Section 125 Plan

BASIC PLAN DOCUMENT

PAYCHEX®

3/22

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ARTICLE I: INTRODUCTION

1.01 Purpose of Plan. Paychex, Inc. has established this Section 125 Plan (the "Plan") as hereinafter set forth, for those Employers who wish to adopt the Plan to provide their Employees with choices among certain employee benefits and cash compensation. If elected by the Employer under Item IV of the Adoption Agreement, the Plan allows an Eligible Employee to pay for his or her share of premiums under the Premium Only Plan, on a pretax salary reduction basis. In addition, the Plan allows an Eligible Employee to contribute, on a pretax salary reduction basis, to accounts for reimbursement of certain medical and dependent care expenses under the respective Medical Flexible Spending Arrangement ("FSA") and Dependent Care FSA. The Premium Only Plan is intended to qualify as a cafeteria plan under section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), the Medical FSA as a medical reimbursement plan under section 105 of the Code, and the Dependent Care FSA as a dependent care assistance program under section 129 of the Code. Furthermore, if elected by the Employer in the Adoption Agreement, an HSA-Eligible Individual can make pretax salary reduction Contributions to a Health Savings Account ("HSA") under section 223 of the Code.

1.02 Restatement of the Plan. If specified in Item II of the Adoption Agreement, this Plan is an amendment, restatement, and continuation of the Prior Plan adopted as of the effective date set forth in Item II of the Adoption Agreement.

1.03 Definitions and Interpretation. The capitalized words and phrases used throughout the Plan have the meanings set forth in APPENDIX A of this Plan document. The Plan is to be interpreted in accordance with the principles set forth in part 11.08.

1.04 Rights of Employees Not Expanded. Neither the Plan, the action of the Employer in establishing or continuing the Plan, or participation in the Plan may be construed as giving any person the right to be employed by, or remain employed with the Employer or, except as provided in the Plan, the right to any payment or benefit.

1.05 Application of ERISA. The Medical FSA portion of the Plan is an "employee welfare benefit plan" within the meaning of section 3(1) of ERISA. Certain requirements of ERISA, including the fiduciary responsibility provisions, apply to the Medical FSA, as referenced in ARTICLES X and XI of this Plan document. The Premium Only Plan and the Dependent Care FSA portions of the Plan are not subject to the requirements of ERISA, and the Plan shall not be interpreted as applying the requirements of ERISA to such portions of the Plan. Furthermore, to the extent that HSA-Eligible Individuals are permitted to make pretax salary reduction contributions to HSAs, such HSAs are not sponsored or maintained by the Employer and are not intended to be subject to the requirements of ERISA, and the Plan shall not be interpreted as applying the requirements of ERISA to any such HSAs.

1.06 Unfunded Plan. The Plan is an unfunded plan without a trust or any other separate funding vehicle. Although Plan bookkeeping accounts are maintained, including amounts attributable to Employee pretax salary reduction elections, all Plan benefits are paid from the general assets of the Employer.

ARTICLE II: ELIGIBILITY AND PARTICIPATION

2.01 Eligibility Requirements. An Eligible Employee is an Employee who satisfies the conditions for eligibility specified in Item III of the Adoption Agreement. The Employer, in its sole discretion, shall determine and specify in the Adoption Agreement the requirements necessary to be eligible for coverage under the Plan. The Employer has the right to limit or expand participation in the Plan, and to set classifications or categories of Employee groups eligible to participate in the Plan, subject to the requirements of sections 105(h), 125 and 223 of the Code.

2.02 Election to Participate.

(a) **If Eligibility Requirements are Satisfied Before the First Day of Plan Year.** An Employee who is an Eligible Employee before the first day of the Plan Year may become a Participant in the Premium Only

Plan and/or the Medical FSA or Dependent Care FSA portions of the Plan (as applicable) for the Plan Year by filing the Flexible Spending Account Enrollment Form ("Enrollment Form") with the Employer prior to the first day of the Plan Year for which it will be effective. Alternatively, for the flexible spending account, an Employee may complete the Enrollment Form by calling Paychex Employee Services at 1-877-244-1771 or through the Participant website at **www.paychexflex.com**.

(b) **If Eligibility Requirements are Satisfied After the First Day of Plan Year.** An individual who does not become an Eligible Employee in the Premium Only Plan and/or the Medical FSA or Dependent Care FSA portions of the Plan (as applicable) until after the first day of a Plan Year may file an Enrollment Form with the Employer and shall become a Participant for those portions of the Plan (as applicable) on the entry date specified in Item III of the Adoption Agreement. For the flexible spending account, an Employee may complete the Enrollment Form by calling Paychex Employee Services at 1-877-244-1771 or through the Participant website at **www.paychexflex.com.** Maximum election amounts for benefits under the Plan will be limited to the maximum amounts specified under Item IV of the Adoption Agreement.

(c) **If Eligibility Requirements are Satisfied Before the First Day of Plan Year.** An Employee who is an Eligible Employee before the first day of the Plan Year may become eligible to make pretax contributions to a Health Savings Account (as applicable) for the Plan Year by filing the Health Savings Account Election Form with the Employer prior to the first day of the Plan Year for which it will be effective. Alternatively, an Employee may complete the Election Form through the Participant website at **www.paychexflex.com**.

(d) **If Eligibility Requirements are Satisfied After the First Day of Plan Year.** An individual who does not become an Eligible Employee for purposes of making pretax contributions to a Health Savings Account (as applicable) until after the first day of a Plan Year may file an Election Form with the Employer and shall become a Participant on the entry date specified in Item III of the Adoption Agreement. For the Health Savings Account, an Employee may complete the election form through the Participant website at **www.paychexflex.com**.

