code. The determination of who is a Highly Compensated Individual shall be made in accordance with the requirements of Section 105(h)(5) of the Code.

1.40 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

1.41 HSA-Covered Employee means an Employee who (a) is an HSA-Eligible Individual, (b) is covered under the High Deductible Health Plan, and (c) has established a Health Savings Account through the HSA Custodian.

1.42 HSA-Eligible Individual means an "eligible individual" for health savings account purposes, as defined in Section 223(c) of the Code. Whether an Employee is an HSA-Eligible Individual shall be based solely on the Employee's certification of his HSA eligibility status during the Plan's enrollment process. The Employee shall provide certification of his HSA eligibility status in a form and manner prescribed by the Plan Administrator; provided, however, the Plan Administrator shall have no obligation to verify the Employee's status as an HSA-Eligible Individual except to the extent of determining whether, as of the first day of a given month, the Employee is covered under the High Deductible Health Plan or a low deductible health plan(s) sponsored by an Employer that disqualifies the Employee from being an HSA-Eligible Individual.

1.43 HSA Custodian means the person or entity that has been designated by the Plan Sponsor to serve as the custodian of the HSAs which are (a) established by Participants in conjunction with participation in the Employer's High Deductible Health Plan, and (b) funded through participation in the Health Savings Account Funding portion of the Plan.

1.44 HSA Funding Agreement means (a) an agreement, (b) in a written or electronic form satisfactory to the Plan Sponsor, (c) by and between an Employer and an Eligible Employee, (d) entered into prior to the applicable Period of Coverage, and (e) pursuant to which such Employee agrees (i) to participate in the Health Savings Account Funding portion of the Plan (Article V) under the terms and conditions thereof and (ii) to a pre-tax reduction in Compensation to be applied towards the funding of contributions to the Employee's individual HSA maintained outside the Plan. To the extent that applicable law requires the Eligible Employee to authorize in writing any such reduction in Compensation, the Eligible Employee's posting of the HSA Funding Agreement in electronic form to the Plan's online enrollment system in accordance with the Plan's procedures shall serve as the requisite written authorization.

1.45 Key Employee means an Employee or former Employee (including any deceased Employee) who at any time during the Plan Year that includes the determination date was an officer of the Employer having annual compensation greater than $185,000 (as adjusted under Section 416(i)(1) of the Code), a 5-percent owner of the Employer, or a 1-percent owner of the Employer having annual compensation of more than $150,000. For purposes of this Section 1.37, annual compensation means compensation within the meaning of Section 415(c)(3) of the Code. The determination of who is a Key Employee will be made in accordance with Section 416(i)(1) of the Code and the applicable regulations and other guidance of general applicability issued thereunder.

The above definition is intended to comply with the requirements of Section 416(i)(1) of the Code. To the extent that any portion of the above definition is more restrictive than or inconsistent with Section 416(i)(1) of the Code, such provision shall be deemed to be inoperative and the Plan shall be operated in a manner which complies with the requirements of Section 416(i)(1) of the Code. The determination of who is a Key Employee shall be made in

accordance with the requirements of Section 416(i)(1) of the Code.

1.46 Medical Care Expense means, in accordance with Section 105(b) of the Code and Article IV of the Plan, expenses incurred by the Participant, or by a Spouse or Dependent of the Participant, for "medical care," as defined in Section 213(d) of the Code as follows:

(a) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,

(b) for transportation primarily for and essential to medical care referred to in (a) above, and

(c) lodging (not lavish or extravagant under the circumstances) while away from home primarily for and essential to medical care referred to in (a) above shall be treated as amounts paid for medical care if --

(1) the medical care referred to in (a) is provided by a physician in a licensed hospital (or in a medical care facility which is related to, or the equivalent of, a licensed hospital), and

(2) there is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

Expenses paid for cosmetic surgery or other similar procedures are not eligible Medical Care Expenses, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. For purposes of the previous sentence, cosmetic surgery is defined as any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. For purposes of clarity, any expenses that are required to be covered under a group health plan for mastectomy-related services including reconstructions and surgery to achieve symmetry between the breasts, as required by the Women's Health and Cancer Rights Act of 1998, are not considered cosmetic surgery and thus will be Medical Care Expenses to the extent they otherwise qualify under this definition.

The above definition is intended to comply with the requirements of Section 213(d) of the Code, without regard to Section 213(d)(1)(D) of the Code which pertains to insurance covering medical care referred to in clauses (a) and (b) of the first paragraph of this Section. To the extent that any portion of the above definition of Medical Care Expenses is inconsistent with the preceding sentence, such portion shall be deemed to be inoperative and the Plan shall be operated in a manner which complies with the requirements of the preceding sentence.

Notwithstanding the foregoing, effective as of January 1, 2020, expenses incurred for a medicine or drug are eligible Medical Care Expenses even if such medicine or drug does not require a prescription (as defined below). Expenses incurred for medicines or drugs may be paid or reimbursed by the Health Care Flexible Spending Account portion of the Plan regardless of whether the medicine or drug is available without a prescription (*e.g.*, an over-the-counter medicine or drug). In addition, expenses incurred for menstrual care products (as defined in

Section 223(d)(2)(D) of the Code) shall be treated as Medical Care Expenses.

A "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

In accordance with Section 1.125-2 of the Income Tax Regulations, the Plan shall not treat Participants' contributions or premium payments for other health coverage as Medical Care Expenses; therefore, the Plan shall not reimburse Participants for contributions or premiums paid for other health coverage, including contributions or premiums paid for health coverage under a plan maintained by the employer of either a Spouse or Dependent of the Participant.

1.47 Medical Conversion Agreement means (a) an agreement, (b) in a written or electronic form satisfactory to the Plan Sponsor, (c) by and between an Employer and an Eligible Employee, (d) entered into prior to the applicable Period of Coverage, and (e) pursuant to which such Employee agrees (i) to participate in the Health Care Flexible Spending Account portion of the Plan (Article IV) under the terms and conditions thereof and (ii) to a pre-tax reduction in Compensation to be credited to his Health Care Flexible Spending Account for purposes of purchasing a pre-determined amount of coverage to be used for reimbursement of Medical Care Expenses. To the extent that applicable law requires the Eligible Employee to authorize in writing any such reduction in Compensation, the Eligible Employee's posting of the Medical Conversion Agreement in electronic form to the Plan's online enrollment system in accordance with the Plan's procedures shall serve as the requisite written authorization. An Eligible Employee's election of coverage under a Health Care Flexible Spending Account shall be effective for the full Period of Coverage to which the election pertains.

1.48 Officer means any then-current Vice President or higher level officer of the Plan Sponsor.

1.49 Participant means an Eligible Employee who is participating in the Plan for a Period of Coverage and whose participation has not ceased in accordance with applicable provisions of the Plan.

1.50 Period of Coverage means the Plan Year during which Covered Benefits are available to and elected by an Eligible Employee; provided, however, the Period of Coverage for an Employee who first becomes an Eligible Employee during a Plan Year (or for an Employee who recommences participation during a Plan Year) shall be the interval commencing on such Employee's Entry Date and ending on the last day of the Plan Year. A Period of Coverage may be terminated prior to the end of a Plan Year for a Participant whose participation has ceased in accordance with applicable provisions of the Plan.

1.51 Plan means the Team, Inc. Cafeteria Benefit Plan, as maintained by the Plan Sponsor pursuant to this document, any and all appendices, exhibits or documents that may be incorporated and made a part hereof by reference, and any amendments that may be made to the Plan from time to time.

1.52 Plan Administrator means the Plan Sponsor, which has the authority and responsibility to manage and direct the operation of the Plan in its discretion. Subject to Section 6.3 the day-to-day administration of the Plan shall be the responsibility of the Plan Administrator. The Plan

Administrator may assign or delegate duties to third parties, such as the Claims Administrator, under the terms of the Plan or by means of a separate written agreement. References herein to the Plan Administrator shall also include, when appropriate, any Claims Administrator or other person or entity who has been delegated the appropriate authority by the Plan Administrator in accordance with Section 6.3.

1.53 Plan Sponsor means Team, Inc., or any successor thereto which continues the Plan.

1.54 Plan Year means a calendar year ending on December 31. For an Employer that adopts the Plan during a Plan Year, the Employer shall be considered an adopting Employer under the Plan for the period beginning on the effective date of the adoption and ending on December 31, *i.e.*, the last day of the Plan Year, unless the Employer terminates its participation in the Plan before the end of the Plan Year.

1.55 Prior Plan Year Cash Balance means the amounts, if any, remaining in a Participant's Cash Account under his Dependent Care Flexible Spending Account as of the end of the Plan Year, from which claims for Employment-Related Expenses incurred during a Grace Period may be reimbursed or paid, as described in Section 3.10.

1.56 Privacy Regulations means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E, as promulgated under HIPAA. References to any section of the Privacy Regulations shall include any amendments or successor provision thereto.

1.57 Protected Health Information or PHI means information, including genetic information, that is created or received in connection with the Health Care Flexible Spending Account portion of the Plan (Article IV) which (a) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (b) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (c) is transmitted or maintained in any form or medium.

1.58 Qualified Benefit means a benefit offered to Participants under the Plan which, with the application of Section 125(a) of the Code, is not includible in the gross income of the affected Participants by reason of an express provision of Chapter 1 of the Code; provided, however, such term shall also include (a) any group-term life insurance which is includible in gross income only because it exceeds the dollar limitation of Section 79 of the Code, and (b) any other benefit permitted as a "qualified benefit" (whether or not includible in the gross income of the affected Participant) under regulations issued under Section 125 or other applicable sections of the Code. Qualifying accident or health plan coverage under Sections 105 and 106 of the Code, group-term life insurance coverage under Section 79 of the Code, and benefits under a dependent care assistance program under Section 129 of the Code will not fail to be Qualified Benefits merely because all or some portion of the value thereof is includible in a Participant's gross income solely because of the application of any nondiscrimination provision of the Code.

Insurance coverage of a type which would otherwise qualify as a Qualified Benefit shall not be a Qualified Benefit if such insurance coverage contains a savings or investment feature (e.g., whole life insurance). Except as specifically provided in regulations or other authority issued under

Section 125 of the Code, a benefit that defers the receipt of Compensation shall not be a Qualified Benefit. Furthermore, except to the extent otherwise provided in regulations or other authority issued by the appropriate governmental authority, the term Qualified Benefit shall not include any of the following:

(a) Qualified scholarships under Section 117 of the Code;

(b) Medical savings accounts under Section 106(b) of the Code;

(c) Education assistance programs under Section 127 of the Code;

(d) Fringe benefits under Section 132 of the Code;

(e) Meals or lodging furnished for the convenience of an Employer under Section 119 of the Code;

(f) Qualified group legal services as described in Code Section 120; and

(g) Long-term care insurance.

The above definition of Qualified Benefit is intended to comply with the requirements of Section 125(f) of the Code. To the extent that any portion of such definition is more restrictive than or inconsistent with the preceding sentence, such portion shall be deemed to be inoperative and the Plan shall be operated in a manner that complies with Section 125(f) of the Code.

1.59 Qualifying Individual means, in accordance with Code Section 21(b)(1), (a) a "qualifying child" dependent of the Participant for federal income tax purposes (as defined in Code Section 152(a)(1)), who is under the age of thirteen (13), (b) a federal income tax dependent of the Participant, as defined in Code Section 152, without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof, who is physically or mentally incapable of caring for himself and who has the same principal place of abode as the Participant for more than one-half of the taxable year of the Participant, or (c) the Spouse of the Participant, if such Spouse is physically or mentally incapable of caring for himself, and who has the same principal place of abode as the Participant for more than one-half of the taxable year of the Participant.

Notwithstanding the foregoing provisions of this Section 1.56, in the case of a divorced or separated Participant, such Participant's child shall be treated as a "Qualifying Individual" in accordance with Code Section 21(e)(5) (*i.e.*, a Qualifying Individual with respect to the custodial parent) for purposes of the Dependent Care Flexible Spending Account portion of the Plan.

1.60 Security Regulations means the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 160 and part 164, subpart C, as promulgated under HIPAA. References to any section of the Security Regulations shall include any amendments or successor provision thereto.

1.61 SPD means the Summary Plan Description of the Plan, including any appendices attached hereto, as amended from time to time.

1.62 Spouse means a person to whom an Employee is lawfully married, which marriage was

solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable Federal law (including, but not limited to, the Code and ERISA), and any regulations promulgated under such applicable Federal law, but will not include an individual separated from the Employee under a legal separation or divorce decree. The term "Spouse" shall also include a common law spouse if the Employee and spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. The Employee must provide proof of a ceremonial or common law marriage acceptable to the Plan Administrator if requested, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state.

1.63 USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

ARTICLE II.
COVERED BENEFITS

2.1 Requirements for Eligibility/Entry Date

An Employee shall be eligible to commence participation in the Covered Benefits portion of the Plan, as described in this Article II, on the Entry Date that such Employee is eligible to commence participation in any of the Covered Benefits described in the Benefits Appendix (other than the Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Health Savings Account Funding portions of the Plan). Subject to the last paragraph of Section 2.3, an Eligible Employee who is rehired by an Employer following a severance of employment with an Employer shall be eligible to participate in the Plan on the same date that such Employee is eligible to commence participation in any of the Covered Benefits described in the Benefits Appendix (other than the Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Health Savings Account Funding portions of the Plan). An Employee shall not be eligible to receive coverage under a Covered Benefit until he satisfies the eligibility and enrollment requirements for that particular Covered Benefit.

The eligibility requirements of the Plan shall not discriminate in favor of Highly Compensated Employees or Key Employees. The determination of an Employee's employment status shall be made by the Plan Sponsor in accordance with the standard employment practices of the Employer, which practices (a) shall be applied on a nondiscriminatory basis to similarly-situated Employees and (b) shall not discriminate in operation in favor of Highly Compensated Employees or Key Employees.

Without regard to whether service would be credited under the preceding paragraph, the Plan Administrator may recognize and credit, for all purposes of the Plan, the past service of an Employee with an organization even though such organization is not an Affiliated Employer and has not adopted the Plan. Any decision by the Plan Administrator to recognize and credit the past service of any Employee with any such organization (a) shall be made on a nondiscriminatory basis pursuant to rules consistently applied to similarly-situated Employees and (b) shall not discriminate in operation in favor of Highly Compensated Employees or Key Employees.

Notwithstanding the first paragraph of this Section, all Employees in the following categories of Employees shall be excluded from participation in the Plan:

(a) Employees who are included in a unit of Employees covered by a collective bargaining agreement between Employee representatives and one or more Employers, if (i) there is evidence that the type of benefits provided under the Covered Benefits portion of the Plan were the subject of good faith bargaining between the Employee representatives and such Employer and (ii) the collective bargaining agreement does not require the Employer to include such Employees in this portion of the Plan; provided, however, with respect to any unit of Employees covered by a collective bargaining agreement who are eligible to participate in this portion of the Plan as of the Effective Date, such Employees shall remain eligible to participate unless and until such Employees are no longer eligible to participate under the terms of the collective bargaining agreement. For purposes of the preceding sentence, the term "Employee representatives" shall not include any organization more than one-half of the members of which are Employees who are owners, officers or executives of the Employer; and

(b) Employees who are nonresident aliens and who receive no earned income (within the meaning of Section 911(d)(2) of the Code) from an Employer which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code).

Notwithstanding any other provision of the Plan to the contrary, (a) any individual who was considered by the Employer to be an independent contractor, but who is later reclassified as a common-law Employee (including any "leased employee" described in clause (b) below) with respect to any portion of the period in which such individual was paid by the Employer as an independent contractor, or (b) any "leased employee" (as defined in Section 414(n) of the Code), shall be excluded from participation in the Plan with respect to the period in which any individual described in clause (a) was considered to be an independent contractor, or the period in which any individual described in clause (b) is a leased employee.

2.2 Application to Participate

Upon initial satisfaction of the eligibility requirements of Section 2.1, the Plan Sponsor shall furnish information regarding the Plan to each Eligible Employee, including a description of the Covered Benefits and an application, in written or electronic form, to participate in the Plan. The initial application to participate must be completed by the Eligible Employee and returned to the Plan Sponsor (or if such application is electronic, posted to the Plan's online enrollment system in accordance with the Plan's procedures) within the time period designated and communicated by the Plan Sponsor and prior to the Entry Date on which the Eligible Employee would be eligible to commence participation in the Plan.

Thereafter prior to the beginning of each Plan Year, the Plan Sponsor shall furnish information regarding the Plan to each Eligible Employee, including a description of the Covered Benefits and a written or electronic application to participate in the Plan. Subject to the provisions of Section 2.9, which permit a continuing election, the application to participate must be completed and returned to the Plan Sponsor (or, if the application is electronic, posted online in accordance

with the Plan's procedures) during the annual enrollment period prior to the first day of the next Plan Year. The application to participate shall include a Covered Benefits Agreement and a Covered Benefits election form. The Eligible Employee shall also be required to furnish such other information and documentation as the Plan Sponsor deems to be necessary or appropriate for the administration of the Plan.

To the full extent permitted by law or regulation, an Eligible Employee upon executing such application to participate shall (a) be bound by all the terms, provisions, conditions, and limitations of the Plan, including any and all amendments, and any decision or determination made by the Plan Administrator or Claims Administrator with respect to the Participant's rights or entitlement to benefits under the Plan, (b) consent to, and fully and honestly respond to, inquiries by the Plan Administrator or Claims Administrator concerning any physician, hospital, or other provider of medical care or other goods or services involved in a claim under the Plan, and (c) submit to the Claims Administrator all bills, invoices, receipts, canceled checks, reports and other documentation or information which may be reasonably requested.

2.3 Termination of Participation

Except as provided in Article III regarding the Dependent Care Flexible Spending Account portion of the Plan, in Article IV regarding the Health Care Flexible Spending Account portion of the Plan, and in Article V regarding the Health Savings Account Funding portion of the Plan, a Participant will cease participation in the Plan for purposes of Covered Benefits on the earlier of:

(a) the effective date of termination of the Plan;

(b) the effective date on which the Participant validly revokes existing elections or does not make a required contribution to the Plan;

(c) the effective date on which the Plan is amended to terminate participation with respect to the class of Employees of which the Participant is a member;

(d) the first day of a Period of Coverage for which the Participant affirmatively elects not to participate in the Plan; or

(e) the date on which the Participant terminates employment for whatever reason or otherwise ceases to be eligible to participate in any of the Qualified Benefits.

Compensation reductions, pursuant to a Covered Benefits Agreement, shall cease as of the date of the Participant's termination of participation in the Plan. Pursuant to Section 2.5, coverage under a Covered Benefit that is a group health plan subject to COBRA may be continued subject to the terms and provisions of COBRA and the documents evidencing such Covered Benefit.

Subject to Section 4.11 for the Health Care Flexible Spending Account portion of the Plan, a former Participant shall once again become an Eligible Employee as of the date provided in Section 2.1; provided that, except with respect to the Health Savings Account Funding portion of the Plan, if a former Participant again becomes an Eligible Employee within thirty (30) days after his prior termination of employment and during the same Plan Year in which he previously ceased to be a Participant, such Eligible Employee may not make new benefit elections under the Plan for

the remainder of such Plan Year and, therefore, subject to Section 2.11, he may only continue his benefit election that was in effect at the time that he ceased to be a Participant earlier in the Plan Year. In such event, no "make-up" or retroactive contributions by the Participant shall be permitted. If a former Participant becomes an Eligible Employee more than thirty (30) days after his prior termination of employment, such Eligible Employee may make new benefit elections under the Plan for the remainder of such Plan Year. The provisions of this paragraph shall be construed in accordance with the requirements of the FMLA or USERRA when applicable.

2.4 Coverage while on FMLA or Other Unpaid Leave of Absence

Subject to Section 4.11 for the Health Care Flexible Spending Account portion of the Plan, in the event that a Participant is on an approved unpaid leave of absence to which he is entitled by reason of the FMLA, such Participant may elect to continue coverage under the Plan during such leave, provided that he continues to make payments (received not later than thirty (30) days after each monthly due date) of the amount of monthly contributions required for the same dollar amount of elected coverage as was in effect immediately before such leave. Such payments shall be made in accordance with one or more of the methods listed immediately below as arranged by the Participant with the Employer before the commencement of such leave. Such Participant's contributions may be made:

(a) At the Participant's option, before the commencement of such leave, on a pre-tax basis pursuant to his Covered Benefits Agreement, by increasing the amount of Compensation reduction for one or more pay periods before the commencement of such leave; or

(b) Directly by the Participant during the course of such leave, on an after-tax basis, with such contributions being due for each month of coverage on the first day of each month; or

(c) Pursuant to any other method in accordance with Section 1.125-3 of the Income Tax Regulations that is voluntarily agreed to between the Employer and the Participant, which may include catch-up payments by increased payroll deductions after the termination of such leave.