2.03 Cessation of Participation. A Participant ceases to be a Participant as of the earliest of:

(a) the date the Participant's Enrollment Form is revoked under the Plan;

(b) the date the Participant ceases to be an Eligible Employee;

(c) the date the Participant terminates employment; and

(d) the date the Plan terminates.

2.04 Reinstatement During the Plan Year. Except as provided for leave under the Family and Medical Leave Act of 1993 ("FMLA Leave") in part 7.07, if a Participant's coverage under the Plan is cancelled during the Plan Year because of termination of employment, leave of absence, or ineligibility for benefits, and that individual resumes employment with status as an Eligible Employee within thirty (30) days of the date coverage was cancelled, his or her elections under this Plan may be reinstated. If an individual resumes employment with status as an Eligible Employee after thirty (30) days, he or she must elect to reinstate coverage on a prospective basis, in accordance with part 2.02(b).

2.05 Continuation of Coverage. Pursuant to section 4980B of the Code, any qualified beneficiary (as defined in section 498B(g)(1) of the Code), who would lose Medical FSA and/or Dependent Care FSA coverage under the Plan as a result of a qualifying event (as defined in section 4980B(f)(3) of the Code), can elect, within a stated election period, continuation coverage of such benefits previously received under the Plan. If a qualified beneficiary timely elects such continuation coverage, the benefits elected will be available outside the Plan for the time period prescribed by law.

2.06 Absence from Employment Due to Military Service. If an Eligible Employee is absent from employment due to military service covered by the Uniformed Services Employment and Reemployment Rights Act, the Eligible Employee and any Dependents may elect to continue coverage under the Plan for up to 24 months from the date the Eligible Employee's coverage would have ceased. If the Eligible Employee is absent from work more than 31 days, the Eligible Employee may be required to pay all costs of coverage, including

administrative fees, as permitted by law. If the Eligible Employee returns to employment within five years, he or she will immediately resume coverage under the Plan as if he or she had never left.

ARTICLE III: PREMIUM ONLY PLAN

3.01 Generally. If an Employer so elects in Item IV of the Adoption Agreement, Eligible Employees may choose to participate in the Premium Only Plan. The purpose of the Premium Only Plan is to provide Eligible Employees with a choice between: (a) payment of Qualifying Premium Expenses; and (b) cash compensation.

3.02 Benefits. The Premium Only Plan permits Eligible Employees to pay for the cost of the types of coverage that the Employer makes available as set forth in Item IV of the Adoption Agreement on a pretax salary reduction basis. The type and amount of benefits offered under the types of coverage elected by the Employer are subject to and governed by the terms and conditions of such coverage. Coverage provided to any individuals who do not satisfy the definition of an Employee, Spouse or Dependent, including a domestic partner who does not qualify as a Dependent, will be paid for on an after-tax basis by the Eligible Employee.

3.03 Qualifying Premium Expenses. Qualifying Premium Expenses are all or a portion of the costs for the Benefit Options made available to an Eligible Employee as set forth in Item IV of the Adoption Agreement. The Employer shall notify the Participant prior to the beginning of the Plan Year what portion of the cost of the Benefit Option is the sole financial responsibility of the Participant.

ARTICLE IV: MEDICAL FLEXIBLE SPENDING ARRANGEMENT

4.01 Generally. If the Employer so elects in Item IV of the Adoption Agreement, Eligible Employees may choose to reduce their salary compensation on a pretax basis under the Medical FSA. The purpose of the Medical FSA is to furnish Eligible Employees with a choice between:

(a) reimbursement for Qualifying Medical Expenses that are not reimbursed by any other plan, or claimed as an income tax deduction; and

(b) cash compensation.

It is intended that the Medical FSA operate in accordance with the rules under section 125 of the Code and qualify as an "accident and health plan" within the meaning of section 105(e) of the Code such that reimbursements will be eligible for exclusion from Participants' taxable income under section 105(b) of the Code.

4.02 Establishment of Account. The Employer establishes and maintains on its books a Medical FSA Account for each Participant who elects to participate in the Medical FSA. Each Plan Year is accounted for separately.

4.03 Crediting of Account. A Participant's Medical FSA Account is credited, as of each date compensation is paid to the Participant (including the final date on which compensation is paid to a Participant terminating from employment), an amount equal to the reduction made in such compensation in accordance with the Participant's Enrollment Form, or by calling Paychex Employee Services at 1-877-244-1771 or by using the website at **www.paychexflex.com**. All amounts credited to the Medical FSA Account are the property of the Employer until paid out pursuant to ARTICLE X.

Notwithstanding the previous paragraph, if the Employer elects the Carryover Option in Item (VI) of the Adoption Agreement, a Participant's account may be credited on January 1 a carryover amount of up to six hundred and ten dollars, no cents ($610.00) (or other amount specified in Item (VI) of the Adoption Agreement) of unused funds remaining from the prior Plan Year, to be used to cover Qualifying Medical Expenses during the current Plan Year (the "Carryover Amount".) The Carryover Amount may be used in accordance with the terms set forth in this Article IV. An Employer may not elect the Carryover Option if Employer elects the Grace Period Option.