With respect to an Employee who participates in the Plan on a pre-tax basis, any payment option described in Section 1.125-3 of the Income Tax Regulations (or its successor) would be acceptable.

If a Participant goes on an unpaid leave of absence which is not pursuant to the FMLA as set out above, and such leave of absence does not affect the Participant's eligibility, then the Participant will continue to participate in the Plan and the contributions due must be paid by the Participant through after-tax contributions while on such leave.

A Participant will continue participation and pre-tax contribution payments during any paid leave of absence.

2.5 Continuation of Group Health Coverage under COBRA

Notwithstanding any provision of the Plan to the contrary, in the event that an Employer is required by COBRA to provide continuation coverage under an Employer-sponsored group health plan upon the occurrence of certain "qualifying events" described in COBRA which would otherwise result in a loss of coverage, then, to the extent that any Covered Benefit elected hereunder is subject to the continuation coverage provisions of COBRA, no provision of the Plan shall operate to deny the COBRA continuation coverage option for such Covered Benefit; provided, however, any person receiving COBRA continuation coverage shall do so on an "after tax" basis and not on a "pre-tax" basis pursuant to this Plan.

2.6 Covered Benefits Available for Selection by Participant

A Participant may elect (in accordance with the procedure set forth in Section 2.8 hereof) (a) one or more Qualified Benefits, which may be offered from time to time under the Plan, or (b) cash or a benefit treated as cash (as described in the next paragraph) which is offered under the Plan (collectively, the benefits described in clauses (a) and (b) which are offered under the Plan are referred to as the Covered Benefits).

As consistent with regulations and other authority issued under Section 125 of the Code, a benefit is treated as cash if such benefit does not defer the receipt of Compensation and an Employee who receives such benefit purchases it with after-tax Employee contributions or is treated, for all purposes of the Code (including, for example, reporting and withholding purposes) as receiving, at the time that such benefit is received, cash Compensation equal to the full value of such benefit at such time and then purchasing such benefit with after-tax Employee contributions.

Each Covered Benefit shall be described in the Benefits Appendix, which Appendix may be amended from time to time by the Plan Administrator. Covered Benefits may be added to or deleted from the Benefits Appendix by the Plan Administrator by revising the Benefits Appendix and without the need for a formal amendment to this Section or any other Section of the Plan.

The Covered Benefits described in the Benefits Appendix are various employee benefits plans or programs maintained by the Plan Sponsor under the Plan. A reference to a Covered Benefit in the Benefits Appendix shall include the benefit descriptions, types, amounts, options and coverage categories, the participation requirements, and such other terms, provisions, conditions, and limitations as are set forth in and are applicable to such Covered Benefit, all as evidenced by the separate documents, contracts and descriptive materials applicable to the Covered Benefit, as the same may be amended from time to time, which documents and materials are hereby incorporated by reference into the Plan.

The benefits available under the Covered Benefits portion of the Plan are the Covered Benefits available to Participants who are in a class of individuals eligible to participate in any such Covered Benefit and described in the Benefits Appendix. Whenever an Eligible Employee elects a Covered Benefit represented or evidenced by a separate policy or other document, such Employee's elected benefits shall be provided under the terms of such document.

2.7 Covered Benefit Costs

Certain of the coverage options and/or categories under the Covered Benefits available under the Plan have Benefit Costs per Period of Coverage. The Benefit Costs which are applicable

with respect to a particular Period of Coverage may be increased, decreased, or otherwise adjusted by the Employer after the commencement of such Period of Coverage. The Benefit Costs of the available Covered Benefits as in effect at the beginning of a Period of Coverage shall be communicated by the Employer to the Eligible Employees within a reasonable period of time prior to the commencement of such Period of Coverage.

2.8 Election of Benefits/Covered Benefits Agreement

An Eligible Employee may elect coverage under one or more of the Covered Benefits described in the Benefits Appendix prior to the first day of a Period of Coverage. Such election shall be made at the time and in the manner specified by the Plan Sponsor pursuant to non-discriminatory rules applied for such elections. The Employer shall provide to each Eligible Employee, prior to the applicable Period of Coverage, the necessary written or electronic election forms for electing coverage under the Plan, including a Covered Benefits Agreement whereby the Eligible Employee must agree to a reduction in Compensation equal to his aggregate Benefit Costs per payroll period for his selected Covered Benefits.

The Participant's Benefit Cost for each elected Covered Benefit pursuant to a Covered Benefits Agreement, shall be deemed (a) Employer contributions on behalf of such Participant to the extent of such Participant's Benefit Cost for any Covered Benefit which is a Qualified Benefit available on a pre-tax basis under applicable provisions of the Code, and (b) Employee contributions to the extent that such Participant's Benefit Cost for any Covered Benefit may not be provided on a pre-tax basis under clause (a) of this sentence. The portion of the Covered Benefits Agreement that applies to the portion of the Participant's Benefit Cost for each elected Covered Benefit which is a Qualified Benefit (available on a pre-tax basis) shall only apply to Compensation that the Participant has not actually or constructively received and which is not otherwise currently available to the Participant.

If a Participant elects any Covered Benefit which has a Benefit Cost, the Employer shall pay or forward an amount equal to such Benefit Cost to the appropriate person or entity from the amount of contributions designated by the Participant, pursuant to his Covered Benefits Agreement, and withheld from his Compensation. Generally, the Compensation reductions pursuant to a Covered Benefits Agreement shall be made in approximately equal amounts over the payroll periods applicable to the Participant during the Period of Coverage; provided, however, the Plan Administrator or its delegate, pursuant to nondiscriminatory rules, may provide for other Compensation reduction schedules corresponding to the Employer's various employment and/or payroll classifications.

The election forms utilized under the Plan should include the following directions or information:

(a) such forms must be (i) completed and signed by the Eligible Employee, if the forms are written, or (ii) posted online in accordance with the Plan's procedures, if the forms are electronic;

(b) completed forms must be returned to the Plan Sponsor (or posted online in accordance with the Plan's procedures) by their due dates, which due date shall be prior to (i), for the initial Period of Coverage of the Eligible Employee, his

applicable Entry Date and (ii), subject to Section 2.9, for subsequent Periods of Coverage, the first day of the Plan Year;

(c) the available options for reducing Compensation and electing desired levels of coverage or participation under selected Covered Benefits; and

(d) elections are irrevocable (except as provided in Sections 2.11, 3.3, 4.3 and 5.3).

2.9 Effect of Failure to Elect

The failure of an Eligible Employee, who did not elect to participate in the Plan during the immediately preceding Period of Coverage, to return the required Covered Benefits Agreement and/or the election forms to the Plan Sponsor (or if such Agreement/forms are electronic, to post them online in accordance with the Plan's procedures) by their due dates shall be deemed an express election and informed consent by the Eligible Employee to receive cash compensation as a benefit hereunder by reason of his failure to authorize a contribution for Covered Benefits in lieu of cash compensation, except for such deemed elections to enroll in any default coverage as specified by a Covered Benefit.

Except with respect to the Dependent Care Flexible Spending Account, Health Care Flexible Spending Account and Health Savings Account Funding portions of the Plan, the failure of an existing Participant to return the election forms by the due date for the next ensuing Period of Coverage shall be deemed an express and automatic election, and informed consent, by the Participant to receive the same Covered Benefits and same level and categories of coverage under his Covered Benefits Agreement and election forms as currently in effect and, moreover, the Participant shall be deemed to have automatically elected a Compensation conversion in such amount as is necessary to provide the same coverage that is in effect for the current Period of Coverage at the Benefit Costs in effect for the ensuing Period of Coverage. Notwithstanding the immediately preceding sentence, the Plan Sponsor may, in its discretion, require an affirmative enrollment for any particular Period of Coverage by announcing such requirement to Eligible Employees in advance of the election period, and, in such event, each Participant shall be required to return a completed election form (or if such form is electronic, to post it online in accordance with the Plan's procedures) by the due date in order to receive any Covered Benefits for that ensuing Period of Coverage.

With respect to elections under the Dependent Care Flexible Spending Account, Health Care Flexible Spending Account and Health Savings Account Funding portions of the Plan, for the next ensuing Period of Coverage, the Plan Sponsor shall require an existing Participant to return the completed and executed election form to the designated person by the designated due date for the next ensuing Period of Coverage with the stipulation that if he fails to do so, no employee contributions for that Period of Coverage shall be made to his Dependent Care Flexible Spending Account, Health Care Flexible Spending Account and/or Health Savings Account (subject to any mid-year enrollments permitted under the Plan). Any such new elections must thus be received and accepted by the person designated by the Plan Sponsor (or if the election form is electronic, posted online according to the Plan's procedures) on or before the designated due date prior to the start of the next Period of Coverage.

Notwithstanding the foregoing, a Participant's failure to make an election under the Health

Care Flexible Spending Account portion of the Plan for the next ensuing Period of Coverage shall not affect the availability of such Participant's Carryover Balance from the prior Plan Year to reimburse or pay claims for Medical Care Expenses incurred by the Participant or his Spouse or Dependent during such ensuing Period of Coverage, except as provided in (a) below. Furthermore, to the extent that a Participant has a Carryover Balance to be applied to a Health Care Flexible Spending Account with respect to the next ensuing Period of Coverage, then whether or not the Participant affirmatively elects coverage under the Health Care Flexible Spending Account portion of the Plan for such Period of Coverage:

(a) if the Participant is an HSA-Covered Employee as of the first day of such Period of Coverage, he will not be enrolled in a Health Care Flexible Spending Account for such Period of Coverage, and any Carryover Balance will be forfeited; and

(b) if the Participant is not an HSA-Covered Employee as of the first day of such Period of Coverage, he will automatically be enrolled in a Health Care Flexible Spending Account for such Period of Coverage.

2.10 Effect of Change in Cost of Benefits

Except with respect to the Dependent Care Flexible Spending Account, Health Care Flexible Spending Account and Health Savings Account Funding portions of the Plan, and to the extent consistent with applicable Treasury regulations, there shall be an automatic adjustment in the amount withheld for the Benefit Costs of the elected Covered Benefits in the event of a change, for whatever reason, during a Period of Coverage in the cost of providing such Covered Benefits. The automatic adjustment shall be equal to Participant's share of the increase or decrease in such cost, as determined by the Employer on a nondiscriminatory basis. The execution of a Covered Benefits Agreement by an Eligible Employee shall constitute agreement and consent to such automatic adjustment.

2.11 Change of Coverage Elections

Except as otherwise provided below in this Section 2.11 or as provided in Sections 3.3, 4.3 and 5.3, a Participant's election of Covered Benefits under the Plan shall be irrevocable (and cannot be terminated, changed, suspended or amended) for the Period of Coverage to which such election pertains.

With respect to a Covered Benefit that is an accident or health plan or group-term life insurance described in Section 79 of the Code, and consistent with the regulations issued under Section 125 and any other applicable sections of the Code, a Participant shall be entitled to revoke a Covered Benefit election after the Period of Coverage has commenced with respect to which the election applies, and make a new election with respect to the remainder of such Period of Coverage, only if both the revocation and new election are on account of, and consistent with, one of the following events:

(a) Change in Status Events. The Plan Sponsor shall permit a Participant to revoke a Covered Benefit election during a Period of Coverage and to make a new Covered Benefit election for the remaining portion of the Period of Coverage for any of the reasons set forth below in this subsection.

(1) *Special enrollment rights.* A Participant may revoke an election for accident or health coverage during a Period of Coverage and make a new election that corresponds with the special enrollment rights provided under HIPAA, including special enrollment rights provided under the Children's Health Insurance Program Reauthorization Act of 2009 and the Affordable Care Act.

(2) *Changes in status for accident or health coverage or group-term life insurance coverage.*

(A) *In general.* A Participant may revoke an election for accident or health coverage if it is a Covered Benefit, or group-term life insurance coverage if it is a Covered Benefit, during a Period of Coverage and make a new election for the remaining portion of the Period of Coverage if, under the facts and circumstances –

(i) A "change in status event" (as defined in subsection (B) below) occurs; and

(ii) The election change satisfies the consistency requirement of subsection (a)(3) below.

(B) *Change in status events.* The following events are considered to be "changes in status" for purposes of this subsection (a):

(i) *Legal marital status.* Events that change a Participant's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment.

(ii) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent.

(iii) *Employment status.* Any of the following events that change the employment status of the Participant, the Participant's Spouse, or the Participant's Dependent: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; and (4) a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the employer of the employee, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this paragraph (iii) (*e.g.* if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid with the consequence that the

employee ceases to be eligible for the plan, then that change constitutes a change in employment status under this paragraph).

(iv) *Work schedule*. A reduction or increase in hours of employment by the Participant, or his Spouse or Dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence.

(v) *Dependent satisfies or ceases to satisfy the requirements for unmarried Dependents*. An event that causes a Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstance as provided in the Covered Benefit under which the Participant receives coverage.

(vi) *Residence or Worksite*. A change in the place of residence or work of the Participant or his Spouse or Dependent.

(vii) *Adoption Assistance*. The commencement or termination of an adoption proceeding if adoption assistance is provided through the Plan.

(3) *Consistency rule for accident or health coverage and group-term life insurance*. A Participant's revocation of an existing election during a Period of Coverage and new election for the remaining portion of the period (referred to below as an "election change") is consistent with a change in status if, and only if –

(A) The change in status results in the Participant, or his Spouse or Dependent, gaining or losing eligibility for coverage under either the Plan or a plan of the Spouse's or Dependent's employer; and

(B) The election change corresponds with that gain or loss of coverage.

A change in status results in a Participant, or his Spouse, or Dependent, gaining (or losing) eligibility for coverage under an accident or health plan only if the individual becomes eligible (or ineligible) to participate in the accident or health plan. The Plan Administrator or its delegate will treat an individual as gaining (or losing) eligibility for coverage if the individual becomes eligible (or ineligible) for a particular benefit package option under an accident or health plan (*e.g.*, a change in status results in an individual becoming eligible for a managed care option or an indemnity option). If, as a result of a change in status, the individual gains eligibility for elective coverage under an accident or health plan of the Spouse's or Dependent's employer, the consistency rule of this

subsection (3) is satisfied only if the individual elects the coverage under the Spouse's or Dependent's employer's plan.

A change in status that affects eligibility under a plan includes a change in status that results in an increase or decrease in the number of an Employee's family members or Dependents who may benefit from coverage under the plan.

(b) Judgment, Decree, or Order. This subsection (b) applies to a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in section 609 of ERISA) that requires accident or health coverage for an Employee's child. Notwithstanding the provisions of Section 2.11(a) above, the Plan Administrator or its delegate may:

(1) Change the Employee's election to provide coverage for the child if the order requires coverage; or

(2) Permit the Employee to make an election change to cancel coverage for the child if the order requires the former Spouse to provide coverage and that coverage is, in fact, provided.

(c) Entitlement to Medicare or Medicaid. If a Participant, or his Spouse or Dependent is enrolled in an accident or health plan that is a Covered Benefit and becomes entitled to coverage (*i.e.*, enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Plan Administrator or its delegate will permit the Participant to make an election change to cancel coverage of that Participant, Spouse or Dependent under the accident or health plan. In addition, if a Participant, or his Spouse or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan will permit the Participant to make a prospective election to commence or increase coverage of that Participant, Spouse, or Dependent under the accident or health plan that is a Covered Benefit hereunder.

(d) Elective Contributions under a Qualified Cash or Deferred Arrangement. This Section 2.11(d) applies only if the Employer maintains a 401(k) plan that is offered as a Covered Benefit under this Plan. If so, then the other provisions of this Section 2.11 will not apply with respect to elective contributions under a qualified cash or deferred arrangement (within the meaning of Section 401(k) or the Code) or employee contributions subject to Section 401(m) of the Code. Therefore, the Plan Administrator or its delegate will permit a Participant to modify or revoke elections, but only in accordance with the requirements of Sections 401(k) and 401(m) of the Code and the regulations thereunder, if a 401(k) plan is a Covered Benefit under the Plan.

(e) Separation from Service. The Plan Administrator shall permit a Participant who

separates from service with the Employer during a Period of Coverage to revoke existing Covered Benefit elections and to terminate the receipt of benefits for the remaining portion of the applicable Period of Coverage. If such Participant is rehired as an Eligible Employee within thirty (30) days from the date of separation from service (and within the same Plan Year in which the separation from service occurred), such Participant shall have his Covered Benefit elections reinstated to provide the same coverage elected by the Participant before the separation from service, and if such Participant is rehired as an Eligible Employee more than thirty (30) days from the date of separation from service (or in a different Plan Year from that in which the separation from service occurred), such Participant shall be eligible to make new Covered Benefit elections for the remaining portion of such Period of Coverage.

(f) Cessation of Required Contributions. A Covered Benefit shall cease to be provided to a Participant for the remaining portion of the applicable Period of Coverage if the Participant fails to make a required payment with respect to the Covered Benefit (*e.g.*, a Participant ceases to make a required payment for COBRA continuation coverage after a separation from service with the Employer). In the event of such cessation of coverage, the Participant shall be prohibited from making new Covered Benefit elections for the remaining portion of such Period of Coverage, unless otherwise permitted by another subsection of this Section 2.11.

(g) Adoption Assistance. For purposes of any adoption assistance provided through the Plan, the commencement or termination of an adoption proceeding is an event which permits a Participant to revoke a Covered Benefit election after a Period of Coverage has commenced, and to make a new election with respect to the remainder of such Period of Coverage, to the extent consistent with such event.

(h) Significant Cost or Coverage Changes.

(1) In General. This subsection (f) sets forth rules for election changes as a result of changes in cost or coverage.

(2) Cost Changes.

(A) *Automatic Changes*. If the cost of a Covered Benefits plan increases (or decreases) during a Period of Coverage and, under the terms of such plan, Participants are required to make a corresponding change in their payments, the Plan Administrator or its delegate will, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Participants' elective contributions for the Plan.

(B) *Significant Cost Increases or Decreases*. If the cost of a Benefit Package Option (as defined below) significantly increases, or significantly decreases, during a Period of Coverage as determined by the Plan Sponsor, the Plan Administrator (or its delegate) may permit Participants to make a corresponding change in election

under the Plan. Changes that may be made include commencing participation in the Plan for the Benefit Package Option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another Benefit Package Option providing similar coverage or dropping coverage if no other Benefit Package Option providing similar coverage is available. For example, if the cost of a point of service ("**POS**") option under an accident or health plan significantly increases during a Period of Coverage, Participants who are covered by the POS option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the POS option and, in lieu thereof, elect coverage under an HMO option (or drop coverage under the accident or health plan if no other Benefit Package Option is offered).

(C) *Application of cost changes.* For purposes of this Section 2.11(h)(2), a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the Plan, whether that increase or decrease results from an action taken by the Employee (such as switching between full-time and part-time status) or from an action taken by an Employer (such as reducing the amount of Employer contributions for a class of Employees).

(D) A "*Benefit Package Option*" is a Covered Benefit, or an option for coverage under a Covered Benefit that is an accident or health plan (such as an indemnity option, an HMO option, or a PPO option).

(3) Coverage Changes.

(A) *Significant curtailment without loss of coverage*. If an Employee (or an Employee's Spouse or Dependent) has a significant curtailment of coverage under a plan during a Period of Coverage that is not a loss of coverage (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under an accident or health plan), any Participant receiving that coverage may revoke his election for that coverage and, in lieu thereof, may elect to receive on a prospective basis coverage under another Benefit Package Option providing similar coverage. Coverage under the Plan is significantly curtailed only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally.

(B) Significant curtailment with loss of coverage. If a Participant (or the Participant's Spouse or Dependent) has a significant curtailment that is a loss of coverage, that Participant may revoke his election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another Benefit Package Option

providing similar coverage or drop coverage if no similar Benefit Package Option is available. For purposes of this paragraph, a loss of coverage means a complete loss of coverage under the Benefit Package Option or other coverage option (including the elimination of a Benefits Package Option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason or an overall lifetime or annual limitation).

In addition, the Plan will treat the following as a loss of coverage –

(i) A substantial decrease in the medical care providers available under the Benefits Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(ii) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or his Spouse or Dependent is currently in a course of treatment; or

(iii) Any other similar fundamental, loss of coverage.

(C) *Addition or improvement of a Benefit Package Option.* If the Plan or a Covered Benefit adds a new Benefit Package Option (or other coverage option), or if coverage under an existing Benefit Package Option or other coverage option is significantly improved during a Period of Coverage as determined by the Plan Administrator, the Participants (whether or not they have previously made an election under the Plan or have previously elected the Benefit Package Option) may revoke their elections under the Plan and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved Benefit Package Option.

(D) *Change in coverage under another employer plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer) if:

(i) The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under the Plan (disregarding this paragraph); or

(ii) The Plan permits Participants to make an election for a Period of Coverage, such as a plan year, that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

(iii) This subsection (3)(D) may apply, for example, if a cafeteria plan maintained by a Spouse's employer has a different plan year than the Plan.

(E) *Loss of coverage under other group health coverage.* The Plan will permit an Employee to make an election on a prospective basis to add coverage under the Plan for the Employee, Spouse, or Dependent if the Employee, Spouse, or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following –

(i) A State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act;

(ii) A medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, or a tribal organization;

(iii) A State health benefits risk pool; or

(iv) A Foreign government group health plan.

The Plan Administrator shall have the right to request and receive from the Participant any representations, documents or other supporting evidence which it deems necessary or appropriate in order to substantiate any of the events enumerated above in this Section 2.11. The documents include a marriage certificate, divorce decree, birth or death certificate, HIPAA certificate of creditable coverage, confirming letter from the Spouse's former employer, or any other document reasonably requested. Each requested representation, document or other supporting evidence shall be provided at the Participant's expense as soon as practicable following the date that the Plan Administrator makes such request to the Participant.

The decision of the Plan Administrator regarding the Participant's ability to revoke an existing election or to make a new election under this Section shall be made in accordance with applicable law and regulation, and shall be final, conclusive, and binding on the Participant and all other interested persons. If a Participant is permitted to revoke an existing election and to make a new election, he must complete a new written or electronic election form (or a change form) and submit such form to the Plan Sponsor (or if the form is electronic, post it online in accordance with the Plan's procedures) as soon as practicable following the date that the Participant is informed of the decision by the Plan Administrator to permit the new election.

Any change which a Participant elects during a Period of Coverage because of any of the events enumerated above in this Section shall be effective as of such date that the Plan Administrator shall prescribe after taking into consideration the documents representing the applicable Covered Benefit; provided, however, in no event shall such date be earlier than the Participant's first pay period beginning after the new election or change form, as applicable, and any requested substantiating documentation is returned to, and accepted by, the Plan Administrator. This Section 2.11 shall be construed in accordance with applicable Treasury regulations.

2.12 Non-Discrimination

The Plan and the Covered Benefits available hereunder shall not discriminate in favor of Highly Compensated Employees or Key Employees as to eligibility to participate, contributions or benefits, in compliance with the requirements of applicable provisions of the Code. Accordingly, the Plan shall be operated and construed in a manner that complies with the nondiscrimination requirements of Section 125 of the Code and other applicable provisions of the Code which apply separately to a particular Covered Benefit. Qualified Benefits provided to Key Employees shall not exceed twenty-five percent (25%) of the aggregate of all Qualified Benefits provided for all Employees under the Plan. For purposes of the preceding sentence, Qualified Benefits shall not include those benefits which (without regard to the preceding sentence) are includible in the gross income of an Employee.

For nondiscrimination testing purposes, all Employees of an Employer and its Affiliated Employers shall be treated as Employees of a single Employer. Additionally, to the extent consistent with the Code, nondiscrimination testing may be performed on a separate line of business basis pursuant to the requirements of the Code.

The Plan Administrator or its delegate may reject any election and/or reduce an amount of contributions or benefits to the extent that it deems necessary (a) to ensure that the Plan does not discriminate in favor of Highly Compensated Employees or Key Employees in violation of applicable provisions of the Code or any other applicable provision of law or regulation, or (b) to prevent the taxation of any Employee under applicable provisions of the Code.

2.13 Non-Discrimination not Guaranteed

No person or entity (including the Employer and the Plan Administrator) represents or in any way guarantees that this Plan, the benefits provided hereunder, or contributions made hereto are, at any particular time, nondiscriminatory, as determined in accordance with applicable provisions of the Code. Provided that an Employer, past or present member of the Plan Administrator, and any Employee who is or was an agent or representative of the Employer or the Plan Administrator acts in good faith, such person or entity shall be held harmless by all Employees, Dependents, beneficiaries and other interested persons or entities, from any and all tax liability, or any other liability, claim, cost or charge of whatever nature, which might arise by reason of the Plan being deemed discriminatory at any time and in any regard.

2.14 Inclusion in Income

In the event that any Covered Benefit becomes taxable by reason of the Plan being deemed discriminatory, such taxable benefit shall be treated as received or accrued in the taxable year of the Participant in which the Period of Coverage ends, unless controlling law or regulation requires inclusion in income at some other point in time.

2.15 USERRA Coverage

Notwithstanding any provisions herein to the contrary, to the extent that USERRA applies to coverage and benefits provided under the Plan during such period as the Participant is absent from employment with the Employer by reason of service in the uniformed services, a Participant's

right to reenter the Plan where coverage was terminated by reason of service in the uniformed services shall be determined in accordance with USERRA and regulations promulgated thereunder. The Plan shall not be in violation of the Code or the Income Tax Regulations solely because it permits a Participant to make a new election of coverage under the Plan or a Covered Benefit (to the extent the Plan and/or such Covered Benefit is subject to USERRA) either upon leaving active employment for an approved military leave of absence or upon return from such military leave of absence.

ARTICLE III.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

3.1 Requirements for Eligibility/Entry Date

A full-time Employee who is regularly scheduled to work a minimum of thirty (30) hours per week shall be eligible to participate in the Dependent Care Flexible Spending Account portion of the Plan, as described in this Article III. Following satisfaction of the election requirements set forth in Section 3.2, coverage under the Dependent Care Flexible Spending Account portion of the Plan shall be effective as follows: (a) for a newly-eligible Employee, the first day of the month following his date of hire (or, if later, the first day of the month following the date he first becomes regularly scheduled to work a minimum of thirty (30) hours per week), or (b) for an ongoing Employee, the first day of the next Plan Year.

Notwithstanding the immediately preceding paragraph, all Employees in the following categories of Employees shall be excluded from participation in the Dependent Care Flexible Spending Account portion of the Plan:

(a) Employees who are included in a unit of Employees covered by a collective bargaining agreement between Employee representatives and one or more Employers, if there is evidence that the type of benefits provided under the Dependent Care Flexible Spending Account portion of the Plan were the subject of good faith bargaining between the Employee representatives and such Employer(s) and the collective bargaining agreement does not require the Employer(s) to include such Employees in this portion of the Plan; provided, however, with respect to any unit of Employees covered by a collective bargaining agreement who are eligible to participate in this portion of the Plan as of the Effective Date, such Employees shall remain eligible to participate unless and until such Employees are no longer eligible to participate under the terms of the collective bargaining agreement. For purposes of the preceding sentence, the term "Employee representatives" shall not include any organization more than one-half of the members of which are Employees who are owners, officers or executives of the Employer;

(b) Employees who are nonresident aliens and who receive no earned income (within the meaning of Section 911(d)(2) of the Code) from an Employer which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code); and

(c) Employees who are part of the Plan Sponsor's Cost Center 253, as designated in the personnel or other business records of the Plan Sponsor or an Affiliated

Employer.

Notwithstanding any other provision of the Plan to the contrary, (i) any individual who was considered by the Employer to be independent contractor, but who is later reclassified as a common-law Employee (including any "leased employee" described in Section 414(n) of the Code) with respect to any portion of the period in which such individual was paid by the Employer as an independent contractor, or (ii) any such leased employee, shall be excluded from participation in the Dependent Care Flexible Spending Account portion of the Plan (Article III) with respect to the period in which any individual described in clause (i) was considered to be an independent contractor, or the period in which any individual described in clause (ii) is a leased employee.

3.2 Application to Participate

Upon satisfaction of the requirements for eligibility, the Plan Sponsor shall furnish to each Eligible Employee information regarding the Plan and a Dependent Conversion Agreement. The Dependent Conversion Agreement must be completed by the Eligible Employee and returned to the Plan Sponsor (or if such Agreement is electronic, posted to the Plan's online enrollment system in accordance with the Plan's procedures) within the time period designated and communicated by the Plan Sponsor and prior to the effective date of this initial participation in the Dependent Care Flexible Spending Account portion of the Plan. Thereafter, prior to the beginning of each Plan Year, the Plan Sponsor shall furnish to each Eligible Employee information regarding the Plan and a Dependent Conversion Agreement. The Dependent Conversion Agreement must be completed by the Eligible Employee and returned to the Plan Sponsor (or if such Agreement is electronic, posted to the Plan's online enrollment system in accordance with the Plan's procedures) during the annual enrollment period prior to the first day of the next Plan Year.

A Dependent Conversion Agreement cannot be modified or revoked during the Period of Coverage, except if such modification or revocation is on account of and consistent with certain "changes in status," as described in Section 3.3 hereof. A Dependent Conversion Agreement is valid for one Period of Coverage; for each succeeding Period of Coverage for which an Eligible Employee desires to participate, a new Dependent Conversion Agreement must be completed and timely returned to the Plan Sponsor (or if the Agreement is electronic, timely posted online in accordance with the Plan's procedures). The Plan Sponsor shall have the right to request and receive such additional information and documentation from Employers, Employees, or other interested persons or entities as deemed necessary or appropriate for the administration of the Plan.

To the full extent permitted by law or regulation, an Employee upon executing a Dependent Conversion Agreement shall (a) be deemed to have consented to and be bound by all the terms, provisions, conditions, and limitations of the Dependent Care Flexible Spending Account portion of the Plan, including any and all amendments, and any decision or determination made by the Plan Administrator or Claims Administrator with respect to the Participant's rights or entitlement to benefits under the Plan, and (b) agree to submit to the Claims Administrator all bills, invoices, receipts, canceled checks, reports and other supporting documentation which is requested to verify whether the claim is eligible to be reimbursed in accordance with Section 129 of the Code and corresponding regulations.

3.3 Benefit Election Irrevocable with Certain Exceptions

Except as otherwise provided below in this Section 3.3, a Participant's election of coverage under the Dependent Care Flexible Spending Account portion of the Plan shall be irrevocable (and cannot be terminated, changed, suspended or amended) for the Period of Coverage to which such election pertains.

Consistent with the Income Tax Regulations issued under Section 125 of the Code, a Participant shall be entitled to revoke a Dependent Care Flexible Spending Account election after the Period of Coverage has commenced with respect to which the election applies, and make a new election with respect to the remainder of such Period of Coverage, only if both the revocation and new election are on account of, and consistent with, one of the following events:

(a) Change in Status Events. The Plan Sponsor shall permit a Participant to revoke a Covered Benefit election during a Period of Coverage and to make a new Covered Benefit election for the remaining portion of the Period of Coverage for any of the reasons set forth below in this subsection.

(1) *Changes in Status for Dependent Care Flexible Spending Accounts.*

(A) *In general.* A Participant may revoke a Dependent Care Flexible Spending Account election during a Period of Coverage and make a new election for the remaining portion of the Period of Coverage if, under the facts and circumstances –

(i) A "change in status event" (as defined in subsection (B) below) occurs; and

(ii) The election change satisfies the consistency requirement of subsection (a)(2) below.

(B) *Change in status events.* The following events are considered to be "changes in status" for purposes of this subsection (a):

(i) *Legal marital status.* Events that change a Participant's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment.

(ii) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent.

(iii) *Employment status.* Any of the following events that change the employment status of the Participant, the Participant's Spouse, or the Participant's Dependent: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; and (4) a change in worksite. In addition, if the

eligibility conditions of the Plan or other employee benefit plan of the employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under such plan, then that change constitutes a change in employment under this paragraph (iii) (*e.g.*, if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan, then that change constitutes a change in employment status under this paragraph).

(iv) *Work schedule*. A reduction or increase in hours of employment by the Participant, or his Spouse or Dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence.

(v) *Dependent satisfies or ceases to satisfy the requirements for unmarried Dependents*. An event that causes a Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstance as determined by the Plan Sponsor.

(vi) *Residence or Worksite*. A change in the place of residence or work of the Participant or his Spouse or Dependent.

(2) *Consistency rule for Dependent Care Flexible Spending Accounts.* A Participant's revocation of an existing election during a Period of Coverage and new election for the remaining portion of the period (referred to below as an "election change") is consistent with a change in status if, and only if –

(A) The change in status results in the Participant, or his Spouse or Dependent, gaining or losing eligibility for dependent care assistance under either the Plan or a similar plan of the Spouse's or Dependent's employer; and

(B) The election change corresponds with that gain or loss of coverage.

A change in status results in a Participant, or his Spouse, or Dependent gaining (or losing) eligibility for coverage under a dependent care assistance plan only if the individual becomes eligible (or ineligible) to participate in the plan. If, as a result of a change in status, the individual gains eligibility for elective coverage under a dependent care assistance plan of the Spouse's or Dependent's employer, the consistency rule of this subsection (2) is

satisfied only if the individual elects the coverage under the Spouse's or Dependent's employer's plan.

(b) Separation from Service. The Plan Administrator will permit a Participant who separates from service with the Employer during a Period of Coverage to revoke an existing Dependent Care Flexible Spending Account election and to terminate the receipt of benefits for the remaining portion of the applicable Period of Coverage. If such Participant is rehired as an Eligible Employee within thirty (30) days following the date of separation from service (but within the same Plan Year in which the separation from service occurred), such Participant shall have his Dependent Care Flexible Spending Account elections reinstated to provide the same coverage elected by the Participant before the separation from service. If such Participant is rehired as an Eligible Employee more than thirty (30) days after the date of separation from service (or in a different Plan Year from that in which the separation of service occurred), such Participant shall be eligible to make new Dependent Care Flexible Spending Account elections for the remaining portion of such Period of Coverage.

(c) Cessation of Required Contributions. Coverage of a Participant under the Dependent Care Flexible Spending Account portion of the Plan shall cease for the remaining portion of the applicable Period of Coverage if the Participant fails to make a required contribution (*e.g.*, a Participant ceases to make a required contribution during an unpaid leave of absence with the Employer). In the event of such cessation of coverage, the Participant shall be prohibited from making a new Dependent Care Flexible Spending Account election for the remaining portion of such Period of Coverage, unless otherwise permitted by another subsection of this Section 3.3.

(d) Significant Coverage or Cost Changes.

(1) *Coverage Changes*. In the event of a significant change in coverage for Dependent Care Assistance hereunder, the Plan Administrator may permit a Participant to change his coverage election. The availability of dependent care services from a new child care provider (whether the new provider is a household employee or family member of the Participant or his Spouse or independent of them) may be considered a significant change in coverage.

(2) *Significant Cost Changes*. In the event that the cost charged to a Participant significantly increases or significantly decreases during a Period of Coverage, the Plan Administrator may permit a Participant to make a prospective election change that is on account of and corresponds with such change. This subsection applies only if the significant cost change is imposed by a dependent care provider who is not a relative of the Participant. For this purpose, a relative is an individual who is related as described in Code Sections 152(d)(2)(A) through (G), incorporating the rules of Code Sections 152(f)(1) and 152(f)(4).

(3) *Change in Coverage of Spouse or Dependent under Other Employer's Plan.*

The Plan Administrator may permit a Participant to make a prospective election change that is on account of and corresponds with a change made under the dependent care assistance plan of the Spouse's, former Spouse's or Dependent's employer if –

(A) A dependent care assistance plan of the Spouse's, former Spouse's, or Dependent's employer permits participants to make an election change that would be permitted under the Plan (disregarding this paragraph); or

(B) The Plan permits Participants to make a coverage election for a Period of Coverage that is different from the period of coverage under the dependent care assistance plan of the Spouse's, former Spouse's, or Dependent's employer.

This subsection (d)(3) may apply, for example, if a dependent care assistance program maintained by a Spouse's employer has a different plan year than the Plan.

The Plan Administrator will have the right to request and receive from the Participant any representations, documents or other supporting evidence which it deems necessary or appropriate in order to substantiate any of the events enumerated above in this Section 3.3. The documents include a marriage certificate, divorce decree, birth or death certificate, confirming letter from Spouse's former employer, or any other document reasonably requested. Each requested representation, document or other supporting evidence shall be provided at the Participant's expense as soon as practicable following the date of the request to the Participant.

Notwithstanding the foregoing, effective as of January 1, 2020, the Plan Administrator may permit a Participant to revoke an election, make a new election, or decrease or increase an existing election regarding Dependent Care Assistance on a prospective basis for the remainder of the 2020 Plan Year, subject to such administrative procedures as determined by the Plan Administrator. However, a Participant may not reduce an existing election under the Dependent Care Flexible Spending Account portion of the Plan for the remainder of the 2020 Plan Year below the aggregate amount that has already been reimbursed as of the effective date of the election change.

The decision of the Plan Administrator regarding the Participant's ability to revoke an existing election or to make a new election under this Section 3.3 will be made in accordance with applicable law and regulation, and will be final, conclusive, and binding on the Participant and all other interested persons. If a Participant is permitted to revoke an existing election and to make a new election, he must complete a new election form (or a change form) and submit such form to the Plan Sponsor (or if such form is electronic, post it online in accordance with the Plan's procedures) as soon as practicable following the date that the Participant is informed of the decision to permit the new election.

Any change which a Participant elects during a Period of Coverage because of any of the events enumerated above in this Section 3.3 will be effective as of such date that the Plan Administrator shall prescribe following approval of such election change by the Plan Administrator (and after taking into consideration the documents representing the applicable

Covered Benefit).

3.4 Termination of Participation

A Participant shall cease participation in the Dependent Care Flexible Spending Account portion of the Plan, *i.e.*, this Article III, on the earlier of:

(a) the effective date of termination of the Plan;

(b) the effective date on which the Participant validly revokes an existing election or does not make a required contribution to the Dependent Care Flexible Spending Account portion of the Plan;

(c) the effective date on which the Plan is amended to terminate participation with respect to the class of Employees of which the Participant is a member; or

(d) the date on which the Participant terminates employment or otherwise ceases to be eligible to participate in the Dependent Care Flexible Spending Account portion of the Plan.

Participation in the Plan may be suspended in accordance with the Employer's established leave of absence policy during any unpaid leave of absence, except as otherwise required by the FMLA or other law or regulation. Compensation reductions, pursuant to a Covered Benefits Agreement, shall cease as of the date of the Participant's termination of participation in the Plan.

A former Participant shall once again become an Eligible Employee as of the date provided in Section 3.1; provided, however, that if a former Participant again becomes an Eligible Employee during the same Plan Year in which he previously ceased to be a Participant and within thirty (30) days after his prior termination of employment, such Eligible Employee shall not be able to make new benefit elections under the Plan for the remainder of such Plan Year and, therefore, subject to Section 3.3, he may only continue his benefit election that was in effect at the time that he ceased to be a Participant earlier in the Plan Year. In such event, no "make-up" or retroactive contributions by the Participant shall be permitted.

3.5 Limitations on Benefits Available

In accordance with Sections 129(a) and (b) of the Code, the maximum aggregate amount that may be elected by a Participant (and thus excluded from his gross income) under the Dependent Care Flexible Spending Account portion of the Plan for any taxable year of such Participant, shall be the lesser of: (a) $5,000, or $2,500 in the case of a separate return filed by a married individual, (b) in the case of a Participant who is not married at the close of such taxable year, the Earned Income of such Participant for such taxable year, or (c) in the case of a Participant who is married at the close of such taxable year, the lesser of (i) the Earned Income of such Participant for such taxable year, or (ii) the Earned Income of the Participant's Spouse for such taxable year. The minimum aggregate amount that a Participant may elect under the Dependent Care Flexible Spending Account portion of the Plan for any taxable year of such Participant shall be such minimum amount, if any, as determined by the Plan Sponsor and communicated to Participants prior to the start of the Plan Year.