4.04 Debiting of Account. A Participant's Medical FSA Account for each Plan Year is debited periodically in the amount of any payment to, or for the benefit of, the Participant for Qualifying Medical Expenses, as provided in part 4.06, only if the Participant applies for reimbursement on or before the end of the Plan Year. Notwithstanding the preceding sentence, if the Employer elects the 2½ month grace period in Item V of the Adoption Agreement (the "Grace Period Option"), a Participant may continue to incur Qualifying Medical Expenses on or before March 15th following the close of the Plan Year. An Employer may not elect the Grace Period if Employer has elected the Carryover Option in Item VI of the Adoption Agreement. Whether or not the 2½ month grace period is elected, all expenses must be submitted for reimbursement prior to March 31st of the following Plan Year.

Notwithstanding the previous paragraph, in the event a Participant terminates employment with the Employer during a Plan Year, such Participant shall have 90 days following the date of termination to submit for reimbursement any Qualifying Medical Expenses incurred prior to the date of termination. In the event a terminated Participant does not submit for reimbursement an incurred Qualifying Medical Expense within the 90 day period following termination, the Participant shall not be reimbursed for such expense.

4.05 Forfeiture of Account.

4.05.1 Plan Year option. If Employer has not elected either the Grace-Period or the Carryover Option any balance which remains credited to the Participant's Medical FSA Account after all reimbursements are made for the Plan Year is not carried over to reimburse the Participant for Qualifying Medical Expenses incurred during a subsequent Plan Year, and is not available to the Participant in any other form. Such balance remains the property of the Plan and the Participant forfeits all rights with respect to such balance.

4.05.2 Grace Period Option. If Employer has elected the Grace Period Option, any balance which remains credited to the Participant's Medical FSA Account after all reimbursements are made for the Plan Year and grace period, is not carried over to reimburse the Participant for Qualifying Medical Expenses incurred during a subsequent Plan Year, is not available to the Participant in any other form. Such balance remains the property of the Plan and the Participant forfeits all rights with respect to such balance.

4.05.3 Carryover Option. If Employer has elected the Carryover Option any balance which remains credited to the Participant's Medical FSA Account after (i) all reimbursements are made for the Plan Year; and (ii) after Employer has carried over the Carryover Amount elected by Employer to reimburse the Participant for Qualifying Medical Expenses incurred during a subsequent Plan Year (as outlined in Item VI of the Adoption Agreement), and is not available to the Participant in any other form. Such balance remains the property of the Plan and the Participant forfeits all rights with respect to such balance.

4.06 Reimbursement of Qualifying Medical Expenses. During a Plan Year each Participant is entitled to receive reimbursement of Qualifying Medical Expenses up to the dollar amount elected by the Employer in Item IV of the Adoption Agreement, plus any eligible Carryover Amount (if applicable) and elected by the Participant in the Enrollment Form provided: (a) such expenses are incurred during the Plan Year and/or grace period (expenses are treated as incurred when the health care services are provided and not when the Participant is billed, charged for, or pays for the services); (b) such expenses are not reimbursable by the Medical Plan or any other medical plan; and (c) If a Participant terminates employment during a Plan Year, Qualifying Medical Expenses will include only those expenses that are incurred prior to the date of termination of employment, unless such individual elects to continue coverage under COBRA.

4.07 Qualifying Medical Expenses. Qualifying Medical Expenses are expenses for "medical care," within the meaning of section 213(d) of the Code, incurred by a Participant, Spouse, or Dependent, but does not include premium payments for other medical plan coverage, including premiums paid for medical coverage under a plan maintained by the employer of a Spouse or Dependent. Examples of Qualifying Medical Expenses are:

(a) deductibles and co-payments under any Medical or Dental Plan sponsored by the Employer, or under other accident and health insurance of the Participant, Spouse, or Dependents;
(b) dental care, including routine dental checkups, orthodontic work, and dentures;
(c) prescription and nonprescription medicine and drugs purchased to remedy current medical conditions for the Participant, Spouse, or Dependents;
(d) eye care, including vision checkups, eyeglasses, and contact lenses;
(e) hearing care, including hearing examinations, and hearing aids; and
(f) routine physical examinations.

4.08 Refund of Duplicate Reimbursement. If a Participant receives reimbursement under the Medical FSA Account, and reimbursement for the same expense is made under another plan, he or she is required to refund the reimbursement under the Medical FSA Account to the Employer. The amount of the Participant's elected coverage under the Plan, to the extent of any such refund, is reinstated for the Plan Year in which the reimbursement was originally made.

4.09 Limited Purpose Medical FSA. If under Item VII of the Adoption Agreement, the Employer elects to establish a Limited Purpose Medical FSA, the provisions of ARTICLE IV, Medical Flexible Spending Arrangement, shall apply to the Limited Purpose Medical FSA, except that Qualifying Medical Expenses as defined in part 4.06 shall include only expenses for dental or vision care, or preventive care benefits as described in IRS Notice 2004-23. For each Plan Year that a Participant elects to contribute to a Health Savings Account, he or she shall only be permitted to participate in a Limited Purpose Medical FSA under the Plan.

ARTICLE V: DEPENDENT CARE FLEXIBLE SPENDING ARRANGEMENT

5.01 Generally. If the Employer so elects in Item IV of the Adoption Agreement, Eligible Employees may choose to reduce their salary compensation on a pretax basis under the Dependent Care FSA. The purpose of the Dependent Care FSA is to provide Eligible Employees with a choice between:

(a) reimbursement for Qualifying Dependent Care Expenses not reimbursed by any other plan, or claimed as an income tax credit; and

(b) cash compensation.