In accordance with Sections 129(b)(2) and 21(d)(2) of the Code, in the case of a Spouse who (a) during each of five calendar months during the Participant's taxable year is a full-time student at an educational organization or (b) is a Qualifying Individual who is physically or mentally incapable of caring for himself, such Spouse (during each month that he is a full-time student or a Qualifying Individual who is physically or mentally incapable of caring for himself) shall be deemed to be gainfully employed and to have Earned Income of not less than (a) $250 per month if there is one Qualifying Individual with respect to the Participant for such taxable year, or (b) $500 per month if there are two or more Qualifying Individuals with respect to the Participant for such taxable year.

In accordance with Section 129(a)(2)(B) of the Code, any amount that exceeds the limits set forth in the two immediately preceding paragraphs shall be includible in the Participant's gross income in the Participant's taxable year in which the Dependent Care Assistance was provided (even if the payment for such Dependent Care Assistance occurs in a subsequent taxable year).

In accordance with Section 129(e)(7) of the Code, no deduction or credit shall be allowed to the Participant under any other section of the Code (*e.g.*, the dependent care tax credit under Section 21 of the Code) for any amount excluded from the gross income of the Participant under Section 129 of the Code by operation of the Plan or any other dependent care assistance program described in Section 129 of the Code.

3.6 Treatment of Onsite Facilities

In accordance with Section 129(e)(8) of the Code, in the case of an onsite facility providing Dependent Care Assistance on the Employer's premises, except to the extent that may otherwise be provided in applicable regulations, the dollar amount of Dependent Care Assistance provided by the Employer to the Participant shall be based on (a) utilization of such onsite facility by the Qualifying Individual of such Participant and (b) the value of the services provided with respect to the Qualifying Individual.

3.7 Dependent Care Flexible Spending Account

The Claims Administrator shall establish a Dependent Care Flexible Spending Account hereunder for each Participant for each Period of Coverage. Each Account shall initially contain zero dollars ($0) at the beginning of the applicable Period of Coverage. A Participant's Dependent Care Flexible Spending Account shall be periodically credited with the portion of his Compensation during the Period of Coverage that he has elected to apply towards Dependent Care Assistance pursuant to his Dependent Conversion Agreement. A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount reimbursed to the Participant for Employment-Related Expenses incurred during the Period of Coverage. Employment-Related Expenses are treated as being incurred when the Dependent Care Assistance is provided, and not when the Participant is actually billed, charged, or pays for such Dependent Care Assistance.

3.8 Claims for Reimbursement or Payment

A Participant shall apply in writing to the Claims Administrator for reimbursement of any Employment-Related Expense incurred by the Participant during the Period of Coverage (or Grace Period, as described in Section 3.10 below).

The claim shall be made on an appropriate form which should set forth the following information:

(a) the amount, date and nature of the expense with respect to which reimbursement is requested;

(b) the name of the Dependent Care Service Provider to whom the expense was paid;

(c) the taxpayer identification number of the Dependent Care Service Provider if such Dependent Care Service Provider is not a charitable, religious or other organization described in Section 501(c)(3) of the Code that is exempt from tax under Section 501(a) of the Code;

(d) the name of the Qualifying Individual for whom the expense was incurred and the relationship of such person to the Participant; and

(e) such other information as the Claims Administrator may from time to time require.

As required by Section 129 of the Code and corresponding regulations, the claim shall be accompanied by bills, invoices, receipts, canceled checks or other statements evidencing the amount of such Employment-Related Expense, together with any other supporting documentation that the Claims Administrator may reasonably request.

3.9 Reimbursement or Payment of Employment-Related Expenses

Subject to the limitations contained in the Dependent Care Flexible Spending Account portion of the Plan, the Claims Administrator shall reimburse a Participant from such Participant's Dependent Care Flexible Spending Account for Employment-Related Expenses incurred during the Period of Coverage for which the Participant submits a proper claim hereunder. The Plan Administrator may, at its option, direct payment of any such claim for Employment-Related Expenses directly to the Dependent Care Service Provider in lieu of reimbursing the Participant. Reimbursement or payment shall be made on a periodic basis no less frequently than at least once a month during the Plan Year.

No reimbursement of Employment-Related Expenses incurred during a Period of Coverage shall at any time exceed the balance of the Participant's Dependent Care Flexible Spending Account at the time when the claim for reimbursement is to be settled. Any Employment-Related Expense not reimbursed as the result of an insufficient Account balance shall be reimbursed only if and when such Account balance permits such reimbursement.

In the event that an individual ceases to be a Participant for any reason, his Dependent Conversion Agreement hereunder shall expire, and the Period of Coverage shall end on such date. Thereafter, he shall be entitled to reimbursement only for Employment-Related Expenses incurred prior to the date of his cessation of participation, but not to exceed the remaining balance in his Dependent Care Flexible Spending Account when he ceased to be a Participant. Claims for reimbursement of Employment-Related Expenses must be submitted to the Claims Administrator by March 31st of the year next following the end of the Plan Year during which such expenses were incurred. No reimbursement shall exceed the remaining balance in his Dependent Care

Flexible Spending Account.

The final reimbursement for claims incurred before the end of the Period of Coverage shall be made as soon as administratively practicable following the close of the Period of Coverage, based on valid claims filed with the Claims Administrator. Reimbursements shall be made only to the extent of the balance remaining in the Participant's Dependent Care Flexible Spending Account as of the end of the Period of Coverage.

After the balance in a Participant's Dependent Care Flexible Spending Account is reduced to zero dollars ($0), any claims outstanding at the end of the Period of Coverage which have not been reimbursed shall be canceled. In no event may such claims incurred during one Period of Coverage be submitted in any succeeding Period of Coverage, or in any way become a liability of an Employer or the Plan Administrator.

3.10 Special Rules for Employment-Related Expenses Incurred During a Grace Period

Claims for Employment-Related Expenses which are incurred during a Grace Period may be paid or reimbursed from amounts that remain in the Participant's Prior Plan Year Cash Balance, provided that the Participant has coverage under the Dependent Care Flexible Spending Account portion of the Plan on the last day of the Plan Year to which the Grace Period relates. Notwithstanding any provision of the Plan to the contrary, the Grace Period shall remain in effect for the entire Grace Period even if the Participant separates from Active Service during the Grace Period.

A Participant's claims for Employment-Related Expenses incurred during a Grace Period and approved for reimbursement or payment in accordance with the Plan and the administrative procedures hereunder shall be reimbursed (or paid) first from any Prior Plan Year Cash Balance, until such Prior Plan Year Cash Balance is reduced to zero (0), and then from the Participant's Cash Account for the Plan Year in which the Employment-Related Expenses are incurred, as provided in Section 3.9. In order to be reimbursed (or paid) from the Prior Plan Year Cash Balance, a claim for Employment-Related Expenses incurred during the Grace Period must be submitted to the Claims Administrator within ninety (90) days following the end of the Grace Period.

The Participant shall not be permitted to cash out or convert his Prior Plan Year Cash Balance to any other Covered Benefit during the Grace Period. For example, the Prior Plan Year Cash Balance cannot be used to pay or reimburse Medical Care Expenses.

Any positive Prior Plan Year Cash Balance which remains after reimbursement and payment of all proper claims for Employment-Related Expenses incurred during the Grace Period (or the prior Plan Year to which it relates) shall not be carried forward to any subsequent Period of Coverage, but instead shall be considered a forfeiture which remains the property of the Employer, and the Participant shall forfeit all rights with respect to such balance.

The Plan's provisions regarding reimbursement or payment of claims for Employment-Related Expenses incurred during a Grace Period are intended to comply with the requirements of applicable sections of the Code, the Income Tax Regulations and other authority issued thereunder.

3.11 No Minimum Needed for Reimbursement

Claims submitted to the Claims Administrator for reimbursement must total $5 in order to be reimbursed from the available balance in the Participant's Dependent Care Flexible Spending Account.

3.12 Forfeiture of Unused Benefits

Any balance remaining in a Participant's Dependent Care Flexible Spending Account following final payment of all valid claims for Employment-Related Expenses incurred during the Period of Coverage, shall remain the property of the Employer and the Participant shall forfeit all rights with respect to such balance. The Employer shall retain forfeitures and/or apply forfeitures to defray the administrative costs of the Plan.

3.13 Reports and Notices to Participants

In accordance with Section 129(d)(7) of the Code, on or before January 31 of each year (or at such other time as may be specified by applicable law or regulation), the Employer shall furnish to each Participant a written statement showing the amounts reimbursed or paid by the Employer (pursuant to the Dependent Care Flexible Spending Account portion of the Plan) for Dependent Care Assistance provided on behalf of the Participant during the previous calendar year.

The Plan Sponsor shall provide a notice to each Participant, which notice shall include (a) a general description of the dependent care tax credit under Section 21 of the Code, (b) the relationship between such tax credit and participation in the Dependent Care Flexible Spending Account portion of the Plan, and (c) the general circumstances under which the tax credit may be more advantageous to the Participant than the exclusion from gross income that is available under the Dependent Care Flexible Spending Account portion of the Plan.

3.14 Identifying Information on Service Provider

In accordance with Section 129(e)(9) of the Code, no amount paid or reimbursed for Dependent Care Assistance provided on behalf of a Participant shall be excludable from the gross income of such Participant unless:

(a) the name, address, and taxpayer identification number of the Dependent Care Service Provider providing the Dependent Care Assistance are included on the Participant's federal income tax return to which such exclusion from gross income relates; or

(b) if the Dependent Care Service Provider is a charitable, religious or other organization described in Section 501(c)(3) of the Code and exempt from tax under Section 501(a) of the Code, the name and address of such Dependent Care Service Provider are included on the Participant's federal income tax return to which such exclusion from gross income relates.

In accordance with Section 129(e)(9) of the Code, in the case of a failure to provide the information required in the immediately preceding sentence, the applicable amount for Dependent

Care Assistance provided on behalf of the Participant may still be excludable from the Participant's gross income if the Participant can show that he exercised due diligence in attempting to provide such required information.

3.15 Non-Discrimination/Reduction of Benefits

In accordance with Section 129(d)(4) of the Code, in no event shall more than twenty-five percent (25%) of the amounts paid or reimbursed, or incurred by, the Employer for Dependent Care Assistance under the Dependent Care Flexible Spending Account portion of the Plan during a Plan Year be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than five percent (5%) of the outstanding stock of the Employer.

The Dependent Care Flexible Spending Account portion of the Plan shall also be subject to the nondiscrimination requirements of Section 129(d)(8) of the Code. Accordingly, the average benefits provided to non-Highly Compensated Employees under the Dependent Care Flexible Spending Account portion of the Plan (and any other dependent care assistance programs described in Section 129 of the Code that are maintained by the Employer) must be at least fifty-five percent (55%) of the average benefits provided to Highly Compensated Employees under the Dependent Care Flexible Spending Account portion of the Plan and any such other dependent care assistance programs. For purposes of this test, in the case of benefits provided through a Dependent Conversion Agreement, there shall be disregarded any Employee whose Compensation is less than $25,000 for such Plan Year. The Employer-provided benefit shall be the value of the benefits provided to, or on behalf of, the Participant, to the extent attributable to Employer contributions (which includes pre-tax contributions made by the Participant pursuant to a Dependent Conversion Agreement).

Any reduction of (a) benefits or (b) amounts that could otherwise be contributed to the Dependent Care Flexible Spending Account portion of the Plan via a Dependent Conversion Agreement, which reduction is deemed necessary to satisfy any nondiscrimination requirement of applicable law or regulation, shall be made by the Plan Administrator on a nondiscriminatory basis. Benefits or contributions which cannot be made because of any reduction imposed under this Section shall be forfeited and retained by the Employer and/or applied by the Plan Administrator to defray the administrative costs of the Plan. A Participant shall be deemed upon executing a Dependent Conversion Agreement to have expressly consented to any modifications deemed necessary by the Plan Administrator to comply with applicable nondiscrimination requirements.

ARTICLE IV.
HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

4.1 Requirements for Eligibility/Entry Date

A full-time Employee who is regularly scheduled to work a minimum of thirty (30) hours per week shall be eligible to participate in the Health Care Flexible Spending Account portion of the Plan, as described in this Article IV. Following satisfaction of the election requirements set forth in Section 4.2, coverage under the Health Care Flexible Spending Account portion of the Plan shall be effective as follows: (a) for a newly-eligible Employee, the first day of the month following his date of hire (or, if later, the first day of the month following the date he first becomes

regularly scheduled to work a minimum of thirty (30) hours per week), or (b) for an ongoing Employee, as of the first day of the next Plan Year.

Notwithstanding the immediately preceding paragraph, all Employees in the following categories of Employees shall be excluded from participation in the Health Care Flexible Spending Account portion of the Plan:

(a) An HSA-Covered Employee shall be excluded from participation in a Health Care Flexible Spending Account (including participation that results from the application of a Carryover Balance from the prior Plan Year) under the Health Care Flexible Spending Account portion of the Plan;

(b) Employees who are included in a unit of Employees covered by a collective bargaining agreement between Employee representatives and one or more Employers, if there is evidence that the type of benefits provided under the Health Care Flexible Spending Account portion of the Plan were the subject of good faith bargaining between the Employee representatives and such Employer and the collective bargaining agreement does not require the Employer to include such Employees in this portion of the Plan; provided, however, with respect to any unit of Employees covered by a collective bargaining agreement who are eligible to participate in this portion of the Plan as of the Effective Date, such Employees shall remain eligible to participate unless and until such Employees are no longer eligible to participate under the terms of the collective bargaining agreement. For purposes of the preceding sentence, the term "Employee representatives" shall not include any organization more than one-half of the members of which are Employees who are owners, officers or executives of the Employer;

(c) Employees who are nonresident aliens and who receive no earned income (within the meaning of Section 911(d)(2) of the Code) from an Employer which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code); and

(d) Employees who are part of the Plan Sponsor's Cost Center 253, as designated in the personnel or other business records of the Plan Sponsor or an Affiliated Employer.

Notwithstanding any other provision of the Plan to the contrary, (a) any individual who was considered by the Employer to be an independent contractor, but who is later reclassified as a common-law Employee (including any "leased employee" described in Section 414(n) of the Code) with respect to any portion of the period in which such individual was paid by the Employer as an independent contractor, or (b) any such leased employee, shall be excluded from participation in the Health Care Flexible Spending Account portion of the Plan (Article IV) with respect to the period in which any individual described in clause (a) was considered to be an independent contractor, or the period in which any individual described in clause (b) is a leased employee.

4.2 Application to Participate

Upon satisfaction of the requirements for eligibility, the Plan Sponsor shall furnish to each

Eligible Employee information regarding the Plan and a Medical Conversion Agreement. The Medical Conversion Agreement must be completed by the Eligible Employee and returned to the Plan Sponsor (or if such Agreement is electronic, posted to the Plan's online enrollment system in accordance with the Plan's procedures) within the time period designated and communicated by the Plan Sponsor and prior to the effective date of this initial participation in the Health Care Flexible Spending Account portion of the Plan. Thereafter, prior to the beginning of each Plan Year, the Plan Sponsor shall furnish to each Eligible Employee information regarding the Plan and a Medical Conversion Agreement. The Medical Conversion Agreement must be completed by the Eligible Employee and returned to the Plan Sponsor (or, if the Agreement is electronic, posted online in accordance with the Plan's procedures) during the annual enrollment period prior to the first day of the next Plan Year.

Notwithstanding any Health Care Flexible Spending Account election by an Eligible Employee to the contrary, if such Employee has a Carryover Balance to be applied to a Health Care Flexible Spending Account with respect to the next Plan Year, then:

(a) if the Participant elects (or is deemed to elect) coverage under the Employer's High Deductible Health Plan as of the first day of such Period of Coverage, he will not be enrolled in a Health Care Flexible Spending Account for such Period of Coverage, and any Carryover Balance will be forfeited; and

(b) if the Participant does not elect (or is not deemed to elect) coverage under the Employer's High Deductible Health Plan as of the first day of such Period of Coverage, he will automatically be enrolled in a Health Care Flexible Spending Account for such Period of Coverage.

A Medical Conversion Agreement is valid for one Period of Coverage; for each succeeding Period of Coverage for which an Eligible Employee desires to participate, a new Medical Conversion Agreement must be completed and timely returned to the Plan Sponsor (or, if the Agreement is electronic, timely posted online in accordance with the Plan's procedures). The Plan Sponsor shall have the right to request and receive such additional information and documentation from Employers, Employees, and other interested persons or entities as deemed necessary or appropriate for the administration of the Plan.

To the full extent permitted by law or regulation, an Employee upon executing a Medical Conversion Agreement shall (a) be bound by all the terms, provisions, conditions, and limitations of the Health Care Flexible Spending Account portion of the Plan, including any and all amendments, and any decision or determination made by the Plan Administrator or Claims Administrator with respect to the Participant's rights or entitlement to benefits under the Plan, (b) consent to, and fully and honestly respond to, inquiries by the Plan Administrator or Claims Administrator concerning any physician, hospital, or other provider of medical care or other goods or services involved in a claim under the Plan, and (c) agree to submit to the Claims Administrator all bills, invoices, receipts, canceled checks, reports and other supporting documentation which may be reasonably requested.

4.3 Benefit Election Irrevocable with Certain Exceptions

Except as otherwise provided below in this Section 4.3, a Participant's election of coverage

under the Health Care Flexible Spending Account portion of the Plan (Article IV) shall be irrevocable (and cannot be terminated, changed, suspended or amended) for the Period of Coverage to which such election pertains. A Participant cannot change his election of coverage under the Health Care Flexible Spending Account portion of the Plan during a Period of Coverage based on a change in his status as an HSA-Eligible Individual unless otherwise permitted for an event under this Section 4.3.

Notwithstanding Section 2.11 or any other provision of the Plan, as consistent with the Income Tax Regulations issued under Section 125 of the Code, a Participant shall be entitled to revoke a Health Care Flexible Spending Account election after the Period of Coverage has commenced with respect to which the election applies, and make a new election with respect to the remainder of such Period of Coverage, only if both the revocation and new election are on account of, and consistent with, the following provisions of this Section 4.3.

(a) Change in Status Events. The Plan Sponsor shall permit a Participant to revoke a Covered Benefit election during a Period of Coverage and to make a new Covered Benefit election for the remaining portion of the Period of Coverage for any of the reasons set forth below in this subsection.

(1) Changes in Status for Health Care Flexible Spending Accounts.

(A) *In general.* A Participant may revoke a Health Care Flexible Spending Account election during a Period of Coverage and make a new election for the remaining portion of the Period of Coverage if, under the facts and circumstances –

(i) A "change in status event" (as defined in subsection (B) below) occurs; and

(ii) The election change satisfies the consistency requirement of subsection (a)(2) below.

(B) *Change in status events.* The following events are considered to be "changes in status" for purposes of this subsection (a):

(i) *Legal marital status.* Events that change a Participant's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment.

(ii) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent.

(iii) *Employment status.* Any of the following events that change the employment status of the Participant, the Participant's Spouse, or the Participant's Dependent: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of

absence; or (4) a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this paragraph (iii) (e.g., if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan, then that change constitutes a change in employment status under this paragraph).

(2) *Consistency rule for Health Care Flexible Spending Accounts.* A Participant's revocation of an existing election during a Period of Coverage and new election for the remaining portion of the period (referred to below as an "election change") is consistent with a change in status if, and only if –

(A) The change in status results in the Participant, or his Spouse or Dependent, gaining or losing eligibility for Medical Care Expense reimbursement under either the Plan or a similar plan of the Spouse's or Dependent's employer; and

(B) The election change corresponds with that gain or loss of coverage.

A change in status results in a Participant, or his Spouse, or Dependent, gaining (or losing) eligibility for Medical Care Expense reimbursement coverage only if the individual becomes eligible (or ineligible) to participate in the plan.

(b) Separation from Service. The Plan Administrator will permit a Participant who separates from service with the Employer during a Period of Coverage to revoke his existing Health Care Flexible Spending Account election and to terminate the receipt of benefits for the remaining portion of the applicable Period of Coverage. If such Participant is rehired as an Eligible Employee within thirty (30) days from the date of separation from service (and within the same Plan Year as such separation from service occurred), such Participant shall have his Health Care Flexible Spending Account election reinstated to provide the same coverage elected by the Participant before the separation from service, and if such Participant is rehired as an Eligible Employee more than thirty (30) days from the date of separation from service (or in a different Plan Year from that in which such separation from service occurred), such Participant shall be eligible to make a new Health Care Flexible Spending Account election for the remaining portion of such Period of Coverage.