It is intended that the Dependent Care FSA qualify as a dependent care assistance program within the meaning of section 129 of the Code.

5.02 Establishment of Account. The Employer establishes and maintains on its books a Dependent Care Account for each Participant who has elected to participate in the Dependent Care FSA. Each Plan Year is accounted for separately.

5.03 Crediting of Account. A Participant's Dependent Care Account for each Plan Year is credited, as of each date compensation is paid to the Participant in such Plan Year (including the final date on which compensation is paid to a Participant terminating from employment), an amount equal to the reduction made in such compensation in accordance with the Participant's Enrollment Form or, if applicable, by calling Paychex Employee Services at 1-877-244-1771 or through the Participant website at www.paychexflex.com. All amounts credited to a Dependent Care Account are the property of the Employer until paid out.

5.04 Debiting of Account. A Participant's Dependent Care Account for each Plan Year is debited from time-to-time in the amount of any payment to, or for the benefit of, the Participant for Qualifying Dependent Care Expenses, as provided in part 5.06, only if the Participant applies for reimbursement on or before the end of the Plan Year. Notwithstanding the preceding sentence, if the Employer elects the 2½ month grace period in Item V of the Adoption Agreement, a Participant may continue to incur Qualifying Dependent Care Expenses on or before March 15th following the close of the Plan Year. Whether or not the 2½ month grace period is elected, all expenses must be submitted for reimbursement prior to March 31st of the following Plan Year.

Notwithstanding the previous paragraph, in the event a Participant terminates employment with the Employer during a Plan Year, such Participant shall have 90 days following the date of termination to submit for reimbursement any Qualifying Dependent Care Expenses incurred prior to the date of termination. In the event a terminated Participant does not submit for reimbursement an incurred Qualifying Dependent Care

Expense within the 90 day period following termination, the Participant shall not be reimbursed for such expense.

5.05 Forfeiture of Accounts. After all reimbursements are made for the Plan Year and grace period, if applicable, any balance remaining credited to the Participant's Dependent Care Account is not carried over to reimburse the Participant for Qualifying Dependent Care Expenses incurred during a subsequent Plan Year, nor is it available to the Participant in any other form. Instead, such balance remains the property of the Employer and the Participant forfeits all rights with respect to such balance.

5.06 Reimbursement of Qualifying Dependent Care Expenses. During a Plan Year each Participant is entitled to receive reimbursement of Qualifying Dependent Care Expenses up to the dollar amount elected by the Employer in Item IV of the Adoption Agreement and elected by the Participant in the Enrollment Form. Subject to the last sentence of this part, Qualifying Dependent Care Expenses are expenses incurred by a Participant which satisfy the following conditions:

(a) are incurred for the care of a Dependent of the Participant or for related household services; expenses are treated as incurred when the services are provided and not when the Participant is billed, charged for, or pays for the services;

(b) are paid or payable to a Dependent Care Service Provider; and

(c) are incurred to enable the Participant (and spouse if applicable) to be gainfully employed for any period in which there are one or more Dependents with respect to the Participant.

Qualifying Dependent Care Expenses do not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is: (i) a Dependent of the Participant who is under the age of 13 and who lives with the taxpayer for over half the calendar year, (ii) a Dependent of the Participant who is mentally or physically unable to care for himself, lives with the taxpayer for over half the calendar year, and regularly spends at least eight hours each day in the Participant's household, or (iii) a Spouse of the Participant who is mentally or physically unable to care for himself, lives with the taxpayer for over half the calendar year, and regularly spends at least eight hours each day in the Participant's household. If a Participant terminates employment during a Plan Year, Qualifying Dependent Care Expenses will include only those expenses that are incurred prior to the date of termination of employment.

5.07 Report to Participants on or Before January 31. On or before each January 31, the Employer will furnish to each Participant who participated in the Dependent Care FSA during the prior calendar year a Form W-2 showing the amount of salary reduction contributions made by the Participant during such year with respect to the Dependent Care Account.

ARTICLE VI: HEALTH SAVINGS ACCOUNT

6.01 Generally. If the Employer so elects in Item IV of the Adoption Agreement, Employees who are HSA-Eligible Individuals may choose to reduce their salary compensation on a pretax basis to make Contributions to the Employee's Health Savings Account ("HSA"). Each HSA is established and maintained outside the Plan by a trustee/custodian to which the Employer can forward Contributions to be deposited.

Pursuant to applicable law, HSA benefits cannot be elected and implemented with respect to any HSA-Eligible Individual if Medical FSA benefits have been elected under the Plan, unless the Limited Purpose Medical FSA option (i.e., for vision, dental or applicable preventive care) is selected and used. An HSA-Eligible Individual shall not be permitted to make salary reduction Contributions to an HSA so long as he or she is participating in a Medical FSA.

6.02 Establishment of Account. Each HSA-Eligible Individual is responsible for establishing his or her own HSA. HSA benefits under this arrangement consist solely of the ability to make Contributions to the HSA on a pretax salary reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. Similarly, the terms and conditions of each HSA-Eligible Individual's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing HSA-Eligible Individual and are not a part of this Plan.

6.03 HSA Not Intended to Be an ERISA Plan. The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code section 223(d)(2) of the Code. The Employer has no authority or control over the funds deposited in any HSA. Even though this Plan may allow pretax salary reduction Contributions to an HSA, the HSA is not sponsored or maintained by the Employer and is not intended to be subject to ERISA.

6.04 Eligibility to Participate. To participate in an HSA, the individual must be an HSA-Eligible Individual and shall also be subject to the additional requirements, if any, specified in any related High Deductible Health Plan.

6.05 Crediting of Account. As of each date compensation is paid to the HSA-Eligible Individual (including the final date on which compensation is paid to such individual when terminating from employment), an HSA-Eligible Individual's HSA shall be credited with an amount equal to the salary reduction amount elected on the HSA-Eligible Individual's Election Form or, if applicable, through the participant website at www.paychex.com/login. All amounts credited to a Health Savings Account are the property of the applicable HSA-Eligible Individual who holds the account.

6.06 Contributions to HSA; Maximum Limits. The salary reduction election amount for any HSA-Eligible Individual for his or her taxable year will be limited to the maximum annual contribution amount set forth in Section 223 of the Code, as indexed and reported by the IRS for each taxable year. The annual Contribution for an HSA-Eligible Individual's HSA benefits is equal to the annual benefit amount elected by the HSA-Eligible Individual, but in no event shall the amount elected exceed the statutory maximum amount for HSA Contributions applicable to the HSA-Eligible Individual's High Deductible Health Plan coverage option (i.e., single or family) for the taxable year in which the Contribution is made (e.g., $3,450 for single and $6,900 for family are the statutory maximum amounts for 2018).

An additional catch-up Contribution of $1,000 may be made by HSA-Eligible Individuals who are age 55 or older before the close of the applicable taxable year.

In addition, the maximum annual Contribution shall be:

(a) Reduced by any matching (or other) Employer Contribution made on the HSA-Eligible Individual's behalf; and

(b) Prorated for the number of months in which the Employee is an HSA-Eligible Individual.

6.07 Right to Modify Elections. Notwithstanding anything to the contrary, an HSA-Eligible Individual can increase, decrease, or revoke his or her HSA salary reduction election at any time on a prospective basis, subject to any restrictions adopted by the Employer as specified in Item IV of the Adoption Agreement. Such restrictions, if any, will apply to all HSA-Eligible Individuals making Contributions in connection with this arrangement. Any HSA election change shall be effective as soon as administratively practicable after the election change is received. For the avoidance of doubt, nothing herein is intended to permit Participants the right to make mid-year changes to elections relating to the Premium Only Plan, Medical FSA or Dependent Care FSA portions of the Plan, except as permitted by applicable law and as set forth in Article VII below or otherwise.

6.08 Termination of Participation. Notwithstanding the previous paragraph, in the event an individual who has made Contributions to an HSA as an HSA-Eligible Individual terminates employment with the Employer, the individual's HSA pretax salary reduction election shall be automatically revoked.

6.09 Distributions from HSA. Distributions from an individual's HSA (whether before or after termination of employment) and all other matters relating to an individual's HSA are outside of this Plan and are to be administered, addressed and resolved by the individual and his or her HSA trustee/custodian in accordance with the agreement between such parties. The federal income tax treatment of the HSA (including any

contributions and distributions) is governed by Section 223 of the Code and shall be the responsibility of the HSA account holder.

6.10 Report to Participants on or Before January 31. On or before each January 31, the Employer will furnish to each individual making HSA Contributions on a pretax salary reduction basis as described herein a Form W-2 (or such successor Form or report, if applicable) properly indicating the amount of Employer Contributions (if any) that were made for the individual's immediately prior taxable year. Each separate HSA holder is responsible to report HSA contributions for tax purposes in compliance with applicable law.

ARTICLE VII: ENROLLMENT FORM

7.01 Period of Coverage; Enrollment Form Generally Irrevocable. Subject to ARTICLE II and the specific rules regarding HSA elections set forth in Article VI, an Enrollment Form is effective beginning on the first day of the month following the date an Employee becomes and Eligible Employee, until revoked. An Enrollment Form is irrevocable during the Plan Year, except as provided in parts 6.07 (with respect to HSA elections only) and parts 7.03 through 7.07.

7.02 Limits on Salary Reduction Amounts Elected. The limits on salary reduction amounts that a Participant may elect on an Enrollment Form shall be determined by the Employer as set forth in Item IV of the Adoption Agreement.

7.03 Change in Election Due to Change in Status. A change in Election during the Plan Year is allowed if the following three conditions are satisfied:

(a) One or more of the following "change in status" events occurs:

1. marriage;
2. divorce;
3. legal separation;
4. annulment;
5. death of Spouse or Dependent;
6. birth, adoption of child, or placement for adoption of child;
7. change in the employment status of the Employee, Spouse, or Dependent;
8. a Dependent satisfying, or ceasing to satisfy, eligibility requirements; or
9. change in the place of residence of the Employee, Spouse, or Dependent.

(b) The proposed change in Election is on account of and corresponds with that change in status (for example, the proposed change bears a logical relationship to the event that has occurred); and

(c) The change in status affects eligibility under the Plan (for example, an Employee, Spouse, or Dependent either gains or loses coverage in response to an event).

7.04 Change in Election Due to Change in Cost or Coverage. If the cost or coverage under a Benefit Option changes, the Employer is authorized to allow each affected Participant to change his or her Election during the Plan year, with respect to the Premium Only Plan and Dependent Care FSA (but not the Medical FSA) in some or all of the circumstances described in this section.

(a) Cost Changes.

(1) **Automatic Changes.** If the cost of a Benefit Option increases or decreases during a Plan Year, the Employer may prospectively increase or decrease the affected Employees' salary reduction contributions for the Plan Year.