(c) Cessation of Required Contributions. Coverage under the Health Care Flexible

Spending Account portion of the Plan shall cease to be provided to a Participant for the remaining portion of the applicable Period of Coverage if the Participant fails to make a required contribution (*e.g.*, a Participant ceases to make a required contribution during an unpaid leave of absence with the Employer). In the event of such cessation of coverage, the Participant shall be prohibited from making a new Health Care Flexible Spending Account election for the remaining portion of such Period of Coverage, unless otherwise permitted by another subsection of this Section 4.3.

This Section 4.3 does not apply to any requested election change with respect to the Health Care Flexible Spending Account portion of the Plan due to a change in cost or coverage. Therefore, for example, a Health Care Flexible Spending Account election cannot be changed mid-year in the event of a cost increase even though the Participant may be entitled to change his group health plan election for that reason.

The Plan Administrator will have the right to request and receive from the Participant any representations, documents or other supporting evidence which it deems necessary or appropriate in order to substantiate any of the events enumerated above in this Section 4.3. Each requested representation, document or other supporting evidence shall be provided at the Participant's expense as soon as practicable following the date of the request to the Participant.

The Participant's requested election change must be on account of and consistent with the change in status. To request a change, the Participant must advise the Plan Sponsor and complete the appropriate form within 31 days of the date of the event giving rise to the change in status (or within 60 days in the case of a special enrollment right provided under the Children's Health Insurance Program Reauthorization Act of 2009); otherwise the Participant must wait to make a change until the next annual open enrollment period before the start of the next Plan Year. Any change which a Participant elects during a Period of Coverage because of any of the events enumerated above in this Section 4.3 shall be effective as of such date that the Plan Sponsor shall prescribe.

If the Participant incurs a change in status event which permits a reduction or revocation of his existing election in accordance with the preceding provisions of this Section 4.3, then notwithstanding any other provision of the Plan, the minimum annual dollar amount of coverage under the Health Care Flexible Spending Account portion of the Plan that such Participant must maintain for the Plan Year in which the change occurs shall be the greater of (a) the Medical Care Expenses reimbursed or paid (or submitted for reimbursement or payment) on the Participant's behalf through the date determined by the Plan Sponsor on which such reduction or revocation shall be effective, or (b) the amount that the Participant contributed to the Plan via a Medical Conversion Agreement through the date on which such reduction or revocation shall be effective.

Notwithstanding the foregoing, effective as of January 1, 2020, the Plan Administrator may permit a Participant to revoke an election, make a new election, or decrease or increase an existing election regarding Medical Care Expense reimbursement on a prospective basis for the remainder of the 2020 Plan Year, subject to such administrative procedures as determined by the Plan Administrator. However, a Participant may not reduce an existing election under the Health Care Flexible Spending Account portion of the Plan for the remainder of the 2020 Plan Year below the aggregate amount that has already been reimbursed as of the effective date of the election change.

The decision of the Plan Administrator regarding the Participant's ability to revoke an existing election or to make a new election under this Section 4.3 will be made in accordance with this Section 4.3 and applicable law and regulation, and will be final, conclusive and binding on the Participant and all other interested persons.

4.4 Termination of Participation

A Participant will cease participation in the Health Care Flexible Spending Account portion of the Plan, *i.e.*, this Article IV, on the earlier of:

(a) the effective date of termination of the Plan;

(b) the effective date on which the Participant validly revokes an existing election or does not make a required contribution to his Health Care Flexible Spending Account;

(c) the effective date on which the Plan is amended to terminate participation with respect to the class of Employees of which the Participant is a member; or

(d) the date on which the Participant terminates employment or otherwise ceases to be eligible to participate in the Health Care Flexible Spending Account portion of the Plan.

Subject to Section 4.11, a former Participant shall once again become an Eligible Employee as of the date provided in Section 4.1; provided, however, that if a former Participant again becomes an Eligible Employee during the same Plan Year in which he previously ceased to be a Participant and within thirty (30) days after his prior termination of employment, such Eligible Employee shall not be able to make new benefit elections under the Plan for the remainder of such Plan Year and, therefore, subject to Section 4.3, he may only continue his benefit election that was in effect at the time that he ceased to be a Participant earlier in the Plan Year. In such event, no "make-up" or retroactive contributions by the Participant shall be permitted. The provisions of this paragraph shall be construed in accordance with the requirements of the FMLA and USERRA when applicable.

4.5 Limitations on Benefits Available

A Participant can be reimbursed, or have payments made on his behalf, for Medical Care Expenses incurred during a Period of Coverage, subject to the following limitations:

(a) The maximum amount by which a Participant can reduce his Compensation (pursuant to a Medical Conversion Agreement) in order to have contributions contributed to a Health Care Flexible Spending Account on his behalf is $2,750, as indexed for inflation for such Plan Year in accordance with section 125(i)(2) of the Code (or other amount, not to exceed such indexed amount, as determined by the Plan Sponsor and communicated to Participants prior to the start of the Plan Year) per each 12-month Plan Year, which contributions will purchase a like amount of coverage for the Participant, and the minimum for each 12-month Plan Year shall

be such minimum amount, if any, as determined by the Plan Sponsor and communicated to Participants prior to the start of the Plan Year.

(b) Amounts reimbursed, or paid on behalf of, a Participant cannot be on account of a Medical Care Expense that is attributable to a federal income tax deduction under Section 213 of the Code for any taxable year (relating to medical expenses in excess of a specified percentage of the taxpayer's adjusted gross income).

(c) The Participant cannot receive, nor be entitled to receive, reimbursement or other direct or indirect payment for any Medical Care Expense for which a claim is submitted hereunder under any insurance arrangement, accident or health plan, Health Savings Account, or another source (other than the Plan).

(d) No advances will be paid for future or projected Medical Care Expenses.

(e) The Plan cannot treat Participants' contributions or premium payments for other health coverage as Medical Care Expenses; therefore, the Plan cannot reimburse Participants for contributions or premiums paid for other health coverage, including contributions or premiums paid for health coverage under a plan maintained by the employer of either the Participant's Spouse or Dependent.

4.6 Uniform Coverage Throughout Period of Coverage

The Health Care Flexible Spending Account portion of the Plan is intended to qualify as an "accident or health plan" under Sections 105 and 106 of the Code. Consequently, even though coverage thereunder is not provided through a commercial insurance contract, the Plan shall, nevertheless, exhibit the risk-shifting and risk-distribution characteristics of insurance and, thus, the Plan shall not eliminate all, or substantially all, of the risk of loss to an Employer. The balance in the Participant's Coverage Account (as reduced for payments or reimbursements on behalf of the Participant) shall be available for coverage at all times during the Period of Coverage without regard to the balance in such Participant's Cash Account as of the date that he submits a claim for reimbursement.

4.7 Health Care Flexible Spending Account

A Health Care Flexible Spending Account shall be established by the Claims Administrator for each Participant for each Period of Coverage. Each Account shall be segregated into two separate subaccounts, the Coverage Account and the Cash Account. The Coverage Account shall be credited as of the beginning of each Period of Coverage with the maximum amount of coverage that the Participant has elected for such Period of Coverage pursuant to his Medical Conversion Agreement, plus the amount, if any, of the Participant's Carryover Balance from the prior Plan Year. The Cash Account shall be credited with zero dollars ($0) as of the beginning of each Period of Coverage, plus the amount, if any, of the Participant's Carryover Balance from the prior Plan Year. The Cash Account, but not the Coverage Account, shall be periodically credited with contributions made to the Plan on behalf of the Participant pursuant to his Medical Conversion Agreement during the Period of Coverage or, in the case of a former Employee who elects COBRA coverage pursuant to Section 4.13 (to the extent the Health Care Flexible Spending Account portion of the Plan is subject to COBRA), for other contributions made to the Plan by such former

Employee during the Period of Coverage. Both the Coverage Account and the Cash Account shall be periodically reduced during the Period of Coverage by amounts reimbursed or paid to, or on behalf of, the Participant for Medical Care Expenses incurred during the Period of Coverage.

To the extent that the Coverage Account or the Cash Account includes a Carryover Balance of the Participant from the prior Plan Year, Medical Care Expenses reimbursed from the Health Care Flexible Spending Account shall be applied to reduce the Carryover Balance pursuant to the procedures established by the Plan Administrator for such purpose in accordance with IRS Notice 2013-71 and any subsequent applicable legal guidance issued by an appropriate government authority.

The Coverage Account cannot be reduced below zero, however, the Cash Account can show a deficit balance if the aggregate amount reimbursed or paid on behalf of the Participant at any given time during the Period of Coverage exceeds the aggregate amount credited to his Cash Account at such time. The total amount reimbursed or paid to, or on behalf of, a Participant during a Period of Coverage cannot exceed the balance credited to his Coverage Account as of the beginning of such Period of Coverage. Medical Care Expenses are treated as being incurred when the medical care that creates the Medical Care Expense is provided, and not when the Participant is actually billed, charged, or pays for such medical care.

4.8 Claims for Reimbursement or Payment

A Participant shall file a claim with the Claims Administrator for reimbursement of a Medical Care Expense incurred during the Period of Coverage. All claims must be submitted to the Claims Administrator by March 31st of the year following the end of the Plan Year in which the Period of Coverage ended. The claim shall be made on the appropriate form furnished by the Claims Administrator and shall set forth the following information:

(a) the amount, date and nature of the expense with respect to which reimbursement is requested;

(b) the name of the person or entity to whom the requested amount was paid;

(c) the name of the person for whom the expense was incurred and the relationship of such person to the Participant; and

(d) such other verification information as the Claims Administrator may from time to time require.

The claim shall be accompanied by bills, invoices, receipts, canceled checks or other supporting documentation evidencing the amount for which the Participant seeks reimbursement. For any item covered by health insurance or a health plan but not paid by the insurer or health plan administrator because of deductibles, co-payments, maximum limits, or other reasons, the Claims Administrator may require a statement from the insurer or health plan administrator denying payment for such item. "Self-substantiation" or "self-certification" of an expense by the Participant does not constitute the required substantiation under this Section 4.8.

In addition, the Claims Administrator of the Employer's group health plan may process a

claim for reimbursement of a Medical Care Expense under the Plan, in accordance with its procedures established for such purpose, provided that the information listed above in this Section 4.8 is included with such claim.

4.9 Reimbursement or Payment of Medical Care Expenses

Subject to the limitations contained in this Article IV, the Claims Administrator shall reimburse a Participant for Medical Care Expenses incurred during the Period of Coverage for which the Participant submits a valid claim hereunder. The Plan Administrator may, at its option, direct payment of any such claim for Medical Care Expenses directly to the medical care service provider in lieu of reimbursing the Participant. Reimbursement or payment shall be made by the Claims Administrator on a periodic basis no less frequently than at least once a month during the Plan Year.

No reimbursement or payment of a Medical Care Expense incurred during a Period of Coverage shall exceed the balance of the Participant's Coverage Account at the time when the claim for reimbursement or payment is to be settled by the Claims Administrator. If a valid claim submitted by a Participant exceeds the balance in his Cash Account but not the balance in his Coverage Account, the Claims Administrator may apply any available forfeitures and income of the Plan for the Plan Year in which the claim was incurred towards the shortfall, *i.e.*, the amount by which the claim exceeds the balance in the Cash Account. To the extent necessary, the Claims Administrator shall direct the applicable Employer to pay the remaining shortfall to the Claims Administrator from the general assets of the Employer. The Claims Administrator shall then apply any remaining balance in the Participant's Cash Account, any available Plan forfeitures and income, and any amount received from an Employer to settle the claim with the Participant. In such event, the Claims Administrator shall reduce the Participant's Coverage Account and Cash Account by the full amount of the settled claim; therefore, the Cash Account may show a deficit balance.

The final reimbursement or payment for claims incurred during any Period of Coverage shall be made as soon as administratively practicable following the close of the Period of Coverage based on proper claims filed with the Claims Administrator, but only to the extent of the balance remaining in the Participant's Coverage Account as of the close of such Period of Coverage. After the balance in a Participant's Coverage Account is reduced to zero (0), all claims incurred during the Period of Coverage which remain unpaid shall be canceled and no additional claims relating to that Period of Coverage will be honored. All claims must be submitted to the Claims Administrator by the deadline specified in Section 4.8.

4.10 Special Rules for Carryover Accounts

Any amount credited to a Participant's Carryover Balance from the prior Plan Year shall not affect his right to reduce his Compensation (pursuant to a Medical Conversion Agreement) during the subsequent Plan Year by the maximum amount allowed under Section 4.5(a) in order to have contributions contributed to a Health Care Flexible Spending Account on his behalf.

To the extent that a Participant has a Carryover Balance from the prior Plan Year that is applied to his Health Care Flexible Spending Account coverage in the subsequent Plan Year, his claims for Medical Care Expenses incurred during the Period of Coverage associated with that

Plan Year, and approved for reimbursement or payment in accordance with the Plan and the administrative procedures hereunder, shall be reimbursed (or paid) from the Participant's Carryover Balance pursuant to the procedures established by the Plan Administrator for such purpose in accordance with IRS Notice 2013-71 and any subsequent applicable legal guidance issued by an appropriate government authority.

The Participant shall not be permitted to cash out or convert his Carryover Balance from a Health Flexible Spending Account to any other Covered Benefit. For example, the Carryover Balance cannot be used to pay or reimburse Employment-Related Expenses incurred for Dependent Care Assistance.

The Plan's provisions regarding reimbursement or payment of claims from a Participant's Carryover Balance for Medical Care Expenses incurred during a Period of Coverage, as well as the Plan's provisions regarding the application of COBRA to a Participant's Carryover Balance, are intended to comply with, and shall be construed in accordance with, the requirements of applicable sections of the Code, Income Tax Regulations and other authority issued thereunder.

4.11 Leave of Absence/Termination of Employment

(a) Leave of Absence: In the event that a Participant is on an approved *paid* leave of absence, such Participant shall continue coverage under the Health Care Flexible Spending Account portion of the Plan for the remainder of the Plan Year (at the same dollar amount of elected coverage) by continuing contributions pursuant to his Medical Conversion Agreement. If the Participant is on an approved *unpaid* leave of absence, participation in the Health Care Flexible Spending Account portion of the Plan may continue but "pre-tax" contributions pursuant to his Medical Conversion Agreement shall cease while he is on the unpaid leave of absence. If the Participant is on an approved *unpaid* leave of absence, he may elect to continue coverage under the Health Care Flexible Spending Account portion of the Plan at his elected dollar amount of coverage for that Plan Year by remitting contributions to his Health Care Flexible Spending Account on an after-tax basis to the end of the (1) Plan Year or (2) unpaid leave of absence, whichever is shorter.

(b) FMLA Coverage: Notwithstanding subsection 4.11(a) above, a Participant taking FMLA leave shall be permitted to (i) continue coverage under the Health Care Flexible Spending Account portion of the Plan; or (ii) revoke an existing election under such portion of the Plan for the remaining Period of Coverage. A Participant upon return from FMLA leave shall be permitted to reenter the Health Care Flexible Spending Account portion of the Plan at the election of the Participant.

If the Participant elects to continue his coverage under the Health Care Flexible Spending Account portion of the Plan during FMLA leave, the Participant may elect to pay contributions during the FMLA leave either (i) in advance of the commencement of the FMLA leave, (ii) during the term of the FMLA leave on the same schedule as payments would be made if the Participant was not on leave, or (iii) under any other system voluntarily agreed to by the Participant and the Employer that is not inconsistent with applicable IRS regulations. Payments made by the Participant may be either by way of pre-tax payroll deduction through a

Medical Conversion Agreement from taxable payments due to the Participant from the Employer or through after-tax payments.

Regardless of the payment option selected for continued coverage under the Health Care Flexible Spending Account portion of the Plan, the full amount of elected coverage, less any prior reimbursements, must be available to the Participant at all times including the FMLA period. If a Participant's coverage under the Health Care Flexible Spending Account portion of the Plan terminates while the Participant is on FMLA leave, the Employee is not entitled to receive reimbursement for claims incurred during the period when the coverage was terminated. If such Employee subsequently elects to be reinstated in the Health Care Flexible Spending Account portion of the Plan upon return from FMLA leave for the remainder of the Plan Year, the Employee may not retroactively elect coverage for claims incurred during the period when coverage was terminated.

If an Employee elects to be reinstated in the Health Care Flexible Spending Account portion of the Plan upon return from FMLA leave, he shall have the option of electing reinstatement (1) at the same coverage level that was in effect before the FMLA leave, with increased contributions for the remainder of the Plan Year, or (2) at a coverage level that is reduced pro-rata for the period of FMLA leave (based on a 365-day year) during which the Employee did not make contributions (under either option, the coverage level shall be reduced by prior reimbursements for the Plan Year). If the Employee elects a coverage level that is a pro-rata reduction for the period of FMLA leave (*i.e.*, option (2)), then his per paycheck deduction amount for payment of reinstated coverage under the Health Care Flexible Spending Account portion of the Plan will be the same per paycheck deduction amount as in effect prior to the FMLA leave, but the coverage amount for the year shall be reduced on a pro-rata basis as attributable to the FMLA leave period.

Participants may change their elections upon returning from FMLA leave in accordance with Section 4.3.

(c) Termination of Employment/COBRA Continuation Coverage:

(1) In the event that a Participant's employment is terminated during a Plan Year for any reason other than gross misconduct, and only to the extent the Health Care Flexible Spending Account portion of the Plan is subject to COBRA, such terminated individual may elect to continue coverage under the Health Care Flexible Spending Account portion of the Plan only if, at the date of his termination of employment, such Participant's pre-tax dollars remitted to his Health Care Flexible Spending Account exceed the amount of his benefit payments from his Health Care Flexible Spending Account through his termination date. Such individual may elect COBRA continuation coverage under the Health Care Flexible Spending Account portion of the Plan only through the last day of the Plan Year in which termination of employment occurred, in accordance with Section 4.13 at the dollar amount of coverage elected under his Medical Conversion Agreement for the Plan Year, by remitting contributions to his Health Care

Flexible Spending Account on an after-tax basis.

(2) To the extent the Health Care Flexible Spending Account portion of the Plan is subject to COBRA, in the event that a Participant's employment is terminated during a Plan Year and the amount of benefit payments from his Health Care Flexible Spending Account during such Plan Year exceed his pre-tax contributions to his Health Care Flexible Spending Account remitted during such Plan Year, such Participant may not elect COBRA continuation coverage under the Health Care Flexible Spending Account portion of the Plan after the date of his termination of employment.

(3) If the terminated Participant discontinues further contributions to his Health Care Flexible Spending Account as described in subsection (c)(1) above, or is not permitted to continue contributions as described in subsection (c)(2) above, or to the extent the Health Care Flexible Spending Account portion of the Plan is not subject to COBRA, then Medical Care Expenses incurred during the Plan Year through the date of termination of employment shall be reimbursed up to the dollar amount of coverage elected under his Medical Conversion Agreement for the Plan Year, provided that claims for reimbursement are made in accordance with Section 4.9. Medical Care Expenses incurred after the date of termination of employment by an individual who did not elect COBRA continuation coverage under the Health Care Flexible Spending Account portion of the Plan shall not be covered under the Plan. In the event that a terminated Employee is rehired by the Employer, such Employee shall be eligible to recommence participation in the Health Care Flexible Spending Account portion of the Plan in accordance with the following: if such Participant is rehired as an Eligible Employee within thirty (30) days from the date of termination of employment (and within the same Plan Year as such termination of employment occurred), such Participant shall have his Health Care Flexible Spending Account election reinstated to provide the same coverage elected by the Participant before the termination of employment, and if such Participant is rehired more than thirty (30) days from the date of termination of employment (or in a different Plan Year from that in which such termination of employment occurred), such Participant shall be eligible to make a new Health Care Flexible Spending Account election for the remaining portion of the applicable Period of Coverage.

4.12 Cessation of Contributions During Period of Coverage

If an Employee or former Employee ceases to make or authorize contributions to the Plan at any time, his Period of Coverage shall expire as of the last day of the payroll period for which his final contribution provided coverage. If there is a positive balance in his Coverage Account as of the last day of the payroll period for which his final contribution provided coverage, the Participant may submit claims for Medical Care Expenses incurred during the Period of Coverage which ended on that date in accordance with Section 4.9.