(2) **Significant Cost Changes.** If the cost of a Benefit Option significantly changes during the Plan Year, the Employer may allow Employees to make a corresponding change in Election.

(b) Cost Change Condition for Dependent Care. Paragraph (a) applies in the case of a Dependent Care FSA only if the cost change is imposed by a dependent care provider who is not a relative of the Employee.

(c) Coverage Changes.

(1) **Significant Curtailment Without Loss of Coverage.** If coverage under a Benefit Option is significantly curtailed (for example, there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost sharing limit under the Medical Plan), the Employer may allow Employees to change their Election with respect to that Benefit Option and elect any similar coverage available under the Plan.

(2) **Significant Curtailment With Loss of Coverage.** If coverage under a Benefit Option is curtailed to the extent that it constitutes a Loss of Coverage as defined in paragraph (3), the Employer may allow Employees to revoke their Election with respect to that Benefit Option and, in lieu thereof, elect either to receive on a prospective basis similar coverage under another option under that Benefit Option or drop coverage if no similar coverage is available.

(3) **Loss of Coverage.** A "Loss of Coverage" means a complete loss of coverage, including but not limited to the elimination of an option under a Benefit Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage by reason of an overall lifetime or annual limitation. The Employer may treat the following as a Loss of Coverage:

(a) a substantial decrease in the medical care providers available under a Benefit Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the Medical Plan);

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

(c) any other similar fundamental loss of coverage.

(4) **Addition or Improvement Under a Benefit Option.** If a Benefit Option adds a new feature, or if coverage under an existing option is significantly improved during the Plan Year, Eligible Employees (whether or not they have previously made an Election under the Plan with respect to that Benefit Option or have previously elected an option) may make an Election on a prospective basis for the improved option.

(5) **Change in Coverage Under Another Employer Plan.** An Eligible Employee may make a prospective Election change that is on account of and corresponds with a change made under another employer's plan, including a plan of a Spouse or Dependent.

7.05 Change in Election Due to Certain Other Events. A Participant may change his or her Election during the Plan Year with the Medical Plan, Dental Plan, or Medical FSA if any of the following events occur:

(a) a special enrollment right under HIPAA;

(b) a judgment, decree or order requiring that an Employee's child receive accident or medical coverage (including a Qualified Medical Child Support Order); and

(c) a Participant's eligibility for Medicare or Medicaid.

7.06 Required Change in Election. A Participant's Election will be changed as necessary pursuant to part 9.05 to comply with the nondiscrimination rules in ARTICLE IX.

7.07 Change in Election Due to FMLA Leave. Notwithstanding part 2.04, a Participant on FMLA Leave may change or revoke his or her Election under the Premium Only Plan with respect to the Medical Plan or the Medical FSA, subject to the following limitations:

(a) Revoking Coverage. A Participant absent on FMLA Leave may elect to cease participation in the Premium Only Plan or Medical FSA at the time the leave begins.

(b) Resuming Coverage. Upon return to employment as an Eligible Employee from FMLA Leave, a Participant who has revoked coverage under the Premium Only Plan may elect to reinstate his coverage on a prospective basis, but only at the level of coverage in effect from the Enrollment Form before his FMLA Leave began (adjusted to conform to any amendments to the Plan or a Benefit Option made during the period of FMLA Leave). With respect to the Medical FSA, the preceding

sentence applies, except that a Participant may either: (1) make up the contributions that were due during the period of FMLA Leave, in which case the Participant will resume coverage at the same annual amount elected before FMLA Leave began, or (2) not make up such contributions, with the annual amount of coverage reduced accordingly.

(c) Continuing Coverage. A Participant on FMLA Leave who wishes to continue participation in the Plan during FMLA Leave may either pay the premiums on a pretax basis before taking FMLA Leave (for example, pre-pay), on an after-tax basis during the FMLA Leave (for example, pay-as-you-go), or on a catch-up basis upon return from FMLA Leave (for example, catch-up). Failure to pay such premiums will result in the discontinuance of coverage under the Plan during the leave period.

(d) It is the responsibility of the Employer to determine if the Employer is bound by FMLA and, if so, ensure that requirements are met in accordance with the rights and provisions described by law.

ARTICLE VIII: CONTRIBUTIONS

8.01 Funding Arrangement. The Employer may, in its discretion, credit an amount under the Plan, each Plan Year, to be allocated in addition to the salary reduction of a Participant's elected benefits under his Enrollment Form. This credited amount, referred to in the Plan for ease of expression as an "Employer Contribution," will be paid from the Employer's general assets. Before the start of each Plan Year, the Employer will determine the annual Employer Contribution, if any, and the costs for a participant's benefit coverage under the Benefit Options and communicate this information to Eligible Employees.

8.02 Participant Contributions. If, after allocation of any employer contribution for the Plan Year, a Participant's elected benefits under his Enrollment Form would not be fully paid, the Participant's pay shall be reduced for each applicable payroll period on a pretax basis in accordance with his Enrollment Form by the amount of the applicable Participant cost.

ARTICLE IX: NONDISCRIMINATION

9.01 Highly Compensated Individuals. The Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate, or as to contributions and benefits, in compliance with the requirements of section 125(b)(1) of the Code.

9.02 Key Employees. Payments made under the Plan for, or on behalf of, Key Employees of the Employer shall not exceed 25 percent of the aggregate of the payments made for, or on behalf of, all employees under the Plan, in compliance with the requirements of section 125(b)(2) of the Code.

9.03 Dependent Care FSA. With respect to the Dependent Care FSA, the average benefits provided to employees who are not Highly Compensated Employees shall be at least 55 percent of the average benefits provided to Highly Compensated Employees in compliance with the requirements of section 129(d)(8) of the Code and the Dependent Care FSA shall not discriminate in favor of Highly Compensated Employees as to eligibility in compliance with section 129(d)(3) of the Code, or as to contributions or benefits in compliance with section 129(d)(2) of the Code.

9.04 Medical FSA. With respect to the Medical FSA, this Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate, or as to contributions and benefits, in compliance with the requirements of section 105(h) of the Code.

9.05 Modification of Election. The Employer shall send a notice to any Participants whose benefits under the Plan would cause the Plan to violate the requirements of this ARTICLE and indicate the salary reduction amount, if elected by the Participant, which would allow the Plan to qualify under the Code by the end of the Plan Year. The Participant so notified under this ARTICLE will then have 30 days to enter into a modified Enrollment Form, valid for the remainder of the Plan Year, electing no more than that salary reduction amount. In the absence of a modification, the Participant's participation in the Plan for the Plan Year will be entirely terminated.

ARTICLE X: BENEFIT CLAIMS AND OTHER PAYMENT PROVISIONS

10.01 Claims Procedures.

(a) Generally. A Participant who has entered into an Enrollment Form for a Plan Year may pay for Qualifying Dependent Care Expenses or Qualifying Medical Expenses with his or her own funds and request reimbursement from the Plan in accordance with the procedures described in part 10.01(b). Alternatively, if so elected by the Employer in Item VII of the Adoption Agreement, such Participant may use the debit card provided by the Employer to pay for these expenses in accordance with the procedures described in part 10.01(c).

(b) Filing a Claim for Reimbursement. A Participant (or an authorized representative) who has entered into an Enrollment Form for a Plan Year may request reimbursement of Qualifying Medical Expenses and/or Qualifying Dependent Care Expenses, and that are reimbursable under ARTICLE IV and/or V, respectively, by submitting the request in writing to the Employer or to the Recordkeeper designated by the Employer in such form as the Employer may prescribe, setting forth:

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

(2) the name of the person to which the expense was or is to be paid; and

(3) such other information as the Employer may from time-to-time require.

Such requests must be accompanied by bills, invoices, receipts, or other statements showing the amounts of such expenses from the provider, together with any additional documentation that the Employer may request.

(c) Debit Card. If so elected by the Employer in Item VII of the Adoption Agreement, a Participant may pay for Qualifying Medical Expenses that are reimbursable under ARTICLE IV, respectively, with a debit card provided by the Employer, subject to the rules of this Subsection.

(1) Conditional Charges. Any debit card charges that do not fit within one of the categories of automatic substantiation described in paragraph (2) are treated as conditional, pending confirmation of the charge. For all conditional charges, a Participant must file a claim for reimbursement with the Employer and submit additional third-party information, such as merchant or service provider receipts, for review and substantiation. If, upon review, the Employer determines that these charges do not satisfy the definition of medical care under section 213(d) of the Code as applicable, the Employer will so notify the Participant. The Employer will then recoup the improper payment by requiring the Participant to reimburse the Employer by check, or alternatively, by requesting the Employer to reduce the Participant's salary on an after-tax basis in an amount equal to the improper payment.

(2) Automatic Substantiation. The following categories of debit card transactions are automatically substantiated without a receipt or further review by the Employer:

(A) transactions that take place at a qualifying medical provider's office, if the amount of the transaction equals the amount of the Participant's co-payment under the Medical Plan;

(B) transactions involving a co-payment amount that equals an exact multiple (or combination of co-payments) of not more than five times the dollar amount of the copayment for the specific service;

(C) transactions where a third-party uses inventory control information to determine whether an expense qualifies as a Qualifying Medical Expense; and

(D) transactions that are recurring and match previously approved claims.

(d) Reimbursement or Payment of Claims. The Employer will cause the Participant to be reimbursed for Qualifying Medical Expenses and/or Qualifying Dependent Care Expenses for which the Participant submits documentation in accordance with part 10.01(b) or (c) and that are reimbursable under ARTICLES IV or V, respectively.

(1) Medical FSA. With respect to the Medical FSA, the total amount elected by the Participant for the Plan Year is, at all times available for reimbursement without regard to whether the claims exceed the balance of the Participant's Medical FSA Account for the Plan Year at the time of the reimbursement.

(2) Dependent Care FSA. With respect to the Dependent Care FSA, no reimbursement or payment under this part 10.01(d) may at any time exceed the balance of the Participant's Dependent Care Account for the Plan Year at the time of the reimbursement or payment. Any Qualifying Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence will be reimbursed or paid if and when the balance in such Dependent Care Account for the Plan Year equals the amount of such expenses.

(e) Denial of Medical FSA and/or Dependent Care FSA Claims. If a claim under the Medical FSA and/or Qualified Dependent Care Expenses is denied, in whole or in part, the Employer will notify the claimant of the decision by written notice, in a manner calculated to be understood by the claimant.

(1) **Timing of Notice.** When a Participant's claim for reimbursement of Qualified Medical Expenses and/or Qualified Dependent Care Expenses is denied, a notice will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. If the Employer determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days and a notice will be sent indicating the circumstances requiring the extension and the date by which the Plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information and the Participant will be given at least 45 days to submit the information. The Employer then will make its determination within 15 days from the date the Plan receives the additional information or if earlier, the deadline to submit the additional information.