4.13 Continuation of Coverage under COBRA

Notwithstanding any other provision of the Plan to the contrary, in the event that an Employer is required under Section 4.11(c) to provide COBRA continuation coverage under the Health Care Flexible Spending Account portion of the Plan upon the occurrence of certain "qualifying events" (as described in COBRA and the regulations issued thereunder) which would otherwise result in a loss of coverage, then the Employer shall offer COBRA continuation coverage to each affected Participant in accordance with COBRA and Section 4.11(c). In the event that the employment of a Participant is terminated during the Plan Year and the benefits paid from his Health Care Flexible Spending Account for that Plan Year exceed the Participant's contributions to his Health Care Flexible Spending Account through his termination date, then in accordance with applicable COBRA regulations, the Participant shall not be entitled to COBRA coverage with respect to the Health Care Flexible Spending Account Benefit. Any person receiving COBRA continuation coverage shall pay the required contributions or premiums at such times and in such amounts as consistent with the Employer's procedures for COBRA administration.

To the extent that a Participant has a Carryover Balance from the prior Plan Year that is applied to his Health Care Flexible Spending Account in the subsequent Plan Year, his entitlement to COBRA continuation coverage under the Health Care Flexible Spending Account Benefit, and the terms and conditions of any such coverage, as described in Section 4.11(c) and this Section 4.13, shall be interpreted in accordance with IRS Notice 2013-71 and any subsequent applicable legal guidance issued by an appropriate government authority.

4.14 No Minimum Needed for Reimbursement

Claims submitted to the Claims Administrator for reimbursement must total $5 in order to be reimbursed from the available balance in the Participant's Health Care Flexible Spending Account.

4.15 Forfeiture of Unused Benefits

Any positive balance remaining in a Participant's Cash Account following final payment of all proper claims for Medical Care Expenses incurred during a Plan Year, and which is not credited to his Carryover Balance for the following Plan Year, shall be considered a forfeiture which remains the property of the Employer and the Participant shall forfeit all rights with respect to such balance

4.16 Application of Forfeitures and Other Income

Forfeitures and any income of the Plan that were not needed to pay benefits for the Plan Year shall be retained by the Employer and/or applied by the Employer to reduce the reasonable administrative costs of the Plan. Any remaining amount shall be applied, as elected by the Plan Administrator, (a) as a contribution or premium refund allocated among all of the Participants in the Health Care Flexible Spending Account portion of the Plan on a per capita basis weighted to reflect the Participants' elected levels of coverage for such Plan Year; provided, however, a Participant must be in the employ of an Employer at the end of such Plan Year in order to be eligible to receive a contribution or premium refund, or (b) to reduce required contribution or premium payments for all such Participants for the next Plan Year on a per capita basis weighted to reflect the Participants' elected levels of coverage for such Plan Year. In no event shall any remaining amount be allocated among Participants based (directly or indirectly) on their individual

claims experience.

4.17 Non-Discrimination

The Plan is intended to not discriminate in favor of Highly Compensated Individuals as to eligibility to participate, contributions or benefits, in compliance with the requirements of applicable provisions of the Code. Accordingly, it is intended that the Health Care Flexible Spending Account portion of the Plan be operated in a manner that complies with the applicable nondiscrimination requirements of Section 105(h) and any other applicable provisions of the Code.

4.18 Changes by Plan Administrator

If the Plan Administrator determines, before or during any Plan Year, that the Health Care Flexible Spending Account portion of the Plan may fail to satisfy any nondiscrimination requirement or exceed any limitation on benefits for Highly Compensated Individuals imposed by the Code, the Plan Administrator shall take such action as it deems necessary or appropriate to assure compliance with such nondiscrimination requirement or limitation. Such action may include, without limitation, a modification of Medical Conversion Agreements or other elections made by Highly Compensated Individuals without the consent of such persons.

Any reduction of benefits which may be necessary to meet the nondiscrimination tests of applicable law or regulation shall be made by the Plan Administrator on a nondiscriminatory basis. Contributions that may not be made because of reductions imposed by this Section shall be forfeited. A Participant shall be deemed upon executing a Medical Conversion Agreement to have expressly consented to any modifications deemed necessary by the Plan Administrator in order to comply with any applicable nondiscrimination requirement.

4.19 Use of Debit Card or Stored Value Card

Notwithstanding Section 4.8, a Medical Care Expense incurred during the Period of Coverage may be paid or reimbursed through the Participant's use of a debit card or stored value card (referred to in this Section 4.19 as the "**Card**").

(a) Certification: A Participant to whom a Card is issued shall certify upon enrollment in the Plan (or issuance of the Card, if different) and each annual enrollment period thereafter that (1) the card shall be used only in payment of a Medical Care Expense incurred during a Period of Coverage by the Participant, the Participant's Spouse or the Participant's eligible Dependent, and (2) any Medical Care Expense for which payment is made by use of the Card has not previously been reimbursed to, or on behalf of, the Participant under the Plan, nor will the Participant seek payment or reimbursement for the same Medical Care Expense under any other plan. The Participant shall reaffirm such certification each time the Card is presented for payment or reimbursement of a Medical Care Expense.

(b) Documentation: The Participant shall acquire and retain sufficient documentation for any expense paid or reimbursed with the Card.

(c) Limitation on Expense: No payment or reimbursement of a claim made by use of

the Card for a Medical Care Expense incurred during a Period of Coverage (referred to in this Section 4.19 as a "**Card Claim**") shall exceed the balance of the Participant's Coverage Account at the time when the claim for reimbursement or payment is to be settled by the Claims Administrator.

(d) Restriction on Medical Care Providers: Except as provided in subsection (e)(4) below, use of the Card shall be ineffective except at merchants and service providers authorized as "medical care providers" by the Plan Sponsor based on their merchant category codes. The Plan Sponsor or Claims Administrator shall adopt such policies and procedures as it deems necessary to ensure that no merchant or service provider is authorized to receive payment by use of the Card unless it is a medical care provider.

Notwithstanding the first paragraph of this subsection (d), use of the Card shall not be permitted at any merchant or service provider with the "Drug Stores and Pharmacies" merchant category code unless (i) such merchant or service provider meets the requirements of subsection (e)(2) below, or (ii) on a store location by store location basis, ninety (90) percent of the merchant/service provider's gross receipts during the taxable year prior to the date of the Card Claim consisted of items that qualify as expenses for medical care under Section 213(d) of the Code (such merchant/service provider referred to herein as a "**90% Pharmacy**"). Solely for the purpose of determining "90% Pharmacy" status, sales of over-the-counter medicines and drugs at the pharmacy may continue to be taken into account after December 31, 2010.

(e) Substantiation Procedures: Every Card Claim shall be substantiated. Notwithstanding Section 4.8, a Card Claim with respect to the following shall be deemed "substantiated" without meeting the requirements set forth under Section 4.8.

(1) Co-payments: Permitted if the group health plan of the Participant has copayments in specific dollar amounts and:

(A) the dollar amount of the transaction at a medical care provider equals the dollar amount of the copayment for that service under the Participant's group health plan;

(B) the dollar amount of the transaction at a medical care provider equals an exact multiple of not more than five times the dollar amount of the copayment for the specific service under the Participant's group health plan; or

(C) the Participant's group health plan has multiple copayments for the same benefit, and the dollar amount of the transaction at a medical care provider equals an exact match of multiples or combinations of the copayments, but not more than the exact multiple of five times the maximum copayment.

The copayment schedule required under the Participant's group health plan must be independently verified by the Plan Sponsor, Claims Administrator or other independent third-party, in accordance with the Plan Sponsor's procedures. Statements or other representations by the Participant are not sufficient to meet the requirements of this subsection (1).

(2) Recurring transactions: Permitted if the expenses incurred are the same with respect to dollar amount, medical care provider, and time period as expenses previously approved under the Plan.

(3) Real-time substantiation: Permitted if the merchant, service provider, or other independent third party, at the time and point of sale, provides information to the Claims Administrator, electronically or otherwise, that the expense incurred is a Medical Care Expense.

(4) Inventory Information Approval System: Permitted if the Card processor provides a system for approving and rejecting Card transactions using "inventory control information" (*e.g.*, stock keeping units ("**SKUs**")) with merchants or service providers who need not be medical care providers.

(5) Direct Third Party Substantiation: Permitted if the Plan Sponsor or Claims Administrator is provided with information from an independent third-party (such as an explanation of benefits from an insurance company) indicating the date of the Medical Care Expense and the Participant's responsibility for payment for that service.

(6) Select Merchants: Permitted from select merchants that primarily provide eligible health care expenses.

If a Participant's Card Claim does not meet the foregoing criteria for deemed substantiation, the Participant's entitlement to reimbursement for such claim shall be conditional, pending substantiation of the claim pursuant to the procedures set forth under Section 4.8 and other applicable terms of the Plan.

(f) Recovery Procedures: Notwithstanding Section 5.7, in the event that reimbursement of a Card Claim is made to or on behalf of a Participant, and is subsequently determined to be impermissible under the terms of the Plan, the following recovery procedures shall be followed by the Plan Sponsor or Claims Administrator:

(1) First, the Participant shall repay to the Plan any amounts reimbursed to or on behalf of the Participant with respect to the impermissible claim.

(2) Second, if the Participant fails to repay to the Plan the amounts reimbursed under the impermissible claim, or any portion thereof, the Company shall withhold such unpaid amount from the Participant's wages or other compensation to the extent not inconsistent with applicable law.

(3) Third, if wage or compensation withholding fails to result in complete recovery of the unpaid amount, the Claims Administrator shall offset future claims reimbursements with such unpaid amount.

(4) Fourth, if the recovery procedures set forth herein fail to result in complete recovery of the unpaid amount, the Plan Sponsor shall treat the unpaid amount as an ordinary business debt until such unpaid amount is recovered.

Pending complete recovery of the amounts reimbursed to, or on behalf of, the Participant with respect to an impermissible claim, the Claims Administrator may, in its discretion, deny the Participant's use of the Card until all such amounts are recovered.

ARTICLE V.
HEALTH SAVINGS ACCOUNT FUNDING

5.1 Requirements for Eligibility/Entry Date

An Employee who, on the first day of any month, (a) is a participant in the Employer's High Deductible Health Plan, (b) is an HSA-Eligible Individual, and (c) is an HSA-Covered Employee with HSA coverage established through the HSA Custodian, shall be eligible to participate in the Health Savings Account Funding portion of the Plan, as described in this Article V, during such month.

Notwithstanding the immediately preceding paragraph, all Employees in the following categories of Employees shall be excluded from participation in the Health Savings Account Funding portion of the Plan:

(a) All Employees except HSA-Covered Employees;

(b) Employees who are covered under a Health Care Flexible Spending Account (including coverage as a result of the application of a Carryover Balance from the prior Plan Year);

(c) Employees who are included in a unit of Employees covered by a collective bargaining agreement between Employee representatives and one or more Employers, if there is evidence that the type of benefits provided under the Health Savings Account Funding portion of the Plan were the subject of good faith bargaining between the Employee representatives and such Employer and the collective bargaining agreement does not require the Employer to include such Employees in this portion of the Plan; provided, however, with respect to any unit of Employees covered by a collective bargaining agreement who are eligible to participate in this portion of the Plan as of the Effective Date, such Employees shall remain eligible to participate unless and until such Employees are no longer eligible to participate under the terms of the collective bargaining agreement. For purposes of the preceding sentence, the term "Employee representatives" shall not include any organization more than one-half of the members of which are Employees who

are owners, officers or executives of the Employer; and

(d) Employees who are nonresident aliens and who receive no earned income (within the meaning of Section 911(d)(2) of the Code) from an Employer which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code).

Notwithstanding any other provision of the Plan to the contrary, (i) any individual who was considered by the Employer to be an independent contractor, but who is later reclassified as a common-law Employee (including any "leased employee" described in Section 414(n) of the Code) with respect to any portion of the period in which such individual was paid by the Employer as an independent contractor, or (ii) any such leased employee, shall be excluded from participation in the Health Savings Account Funding portion of the Plan (Article V) with respect to the period in which any individual described in clause (i) was considered to be an independent contractor, or the period in which any individual described in clause (ii) is a leased employee.

5.2 Application to Participate

Upon satisfaction of the requirements for eligibility, the Plan Sponsor shall furnish to each Eligible Employee information regarding the Plan and an HSA Funding Agreement. The HSA Funding Agreement must be completed by the Eligible Employee and returned to the Plan Sponsor (or if such Agreement is electronic, posted to the Plan's online enrollment system in accordance with the Plan's procedures), within the time period designated and communicated by the Plan Sponsor and prior to the effective date of this initial participation in the Health Savings Account Funding portion of the Plan. Thereafter, prior to the beginning of each Plan Year, the Plan Sponsor shall furnish to each Eligible Employee information regarding the Plan and an HSA Funding Agreement. The HSA Funding Agreement must be completed by the Eligible Employee and returned to the Plan Sponsor (or, if the Agreement is electronic, posted online in accordance with the Plan's procedures) during the annual enrollment period prior to the first day of the next Plan Year.

An HSA Funding Agreement is valid for one Period of Coverage; for each succeeding Period of Coverage for which an Eligible Employee desires to participate, a new HSA Funding Agreement must be completed and timely returned to the Plan Sponsor or its delegate (or if the Agreement is electronic, posted online in accordance with the Plan's procedures). The Plan Sponsor shall have the right to request and receive such additional information and documentation from Employers, Employees, and other interested persons or entities as it deems necessary or appropriate for the administration of the Plan.

To the full extent permitted by law or regulation, an Employee upon executing an HSA Funding Agreement shall be bound by all the terms, provisions, conditions, and limitations of the Health Savings Account Funding portion of the Plan, including any and all amendments, and any decision or determination made by the Plan Administrator or Claims Administrator with respect to the Participant's rights or entitlement to benefits under the Plan.

5.3 Election Changes

A Participant is permitted to make a prospective change in his contributions to his HSA,

including an increase, decrease, or revocation of contributions, at any time during the Plan Year to be effective as of the next administratively feasible payroll period. A Participant who becomes ineligible to make HSA contributions may prospectively revoke his salary reduction election for HSA contributions.

5.4 Termination of Participation

A Participant will cease participation in the Health Savings Account Funding portion of the Plan on the earlier of:

(a) the effective date of termination of the Plan;

(b) the effective date on which the Participant validly revokes an existing election or does not make a required contribution through the Health Savings Account Funding portion of the Plan (Article V);

(c) the effective date on which the Plan is amended to terminate participation with respect to the class of Employees of which the Participant is a member; or

(d) the date on which the Participant terminates employment or otherwise ceases to be eligible to participate in the Health Savings Account Funding portion of the Plan.

Distributions from a Participant's HSA (whether before or after termination of employment with the Employer) are administered outside the Plan and are the responsibility of the HSA Custodian.

5.5 HSA Funding Benefits

A Participant may reduce his Compensation (pursuant to an HSA Funding Agreement) during a Period of Coverage in order to have contributions funded to an individual HSA which is (a) established by the Participant outside the Plan, and (b) administered by the HSA Custodian. The Participant's HSA itself is not a Covered Benefit under the Plan, and the Plan Sponsor does not sponsor an HSA to any extent. Instead, the Covered Benefit under the Plan is the pre-tax Compensation reduction feature that facilitates the funding of a Participant's contributions to his individual HSA which is administered by the HSA Custodian. Contributions toward each Participant's HSA coverage shall be accumulated by the Employer by way of pre-tax payroll deductions from the Participant's Compensation, pursuant to the Participant's HSA Funding Agreement. Such contributions shall then be forwarded by the Employer to the HSA Custodian on a periodic basis (in accordance with timing requirements of the Code and Treasury Regulations) for funding of individual Participant accounts.

The amounts by which a Participant may reduce his Compensation pursuant to an HSA Funding Agreement in order to have contributions funded to his HSA (including any age-based "catch up contributions", as described in Code Section 223(b)(3)) shall be subject to the limitations set forth in Code Section 223(b).

The Employer may decide to make a contribution to Participants' HSAs. If the Employer decides to make a contribution for a Plan Year, the Employer will notify Participants of the amount

of such contribution prior to the start of such Plan Year.

The total amount of a Participant's HSA contributions, including any Employer HSA contributions, for a Plan Year shall be subject to the limitations set forth in Section 223(b) of the Code. It is the Participant's responsibility to ensure compliance with such limits, except that the Plan Administrator shall confirm whether a Participant is eligible to make HSA contributions that are age-based "catch up" contributions under Section 223(b)(3) of the Code based on the Plan Administrator's determination of the Participant's age. For such purpose, the Plan Administrator shall be permitted to rely on the Participant's representation as to his date of birth. Notwithstanding the foregoing, in no event shall the aggregate amount of the Participant HSA contributions and any Employer HSA contributions which are funded to a Participant's HSA for a Plan Year exceed the annual limit for family coverage, plus applicable age-based catch up contributions, for that Plan Year under Section 223(b) of the Code.

The Health Savings Account Funding portion of the Plan is not an employee welfare benefit plan subject to ERISA and shall be construed accordingly. Except for the funding feature described in this Plan document, the HSA Custodian is responsible for all administration related to each Participant's HSA, based on the terms of the individual custodial agreements between the HSA Custodian and each such Participant.

5.6 Effect of Failure to Elect

The Plan Sponsor requires an existing Participant to return the completed and executed HSA Funding Agreement to the designated person by the designated due date for the next ensuing Period of Coverage, with the stipulation that if he fails to do so, no pre-tax Compensation reduction for funding contributions to his HSA for that year shall be made under the Plan. Any such new elections must thus be received and accepted by the person designated by the Plan Sponsor (or if the Agreement is electronic, posted online according to the Plan's procedures) on or before the designated due date prior to the start of the next Period of Coverage.

5.7 Changes by Plan Administrator

If the Plan Administrator determines, before or during any Plan Year, that the Health Savings Account Funding portion of the Plan may fail to satisfy any nondiscrimination requirement or exceed any limitation on benefits for Highly Compensated Individuals imposed by the Code, the Plan Administrator shall take such action as it deems necessary or appropriate to assure compliance with such nondiscrimination requirement or limitation. Such action may include, without limitation, a modification of HSA Funding Agreements or other elections made by Highly Compensated Individuals without the consent of such persons.

Any reduction of benefits which may be necessary to meet the nondiscrimination tests of applicable law or regulation shall be made by the Plan Administrator on a nondiscriminatory basis. Contributions that may not be made because of reductions imposed by this Section shall be forfeited to the extent permitted by applicable law and regulations. A Participant shall be deemed, upon executing an HSA Funding Agreement, to have expressly consented to any modifications deemed necessary by the Plan Administrator in order to comply with any applicable nondiscrimination requirement.

5.8 Legal Compliance

The Plan's provisions regarding funding of contributions to a Participant's HSA are intended to comply with the requirements of applicable sections of the Code, Income Tax Regulations and other authority issued thereunder.

ARTICLE VI.
PLAN ADMINISTRATION

6.1 Allocation of Authority

The Plan Administrator shall control and manage the operation and administration of the Plan, subject to Section 6.3. Any decisions made by the Plan Administrator (or any other person or entity delegated authority by the Plan Administrator) shall be final and conclusive on all Participants, and all other persons and entities, subject only to the claims appeal provisions of the Plan. Neither the Plan Administrator nor any Employee shall receive any compensation from the Plan with respect to services provided under the Plan, except as an Employee may be entitled to benefits hereunder.

6.2 Administrative Powers and Duties

The Plan Administrator shall have the power to take all actions reasonably required to carry out the terms and provisions of the Plan, including, but not limited to, the following:

(a) To construe, construct, and interpret the Plan, including, as necessary, correcting any defect, supplying any omission or reconciling any inconsistency which may arise hereunder;

(b) To make written rules and regulations which are not inconsistent with the Plan, to the extent deemed necessary or appropriate;

(c) To decide all questions as to eligibility to become a Participant in the Plan and as to the rights of Participants under the Plan;

(d) To file or cause to be filed such annual reports, returns, schedules, descriptions, financial statements and other information as may be required by any law or regulation, agency, or authority;

(e) To obtain from the Employer, Affiliated Employers, Employees, Participants, Dependents, beneficiaries or other interested persons such information as may be necessary for the proper administration of the Plan;

(f) To determine the proper amount, manner, and time of contributions to the Plan and payment of benefits hereunder;

(g) To contract with insurance carriers or other providers of Covered Benefits;

(h) To communicate to any insurer, or other provider of Covered Benefits, all information and directions which may be reasonably required;

(i) To notify interested persons of any amendment or termination of the Plan, or of a material change in any Covered Benefits;

(j) To prescribe such forms as may be required for Eligible Employees to make elections under the Plan; and

(k) To do such other acts as it deems necessary or appropriate to administer the Plan in accordance with the terms and provisions of the Plan and the Covered Benefits available hereunder, or as may otherwise be required by applicable law or regulation.

The Plan Administrator shall have no power to waive or fail to apply any eligibility requirement of the Plan or any Covered Benefit offered hereunder. Subject to Section 6.5, the decision or judgment of the Plan Administrator shall be final, binding and conclusive as to all interested persons and entities.

When making a determination or computation hereunder, the Plan Administrator shall be entitled to rely upon any information or directions furnished, or actions taken, by an Employer, Employee, Participant, Dependent, beneficiary, insurer or other person or entity. Furthermore, it is intended that the Plan Administrator shall be responsible for the proper exercise of its powers, duties and responsibilities hereunder, and shall not be responsible for any act, omission or failure to act, of any Employer, Employee, Participant, Dependent, beneficiary, insurer or any other person or entity.

6.3 Allocation of Duties/Employment of Agents:

The Plan Administrator may provide for the allocation or delegation of its duties among its authorized agents or representatives, including, without limitation, the Claims Administrator and designated Employees. The Plan Administrator shall also be authorized to engage or employ attorneys, accountants, consultants, or other advisors or agents which it deems necessary or appropriate to assist the Plan Administrator in discharging its duties hereunder.

In any case where any form, notification or election under the Plan is required to be filed with the Plan Administrator or the Employer, such form, notification or election shall be deemed to be filed with the Plan Administrator or the Employer, as applicable, if it is filed with an authorized agent or representative of the Plan Administrator or the Employer, such as the Claims Administrator, unless the Plan Administrator or Employer has established and communicated procedures to the contrary.

6.4 Fiduciary Duties

The Plan Administrator and any other fiduciary of the Plan, within the meaning of ERISA, shall discharge its duties solely in the interests of Participants and their beneficiaries, and:

(a) for the exclusive purpose of providing benefits to Participants and their beneficiaries, and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence, and diligence under the circumstances then prevailing

that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and aims; and

(c) in accordance with the documents and instruments governing the Plan and the Covered Benefits offered hereunder, insofar as such documents and instruments are consistent with applicable law or regulation.

6.5 Claims Procedure

(a) Notice of Claim. In the event that a Participant, Dependent, beneficiary or other person or entity (collectively referred to in this Section as the "Claimant") has a claim for any benefits provided under the Plan, the Claimant must file a claim in accordance with the claims procedures for the applicable Covered Benefit (including insurers and Claims Administrators of Covered Benefits provided hereunder) on a form provided for such purpose. The claims procedures for the Health Care Flexible Spending Account portion of the Plan are set forth in the Summary Plan Description of the Plan and incorporated by this reference into the Plan. If the Claimant fails to file a claim for benefits, the Plan Administrator may take whatever steps are necessary and proper to dispose of the Claimant's potential benefits under the Plan, and shall be held harmless by Claimant and all other persons and entities in the performance of same.

Prior to making any payment of benefits hereunder, the Plan Administrator or other designated entity may require the Claimant to provide such information and to complete any appropriate documents or forms which it deems necessary or appropriate for the proper administration of the Plan, including filing of all claims and requests for payment from any (1) other plan offered by the Employer or (2) insured arrangement covering the Claimant.

(b) Claims Review Procedure. Only to the extent that a particular Covered Benefit does not have an established claims review procedure, or to the extent that the claims review procedure is inconsistent with the requirements of applicable provisions of ERISA, the following claims review procedure shall apply. If any claim for benefits filed by a Claimant is wholly or partially denied, the Plan Administrator, its delegate, or other designated entity (including insurers and Claims Administrators) will notify the Claimant of its decision in writing. Such notification will be written in a manner calculated to be understood by the average Claimant, and will contain (1) specific reasons for the denial, (2) specific reference to pertinent Plan or Covered Benefit provisions, (3) a description of any additional material or information necessary for the Claimant to perfect such claim and an explanation of why such material or information is necessary, and (4) information as to the steps to be taken if the Claimant wishes to submit a request for review, including the time limits applicable to such review and a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review if the Covered Benefit is subject to ERISA. Such notification will be given within sixty (60) days (or thirty (30) days for group health plan claims) after the claim is received by the Plan Administrator or other designated entity, or within one-hundred twenty (120) days (forty-five (45)

days for group health plan claims) if special circumstances require an extension of time for processing the claim, and if written notice of such extension, including the circumstances requiring such extension and the date by which the Plan expects to render the benefit determination, is given by the Plan Administrator or other designated entity to the Claimant within the initial 60-day (or 30-day) period.

Within sixty (60) days (or 180 days for group health plan claims) after the date on which a Claimant receives a written notice of a denied claim, the Claimant (or his authorized representative) may (1) file a written request (including pertinent documents) with the Plan Administrator or other designated entity for a review of the denied claim, and (2) submit written issues, comments, records, and other information relating to the claim appealed, to the Plan Administrator or other designated entity. Each Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Plan or Covered Benefit. For the purposes of this subsection (b), a document, record, or other information shall be considered "relevant" to a Claimant's claim if such document, record, or other information (1) was relied upon in making the benefit determination; (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or (3) demonstrates compliance with any administrative processes and safeguards in making the benefit determination.

The review by the Plan Administrator or other designated entity of the Claimant's claim shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan Administrator or other designated entity will review the claim and notify the Claimant of its decision in writing. Such notification will be written in a manner calculated to be understood by the Claimant and will contain (1) specific reasons for the decision, (2) specific references to pertinent Plan or Covered Benefit provisions, (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement of the Claimant's right to bring an action under Section 502(a) of ERISA if the Covered Benefit is subject to ERISA. The decision on review will be made within sixty (60) days after the request for review is received by the Plan Administrator or other designated entity or, with respect to claims other than group health plan claims, within one hundred twenty (120) days if special circumstances require an extension of time for processing the request, such as a decision by the Plan Administrator to hold a hearing, provided that written notice of such extension, including the circumstances requiring such extension and the date by which the Plan expects to render the benefit determination on review, is given to the Claimant within the initial 60-day period.

6.6 Claim Authority of Administrator

In making claim determinations, the Plan Administrator or Claims Administrator shall consider the terms and provisions of the Plan and shall have the power and discretion to interpret, construe and construct the Plan. All such determinations made by the Plan Administrator or Claims Administrator, whether in the case of an appeal from an initial claim denial or in the case of an initial determination which is not appealed, arising in connection with the administration, interpretation and/or application of the Plan shall be conclusive and binding upon all persons.

The Plan Administrator reserves the absolute and unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including, without limitation, correcting any error or defect, supplying any omission, and reconciling any inconsistency. The Plan Administrator also reserves the absolute and unilateral right and power to make all decisions that may impact eligibility or a claim for benefits, including without limitation, factual determinations. Subject only to the claims appeal procedure set forth in the Plan, any determination, decision, computation, or interpretation made by the Plan Administrator under the Plan shall be final, binding and conclusive on all persons and entities.

The Plan shall be interpreted by the Plan Administrator and the Claims Administrator in accordance with the terms of the Plan and their intended meanings. However, the Plan Administrator and the Claims Administrator shall have the discretion to make any findings of fact needed in the administration of the Plan, and shall have the discretion to interpret or construe ambiguous, unclear or implied (but omitted) terms in any fashion deemed appropriate in their judgment. The validity of any such finding of fact, interpretation, construction or decision shall not be given de novo review if challenged in court, by arbitration or in any other forum, and shall be upheld unless clearly arbitrary or capricious.

To the extent the Plan Administrator, Claims Administrator or another Plan fiduciary has been granted discretionary authority under the Plan, the prior exercise of such authority by the Plan fiduciary shall not obligate it to exercise its authority in a like fashion thereafter.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The provisions of this Section may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretation by the Plan Administrator or Claims Administrator. All actions taken and all determinations by the Plan Administrator or by other Plan fiduciaries shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

6.7 Recovery of Excess Payments

Whenever the Plan has made payments which exceed the appropriate amount provided for under the Plan, the Plan Administrator or the Claims Administrator shall have the right to recover for the benefit of the Plan such excess payments from any of the following:

(a) any person to, for, or with respect to whom such payments were made;

(b) any insurance company; and

(c) any other organization.

Each person claiming Covered Benefits under the Plan shall furnish to the Plan Administrator or to the Claims Administrator such information, execute such documents and take such other actions as may be necessary to implement the provisions of this Section.

6.8 Indemnification

To the full extent permitted by law, the Plan Sponsor and each other Employer (collectively, for purposes of this Section 6.8, the "**Employer**") jointly and severally shall indemnify each past, present and future Employee and Plan Administrator (and each member thereof, if the Plan Administrator is a committee) who acts in the capacity of an agent, delegate or representative of the Plan Administrator or the Plan Sponsor under the Plan (collectively, each such Plan Administrator, each such member of the Plan Administrator and each such other Employee agent, delegate or representative shall be referred to in this Section as a "**Plan Administration Employee**") against, and each Plan Administration Employee shall be entitled without further act on his part to indemnity from the Employer for, any and all losses, liabilities, costs and expenses (including the amount of judgments, court costs, attorneys' fees and the amount of approved settlements made with a view to the curtailment of costs of litigation, other than amounts paid to an Employer) incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened or anticipated possible action, suit, or other proceeding, including any investigation that might lead to such a proceeding, in which he is or may be involved by reason of, or in connection with, his being or having been a Plan Administration Employee. **This indemnity obligation is intended to indemnify the Plan Administration Employee against the consequences of his active, passive, concurrent or partial negligence; provided, however, such indemnity shall not include any and all losses, liabilities, costs and expenses incurred by any such Plan Administration Employee (a) with respect to any matters as to which he is finally adjudged in any such action, suit or proceeding to have been guilty of gross negligence or willful misconduct in the performance of his duties as a Plan Administration Employee, or (b) with respect to any matter to the extent that a settlement thereof is effected in an amount in excess of the amount approved by the Plan Sponsor (which approval shall not be unreasonably withheld).**

No right of indemnification hereunder shall be available to, or enforceable by, any such Plan Administration Employee unless, within twenty (20) days after his actual receipt of service of process in any such action, suit or other proceeding (or such longer period as may be approved by the Plan Sponsor), he shall have offered the Plan Sponsor, in writing, the opportunity to handle and defend same at its sole expense, and the decision by the Plan Sponsor to handle the proceeding shall conclusively determine that the Plan Administration Employee is entitled to the indemnity provided herein unless he then expressly agrees otherwise.

Until and unless a final judicial determination has been made that indemnity is not applicable, all the costs and expenses of the Plan Administration Employee shall be promptly and fully paid or reimbursed by the Employer upon demand.

The foregoing right of indemnification shall inure to the benefit of the heirs, executors, administrators and personal representatives of each Plan Administration Employee, and shall be in addition to all other rights to which he may be entitled as a matter of law, contract, or otherwise.

ARTICLE VII.
AMENDMENT AND TERMINATION

7.1 Amendment of Plan

The Board (or a committee of the Board), the CEO and any Senior Vice President of the Plan Sponsor shall each have the right, authority and power to amend the Plan at any time and from time to time without prior notice to any extent that it or he deems advisable. Any such amendment shall be set out in a written instrument which is (a) identified as an amendment to the Plan and (b) duly authorized by a person or entity designated in the previous sentence. Upon approval and execution of such an instrument amending the Plan, the Plan shall be deemed to have been amended in the manner and to the extent and effective as of the date therein set forth, and thereupon any and all Participants, whether or not they became Participants prior to such amendment, shall be bound thereby. The Plan may be amended in such manner as may be required at any time to conform it to the requirements of the Code or ERISA, or any other applicable law or regulation. Notwithstanding the foregoing, no amendment shall reduce or eliminate a Participant's right to receive benefits for covered expenses incurred for supplies or services that are actually received or rendered on his behalf prior to the effective date of such amendment. An amendment may reduce or eliminate a Participant's right to receive benefits for expenses that are or will be received or incurred in connection with supplies or services that are actually received or rendered on or after the effective date of the amendment, even if such supplies or services were approved by the Claims Administrator or the Plan Administrator prior to such effective date or are part of a series of treatments or services that began prior to such effective date.

Each adopting Employer shall be deemed to have consented to and adopted any amendment of the Plan, as adopted by the Plan Sponsor, unless the Employer notifies the Plan Administrator to the contrary in writing within thirty (30) days of receipt of a copy of the amendment, in which case such rejection shall constitute a withdrawal from the Plan by the affected Employer.

7.2 Termination of Plan

It is intended that the Plan will be continued indefinitely; however, future conditions affecting the Plan Sponsor cannot be anticipated or foreseen. Accordingly, the Plan Sponsor must necessarily and does hereby reserve the absolute right to terminate the Plan for any reason, in whole or in part, at any time with respect to all interested persons, including, but not limited to, active Employees. The Board (or a committee of the Board), the CEO and any Senior Vice President of the Plan Sponsor shall have the right, authority, and discretion to terminate the Plan at any time, in whole or in part, without prior notice to the extent that it or he deems advisable in its or his discretion. Neither the Board (or a committee of the Board), Plan Administrator, Plan Sponsor nor any other Employer shall have any further obligations hereunder, financial or otherwise, which arise subsequent to the effective date of Plan termination.

7.3 Preservation of Rights

The Plan is maintained for the exclusive benefit of the Eligible Employees and their rights hereunder are legally enforceable in accordance with the terms and provisions of the Plan and controlling law.

ARTICLE VIII.
ADOPTION OF PLAN BY OTHER EMPLOYERS

8.1 Adoption of Plan by Other Employers

Any entity, regardless of whether it is an Affiliated Employer, may, with the approval or ratification of the Plan Administrator, adopt this Plan for all or any classification of its Employees (provided that such classification is deemed to be nondiscriminatory) by furnishing to the Plan Administrator:

(a) a certified resolution or consent of its board of directors (or equivalent governing authority) or a duly executed adoption instrument (approved by its board of directors or equivalent governing authority) setting forth its agreement to be bound by all the terms, provisions, conditions and limitations of the Plan, except those, if any, specifically set forth in the adoption instrument; and

(b) all other information required by the Plan Administrator.

Notwithstanding any other provision of the Plan to the contrary, if the adoption of the Plan by any entity, or if the continued participation in the Plan by an Employer, would result (in the opinion of legal counsel to the Plan) in the Plan being a "multiple employer welfare arrangement" described in Section 3(40) of ERISA, such entity or Employer shall not be entitled to adopt the Plan or continue to participate in the Plan, as applicable; instead, such entity or Employer shall be deemed to adopt a plan substantially identical to the Plan, whereunder such substantially identical plan, the name of the Plan Sponsor shall be deleted wherever it appears and the name of the affected entity or Employer shall be substituted in lieu of the name of the Plan Sponsor.

8.2 No Joint Venture

The adoption instrument, when executed, shall become a part of the Plan. However, neither the adoption of the Plan by any entity, nor any act performed by such entity in relation to the Plan, shall ever create a joint venture or partnership relation between such entity and any other Employer.

8.3 Termination of Participation by Employer

Any Employer may terminate its participation in the Plan by executing and delivering to the Plan Administrator a written notice which specifies the date on which its participation in the Plan will terminate. Any such termination of participation in the Plan by one or more participating Employers shall not terminate the Plan with respect to any remaining Employer which continues to maintain the Plan for its Eligible Employees.

ARTICLE IX.
HIPAA PRIVACY AND SECURITY

9.1 HIPAA Privacy and Security in General

This Article IX is intended to comply with the requirements under HIPAA, the Privacy Regulations, the Security Regulations, the HIPAA Enforcement Rule at 45 CFR part 160, subparts C through E ("**Enforcement Rules**") and the "**Breach Notification Rules**" issued under the Health Information Technology for Economic and Clinical Health Act ("**HITECH**"), as each of the foregoing were amended, generally effective as of September 23, 2013, by the regulations issued on January 25, 2013 ("**HIPAA Omnibus Rules**"). References to any section of the Privacy Regulations, the Security Regulations, the Enforcement Rules or the Breach Notification Rules shall include any amendments or successor provisions thereto, including the HIPAA Omnibus Rules.

9.2 Designation of Health Care Components and Safeguard

The Plan is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy Regulations), and as such, the provisions of this Article IX shall only apply to the health care component of the Plan (referred to as the "**Health Care Component**"), as set forth below in this Section 9.2. All references to Protected Health Information ("**PHI**") or Electronic Protected Health Information ("**EPHI**") in this Article IX refer to PHI or EPHI that is created or received by or on behalf of the Health Care Component. The Health Care Component shall thus comply with the following requirements:

(a) The Health Care Component shall not disclose PHI to another component of the Plan in circumstances in which the Privacy Regulations would prohibit such disclosure if the Health Care Component and the other component were separate and distinct legal entities; and

(b) If an employee of the Plan Sponsor performs duties for both the Health Care Component and for another component of the Plan, such employee shall not use or disclose PHI created or received in the course of, or incident to, the employee's work for the Health Care Component in a way prohibited by the Privacy Regulations.

For purposes of this Article IX, the Health Care Component of the Plan is the Health Care Flexible Spending Account portion of the Plan as described in Article IV.

9.3 Use and Disclosure of Protected Health Information

The Plan Sponsor may only use and disclose PHI that it receives from the Health Care Component, which is considered a "group health plan" as defined by the Privacy Regulations, as permitted and/or required by, and consistent with, the Privacy Regulations. This includes, but is not limited to, the right to use and disclose a Participant's PHI in connection with payment, treatment, and health care operations or as otherwise permitted or required by law. The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

(a) "Payment" includes activities undertaken by the Health Care Component to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided.

These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);

(2) Coordination of benefits or non-duplication of benefits;

(3) Adjudication of health benefit claims (including appeals and other payment disputes);

(4) Subrogation of health benefit claims;

(5) Establishing employee contributions;

(6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) Billing, collection activities and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of contributions, premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(13) Obtaining reimbursements due to the Plan.

(b) "Health care operations" include, but are not limited to, the following activities:

(1) Quality assessment;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and

(7) Business management and general administrative activities of the Plan, including, but not limited to:

(A) Management activities relating to the implementation of, and compliance with, HIPAA's administrative simplification requirements;

(B) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(C) Resolution of internal grievances; and

(D) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

9.4 Certification of Amendment of Plan Documents by the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in Section 9.5.

9.5 Plan Sponsor Agrees to Certain Conditions for PHI

The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(e) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to an individual in accordance with HIPAA's access requirements;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

(k) Establish separation between the Plan and the Plan Sponsor in accordance with 45 CFR § 164.504(f)(2)(iii).

To the extent the Health Care Component is subject to the Security Regulations, and with respect to EPHI, the Plan Sponsor agrees, on behalf of the Plan, to:

(a) 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;

(b) Ensure that adequate separation required by 45 CFR §164.504(f)(2)(iii) under the Privacy Regulations is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the Plan agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware, in accordance with the administrative procedures adopted by the Plan for compliance with the Security Regulations.

9.6 Adequate Separation Between the Plan and the Plan Sponsor

In accordance with the Privacy Regulations, only the employees or classes of employees designated in the HIPAA Privacy Employee Designation Appendix may be given access to PHI.

9.7 Limitations of PHI Access and Disclosure

The persons described in the HIPAA Privacy Employee Designation Appendix to the Plan may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

9.8 Noncompliance Issues

If the persons described in the HIPAA Privacy Employee Designation Appendix to the Plan do not comply with the Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

9.9 Additional Requirements Imposed by HITECH

The provisions of this Section will apply to the Plan to the extent that a Health Care Component is a "covered entity" as defined in 45 CFR § 160.103. In accordance with, and to the extent required by, HITECH and the regulations and other authority promulgated thereunder by the appropriate governmental authority, the Plan will (a) comply with notification requirements when unsecured PHI has been accessed, acquired, or disclosed as a result of a breach, (b) comply with an individual's request to restrict disclosure of PHI, (c) limit disclosures of PHI to a limited data set or the minimum necessary, (d) provide an accounting of disclosures, and (e) provide access to PHI in electronic format.

9.10 Limitation on the Use and Disclosure of Genetic Information.

Notwithstanding anything herein to the contrary, no "genetic information" (as defined by Section 105 of the Genetic Information Nondiscrimination Act of 2008) shall be used or disclosed for underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, or ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance).

9.11 Notification in Case of a Breach of Unsecured PHI.

In the event of the acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Regulations that constitutes a "Breach," as such term is defined in 45 CFR 164.402, the Plan, or its designee, shall notify each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, used or disclosed as a result of the Breach no later than sixty (60) days after the Plan, or its designee, discovers the Breach, unless notification may be delayed as permitted by 45 CFR 164.412 because such notice would impede a criminal investigation or damage national security. The Plan, or its designee, will mail individual notifications by first-class mail to the individual's last known address or by electronic mail, provided that electronic disclosure is permitted by the applicable regulations. The individual notification will include the

following information:

- A brief description of what happened, including the date of the Breach and the date of its discovery, if known;

- A description of the type of PHI involved, such as name, social security number, date of birth, address, account number, diagnosis, disability code, or other type of information involved;

- Any steps the individual should take to protect himself from potential harm resulting from the Breach;

- A brief description of what the Plan or its business associate is doing to investigate the Breach, mitigate harm to individuals, and to protect against further Breaches; and

- Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, e-mail address, web site, or postal address.

If the Breach involves more than 500 residents of a state or jurisdiction, the Plan, or its designee, will also notify prominent media outlets that service the state or jurisdiction of the Breach. Additionally, the Plan will notify the Secretary of the Department of Health and Human Services of the Breach as required by 45 CFR 164.408.

9.12 Other Medical Privacy Laws

The Plan shall comply with the Privacy Regulations and the Security Regulations, as well as with any applicable federal, state and local laws governing confidentiality of health information, to the extent that (a) the Health Care Component is subject to the Privacy Regulations and/or the Security Regulations and (b) such laws are not preempted by HIPAA or ERISA.

ARTICLE X.
MISCELLANEOUS

10.1 Incapacitation

Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age unless and until the Plan Administrator receives a written notice, in a form and manner acceptable to the Plan Administrator, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with his care has been appointed. If, however, the Plan Administrator should determine that, in its opinion, any person to whom a benefit is payable under the Plan is unable to care for his affairs because of any mental or physical incapacity or incompetency or because he is a minor, any payment due (unless a prior claim was made by a duly appointed legal representative of such person) may be paid to the Spouse, a child, a parent, or a brother or sister, or to any person with whom he is residing, or to any other person or institution deemed by the Plan Administrator to have incurred expense for such person otherwise entitled to payment. In the event that a

guardian, conservator or other person legally vested with the care of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments shall be made to such guardian, conservator or other person, provided that proper proof of appointment is furnished in a form and manner acceptable to the Plan Administrator. To the full extent permitted by law, any payment made in accordance with this Section shall be a complete discharge of any liability under the Plan to the full extent of such payment.

10.2 Lost Payee

Any amount properly due and payable to a Participant, Dependent, beneficiary, or other person shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate such person to whom payment is due. Any such forfeited amount shall be reinstated through a special contribution to the Plan by the appropriate Employer and become payable if a proper claim (*i.e.*, a claim which is otherwise payable under the Plan) is later made by such person, subject, however, to applicable statutes of limitation and other controlling law.

10.3 Limit on Liability

Nothing contained in the Plan shall impose on any member of the Plan Administrator, any officer or director of an Employer, any liability for the payment of benefits under the Plan. The liability of an Employer for benefits hereunder, if any, shall not exceed that expressly provided for in the Plan.

10.4 Plan Not a Contract of Employment

Nothing contained in the Plan shall be construed as (a) a contract of employment between an Employer and any Employee, (b) a right of any Employee to be continued in the employment of an Employer, (c) consideration or inducement for employment with an Employer, (d) a condition of employment between an Employer and any Employee, or (e) a limitation of the right of an Employer to discharge any Employee, with or without cause, at any time.

10.5 Benefits from Insurance Contracts

The benefits provided under the Covered Benefits will be paid from, or in accordance with, the insurance or other policies, contracts or other documents representing such Covered Benefits. To the extent not inconsistent with applicable law or regulation, nothing herein shall be construed to require any Employer to maintain any trust, fund, or otherwise segregate any amount for the benefit of any Participant or other person. Furthermore, to the extent not inconsistent with applicable law or regulation, no person with a claim for benefits hereunder shall have any claim against, right to, security or other interest in, any fund, account, or assets of any Employer.

10.6 Limitation on Liability For Insured Benefits

Neither the Board, the Plan Administrator, nor any Employer or its officers in any manner guarantee or represent that any benefits payable under any insurance policy, contract, or other agreement for insured benefits described, referred to, or incorporated herein by reference, will be paid. Any benefits payable thereunder shall be the exclusive responsibility of the insurer or other entity which is required to provide the benefits under such policy, contract or other agreement.

10.7 Benefits Provided through Third Parties

In the case of any benefit provided pursuant to an insurance policy, contract or other agreement with a third-party provider, the Plan Administrator may change third-party providers, policies, contracts or agreements without changing the language of this Plan document, provided that copies of the documents representing the benefits provided through third parties are filed with the Plan by the Plan Administrator and the Participants are informed as to the material effects of any such change. To the extent that any such change affects the Benefits Appendix, the Plan Administrator shall update the Benefits Appendix to reflect such change at the earliest administratively practicable date. In the case of any Covered Benefit provided through a third party, such as an insurance company, pursuant to a policy, contract or other agreement with such third party, if there is any conflict or inconsistency between the terms or provisions contained in the Plan and those contained in such agreement, the terms and provisions of such agreement shall control to the extent not inconsistent with applicable law or regulation; provided, however, the Plan and such agreement shall be construed as mutually consistent to the full extent possible. Furthermore, the authority of the Plan Administrator shall not extend to any claim or other matter under any Covered Benefit provided through a third party as to which an insurer, third party administrator or any other person or entity has been accorded the appropriate responsibility and authority, such as the authority to make decisions, computations or determinations.

10.8 Designation of Beneficiary

In the case of any payments or other benefits which are provided with respect to or after the death of a covered person pursuant to any separate benefit which is available as a Covered Benefit, the terms of such Covered Benefit relating to the designation of beneficiary(ies) shall be applicable.

10.9 Non-Alienation and Prohibition on Assignment of Benefits

Benefits provided under this Plan shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any relative of the Participant, prior to actually being received by the person entitled to the benefit under the Plan.

Without limiting the foregoing, no rights, causes of action and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, an out-of-network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to, or on behalf of, a Participant except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Administrator, or other delegate of the Plan Administrator is a named party (a "**Plan Agreement**"). For purposes of clarification and not limitation, such rights and causes of action shall include any administrative, statutory, or legal right or cause of action that a Participant or other individual may have under ERISA, including, but not limited to, any right to (a) make a claim for Plan benefits with respect to a Covered Benefit that is subject to ERISA, (b) request the Plan document or other documents related to the Plan or a claim for benefits with respect to a Covered Benefit that is subject to ERISA, (c)

file an appeal of a denied claim for Plan benefits with respect to a Covered Benefit that is subject to ERISA, or (d) file a lawsuit under ERISA, as applicable, or other applicable law.

In the absence of a Plan Agreement which specifically provides for assignment of the Participant's benefits and/or rights under the Plan (*i.e.*, is not merely an agreement between the Participant and the provider or its representative or agent), the Plan Administrator and Claims Administrator, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the provider, the Participant, or to another designated person or entity, with or without the Participant's authorization, with each such payment being made on behalf of the Participant, and not to such payment recipient in its, his or her own right. Moreover, if the Plan Administrator or Claims Administrator, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator or Claims Administrator of the anti-assignment provisions of this Section Error! Reference source not found.. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the Participant for benefits under the Plan to the full extent of such payment. Accordingly, if a healthcare or dependent care provider is overpaid as the result of accepting a payment for the same covered health care or dependent care service from both the Participant and from the Plan, the provider, and not the Plan, shall be responsible for reimbursing the Participant for such overpayment.

Any attempt to alienate, sell, assign, pledge, charge or otherwise transfer or encumber any right to benefits provided hereunder shall be void and without effect. The Board, the Plan Administrator (and any individual member thereof), and any Employer and its officers shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of, or claims against, any person entitled to benefits hereunder.

10.10 Reference to Other Documents

The types, amounts, and costs of coverage and benefits available under each of the Covered Benefits, and the other terms, conditions and limitations of coverage, participation and benefits, are as set forth in the separate, written insurance policies, certificates of coverage, plans, contracts or other documents which describe and represent such Covered Benefits and which are incorporated herein by reference. In the case of any conflict between the terms or provisions of the Plan and the terms or provisions of the documents which represent the particular Covered Benefit, the documents representing the Covered Benefit shall control to the extent not inconsistent with controlling law or regulation; provided, however, the Plan and all documents incorporated by reference herein shall be construed as mutually consistent to the full extent possible.

10.11 No Guarantee of Tax Consequences

Neither the Board, the Plan Administrator, nor any Employer or its officers make any representation, commitment or guarantee that any amounts contributed to the Plan, or paid to or for the benefit of any Participant, Dependent, beneficiary, or other person under the Plan (including any Covered Benefit), will be excludable from such person's gross income for any tax purpose, or that any other tax treatment will apply or be available to such person.

10.12 Severability

In the event that any term or provision of the Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall be fully severable and shall not affect the remaining terms and provisions of the Plan, and, furthermore, the Plan shall be construed and enforced as if the illegal or invalid term or provision had not been included herein. In addition, the Plan is intended to comply with the requirements of Section 125 of the Code and regulations or other authority issued thereunder by the appropriate governmental authority. If the Plan Administrator determines that any term or provision of the Plan or any Covered Benefit is inconsistent with the preceding sentence, such term or provision shall be deemed to be inoperative and the Plan shall be operated in a manner which complies with the requirements of the preceding sentence.

10.13 Mistake of Fact

When a Plan fiduciary becomes aware of any mistake of fact in a document, he shall correct the mistake and make any proper adjustment required. A fiduciary shall not be liable in any manner for any such determination made in good faith.

10.14 Waiver

The failure by an Employer or Plan fiduciary to enforce strictly any term or provision of the Plan shall not be construed as a waiver of such term or provision. The Employer and the Plan Administrator and other Plan fiduciaries reserve the right to enforce strictly any term or provision of the Plan at any time, regardless of the nature or number of prior occurrences or the similarity of the circumstances.

10.15 Right to Receive and Release Necessary Information

In order to implement the terms and provisions of the Plan, the Plan Administrator and Claims Administrator, and their delegates, may release or obtain information deemed necessary or appropriate concerning a Participant without the consent or knowledge of that person except when prohibited by the Privacy Regulations under HIPAA or any applicable state privacy law. Any Participant claiming benefits under the Plan, including any assignees of Participants, will provide the Plan Administrator and Claims Administrator, and their delegates, with any information deemed necessary or appropriate to process or pay the claim; and the Employer, Plan Administrator and Claims Administrator shall not be responsible for the direct or indirect consequences of any failure by any Participant or assignee to timely provide the required information.

10.16 Subrogation and Reimbursement

The provisions of this Section 10.16 apply solely to the Health Flexible Spending Account Portion of the Plan. References in Section 10.16 to "the Plan" shall be limited to mean the Health Flexible Spending Account portion of the Plan.

(a) Claims Covered. In the event of any benefit payments made under the Health Flexible Spending Account portion of the Plan to or on behalf of any Participant, the Plan shall, to the extent of such payments, be fully subrogated to all the rights of recovery and other rights of the Participant arising out of any claim or cause of action which may accrue because of the alleged accidental, negligent, intentional,

or tortuous conduct, act or omission of another person or entity including, without limitation, a tortfeasor, the Employer or another Participant and its and their insurers (hereinafter all such persons or entities shall be individually and collectively referred to in this Section as a "third party"). Participant, by participation in the Plan, agrees that his estate, and the legal representative of his estate, shall likewise be obligated and that the Plan shall be fully subrogated to, and entitled to reimbursement from, any recovery or right of recovery that the estate may have against any third party on account of, or arising out of, the Participant's injury or illness, including without limitation, any wrongful death claim or action.

The Participant, or the legal representative or beneficiaries of Participant or his estate, shall notify the Plan Sponsor of any claim or lawsuit against a third party or insurance carrier within thirty (30) days of the date that the claim is made or the lawsuit is filed. The Plan and the Plan Sponsor, on behalf of the Plan, have the right, in its discretion, to pursue any action to enforce its subrogation rights and its reimbursement rights against a third party or another person or entity.

(b) Participant's Agreement to Subrogation and Reimbursement. Participant, on behalf of himself and each beneficiary of a payment made on Participant's behalf by accepting benefits under the Plan, consents and agrees (1) that the Plan shall first be promptly reimbursed for any payments made to or on the Participant's behalf under the Plan out of any monies recovered as the result of any lawsuit, judgment, order, award, settlement, compromise, arbitration or other arrangement (regardless of whether or not there has been a full recovery or such sums are allocated to any particular type of loss, damage or expense), and (2) to include all benefits paid or payable under the Plan in any liability or other claim against a third party. Furthermore, Participant and said beneficiaries promise and agree to take such action, to furnish such information and assistance, to execute and deliver any assignments, subrogation and reimbursement agreements, and other instruments as the Plan Sponsor or its agent may require to facilitate enforcement of the Plan's subrogation and reimbursement rights, and not to prejudice, or in any way detrimentally affect such rights. The Plan's rights shall not be affected by any release, including a partial release, that is entered into without the consent of the Plan Sponsor. The Plan's rights shall extend to (1) all conceivable sources of recovery, other than the Plan itself, including, by the way of example and not limitation, any and all automobile insurance coverage (including uninsured/under-insured motorist coverage), no-fault coverage, medical insurance coverage, school insurance coverage, disability coverage, personal injury awards or settlements, and medical malpractice awards or settlements, and (2) all types of payments made by or on behalf of a third party, regardless of how designated, including, without limitation, payments for medical expenses, disability, accidental death or dismemberment, past or future wages or loss of earning capacity, pain and suffering, mental anguish, loss or consortium or companionship, and exemplary damages of any kind. For purposes of clarity and not limitation, to the extent that a recovery from a third party is obtained by an attorney for the Participant, the full amount that the Plan is entitled to recover hereunder shall not be offset or otherwise reduced by any attorney's fees or other costs of recovery that were not specifically

approved in advance in writing by the Plan Sponsor.

(c) Limitation to Plan's Subrogation and Reimbursement Rights. The Plan's subrogation rights and its reimbursement rights (1) shall extend only to the recovery by the Plan of (A) the benefits under the Health Flexible Spending Account portion of the Plan that have been paid or will be paid to or on behalf of the Participant and (B) the cost of prosecuting the claim for recovery, including attorney's fees and court and collection costs, and (2) shall fully apply even if the Participant or his beneficiary has only received a partial recovery from a third party. Upon the advice of legal counsel, the Plan Sponsor shall create a trust in connection with the Health Flexible Spending Account portion of the Plan to hold any monies received, pursuant to the provisions of this Section, which constitute "plan assets" under ERISA.

(d) Subrogation and Reimbursement Rights Not Affected By Payment. The Plan's subrogation and reimbursement rights shall not be affected if benefits are paid before the Plan Sponsor obtains any additional agreement from the Participant (or from any other payee) or if the Plan Sponsor does not request any such agreement. In addition, the failure or refusal of a Participant (or other payee) to sign an agreement at the request of the Plan Sponsor recognizing the Plan's or Qualified Benefit's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that Participant (or other payee) even if such benefits have already been paid, and the Plan Sponsor shall retain a right to recover paid benefits which are forfeited in such a manner; moreover, any such failure or refusal shall not affect the enforceability of such rights.

(e) Lien on Proceeds. The Plan Sponsor, on behalf of the Plan, shall have a first and primary lien against the proceeds of any settlement, award or judgment that results from a claim, lawsuit, or other action by or on behalf of a Participant for whom benefits were paid under the Plan. Notice of the lien is sufficient to establish the Plan's lien against the third party or insurance carrier. The Plan Sponsor shall be entitled to (1) deduct the amount of the lien from any future claims payable to or on behalf of the Participant if (A) the lien is not repaid or otherwise promptly recovered by the Plan Sponsor or (B) the Participant or other claimant fails to promptly notify the Plan Sponsor of a payment received from a third party or insurance carrier that is subject to the Plan's rights, and (2) to otherwise take any action that the Plan Sponsor deems necessary or appropriate, in its discretion, to enforce these subrogation rights and reimbursement rights to the full extent possible.

10.17 Construction

Whenever the context so requires, words of the masculine gender used herein shall include the feminine gender, and words used in the singular shall include the plural. The words "herein," "hereof," "hereunder," and other similar compounds of the word "here" shall refer to the entire Plan, not to any particular section or provision of the Plan. Headings of Articles, Sections and

subsections as used herein are inserted solely for convenience and reference and constitute no part of the construction of the Plan.

10.18 Governing Law

The terms, conditions and provisions of the Plan and the Covered Benefits available hereunder shall be construed and governed by the laws of the State of Texas, except as may be preempted by controlling federal law, and in accordance with applicable provisions of the Code and ERISA.

As the Plan is administered in Fort Bend County, Texas, mandatory venue for any claim, legal suit, action or other proceeding arising out of, or relating to, the Plan, other than an interpleader action under the Plan that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof, shall be the Federal District Court for the Southern District of Texas—Houston Division or any judicial district court that is situated in either Fort Bend County, Texas, or Harris County, Texas subject to removal of any such action under ERISA (under 28 U.S.C. §§ 1441 et seq. or any successor provision). Venue for an interpleader action under the Plan that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof shall be, as decided by the Plan Administrator in its discretion, in (a) the state where the deceased Participant resided at his death (if the benefits which are the subject of the interpleader action are those of a deceased Participant), (b) the state in which at least one defendant in the interpleader action resides, or (c) the Federal District Court for the Southern District of Texas—Houston Division or any judicial district court that is situated in either Fort Bend County, Texas, or Harris County, Texas.

Each Participant, as the result of, and in consideration for, participation in the Plan, and his designated representative, with respect to any claim or dispute relating in any way to, or arising out of, the Plan, consents and agrees to such jurisdiction and venue as described in this Section 10.18 and waives any objection to such jurisdiction or venue including, without limitation, that it is inconvenient. Such parties shall not commence any legal action other than before the above-named courts. Notwithstanding the previous sentence, a party may commence any legal action in a court other than the above-named courts solely for the purpose of enforcing an order or judgment issued by one of the above-named courts.

[*Signature page follows.*]

IN WITNESS WHEREOF, the Plan Sponsor has caused this amended and restated Plan to be duly executed in its name and on its behalf by its duly authorized officer, to be effective as of January 1, 2020.

ATTEST	**TEAM, INC.**
By: _____	By: André C. Bouchard
Name: _____	Name: André C. Bouchard
Title: _____	Title: EVP, chief Legal officer

TEAM, INC.
CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2020)

COVERED BENEFITS APPENDIX

As of January 1, 2020, the Covered Benefits, other than cash, offered pursuant to the Plan are coverages under the following employee welfare benefit plans and programs maintained by the Plan Sponsor:

- Pre-tax premium conversion for the group medical, dental, and vision welfare programs offered under the Team, Inc. Welfare Benefit Plan;
- Health Care Flexible Spending Account portion of the Plan (as described in the Plan);
- Dependent Care Flexible Spending Account portion of the Plan (as described in the Plan); and
- Health Savings Account Funding portion of the Plan (as described in the Plan).

Except as otherwise noted, the operative plan and other documents evidencing the actual terms and provisions of the Covered Benefits are hereby incorporated herein by reference, including any exhibits, amendments or modifications to such documents as in effect from time to time.

TEAM, INC.
CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2020)

ADOPTING EMPLOYERS APPENDIX

As of January 1, 2020, the following Employers have adopted and are participating in the Plan, in addition to Team, Inc., the Plan Sponsor:

- Team Industrial Services, Inc.;
- Furmanite America, Inc.;
- QualSpec, LLC;
- Quest Integrity USA LLC;
- DK Valve and Supply Company, Inc.; and
- TCI Services Incorporated.

TEAM, INC.
CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2020)

HIPAA PRIVACY EMPLOYEE DESIGNATION APPENDIX

The following job classifications of employees (or classes of employees) are hereby designated as being entitled to receive Protected Health Information in connection with the Health Care Flexible Spending Account portion of the Plan:

- General Counsel;
- Director Corporate Benefits;
- Sr. Director HRMS/Payroll;
- Sr. Director HR;
- Employee Benefits Administrators; and
- Employee Benefits Manager.