(2) **Content of Notice.** The notice will set forth:

(A) the specific reasons for the denial of the claim;

(B) a reference to provisions of the Plan on which the denial is based;

(C) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

(D) an explanation of the procedure for review of the denied or partially denied claim, including the claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review;

(E) a disclosure of any internal rule, guideline, or protocol relied on in making the adverse determination (or statement that such information is available free of charge upon request); and

(F) if the denial is based on a medical necessity or experimental treatment, or similar limit, an explanation of the scientific or clinical judgment for the determination (or statement that such information will be provided free of charge upon request).

(f) Request for Review of Denial of Medical FSA and/or Dependent Care FSA Claim. Upon denial of a claim in whole or in part, a claimant (or his authorized representative) has the right to submit a written request to the Employer for a full and fair review of the denied claim by the Employer, and upon request and free of charge, the right to reasonable access and copies of all documents, records, and other information relevant to the claimant's claim for benefits, and may submit issues and comments in writing.

(1) **Scope of Review.** The review takes 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.

(2) **Timing of Request for Review.** A request for review of a claim must be submitted within 180 days of the receipt by the claimant of written notice of the denial of the claim. If the claimant fails to file a request for review within 180 days of the denial notification, the claim is deemed abandoned and the claimant precluded from reasserting it.

(3) **Contents of Request for Review.** If the claimant files a request for review, his or her request must include a description of the issues and evidence he or she deems relevant. Failure to raise issues or present evidence on review will preclude those issues or evidence from being presented in any subsequent proceeding or judicial review of the claim.

(g) Denial Upon Review of Medical FSA and/or Dependent Care FSA Claim.

(1) **Timing of Denial Notice.** The Employer must render a decision on the review of the claim no more than 60 days after the Employer's receipt of the request for review.

(2) **Contents of Denial.** If the Employer issues a negative decision, it will provide a written decision setting forth:

(A) the specific reason or reasons for the denial of the claim;

(B) a reference to specific Plan provisions on which the adverse determination was made;

(C) 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;

(D) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures and a statement of the claimant's right to bring an action under ERISA section 502(a);

(E) a disclosure of any internal rule, guideline, or protocol relied on in making the adverse determination (or statement that such information is available free of charge upon request); and

(F) if the denial is based on a medical necessity or experimental treatment, or similar limit, an explanation of the scientific or clinical judgment for the determination (or statement that such information will be provided free of charge upon request).

(3) **Authority of the Employer.** To the extent of its responsibility to review the denial of benefit claims, the Employer has full authority to interpret and apply in its discretion the provisions of the Plan. The decision of the Employer is final and binding upon any and all claimants and any person making a claim through or under them. Benefits will be paid only if the Employer decides in its discretion that the claimant is entitled to them.

(h) Limits on Right to Judicial Review. A claimant must follow the claims procedures described by this section before taking action in any other forum regarding a claim for benefits under the Plan. Any suit or legal action initiated by a claimant under the Plan must be brought by the claimant no later than one year following a final decision on the claim for benefits under these claims procedures. The one year statute of limitations on suits for benefits applies in any forum where a claimant initiates such suit or legal action. If a civil action is not filed within this period, the claimant's benefit claim is deemed permanently waived and abandoned.

10.02 Payments to Minors and Incompetents. Upon proof satisfactory to the Employer that an individual entitled to receive a payment under the Plan is legally incompetent, including by reason of being a minor, the Employer may direct the distributions be made in any one or more of the following ways:

(a) to the individual's Spouse, child, parent, other blood relative, or dependent whom he has the duty to support;

(b) to the individual's legal guardian or conservator; or

(c) to any other person, including a recognized charity or governmental institution, to be held and used for the individual's benefit.

The decision of the Employer is final and binding upon all parties. Once payment is made pursuant to this part, the Employer shall have no further obligation to make payment to any other party. The Employer is not obliged to see to the proper application or expenditure of any payments so made.

10.03 Discharge of Obligation; Receipt and Release. All payments from the Plan constitute a complete discharge of all obligations of the Plan and the Employer to the extent of the portion of the account paid. The Employer may require the payee, as a condition precedent to any payment, to execute a receipt and release.

10.04 Nonalienation. No benefit payable under the Plan may be subject in any manner to anticipation, sale, transfer, assignment, pledge, encumbrance, security interest or charge, and any attempt to anticipate, alienate, sell transfer, assign, pledge, encumber, charge, or grant a security interest in the same is void and of no effect; nor may any such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of the person entitled to such benefit.

10.05 Withholding Taxes. The Employer may make any appropriate arrangements to deduct from all amounts paid under the Plan any taxes required to be withheld by any government or government agency. The Participant bears all taxes on amounts paid under the Plan to the extent that no taxes are withheld, irrespective of whether withholding is required.

10.06 Missing Persons. If the Employer cannot locate a Participant after making a reasonably diligent effort, including by giving written notice addressed to the Participant's last known address as shown by the records of the Employer, the amount payable to the Participant is forfeited. If the Participant subsequently applies for benefits, the amount so forfeited will be paid to the Participant.

10.07 Clerical Errors or Omissions. Clerical errors or omissions in information provided to a Participant do not deprive a Participant of his right to receive a benefit, and do not affect the amount of his benefit. Conversely, clerical errors or omissions do not cause a Participant to have the right to receive a benefit to which he is not entitled and a Participant receiving an overpayment by mistake must repay the overpayment, if requested to do so. The Employer reserves the right to correct any mistake in any reasonable manner, including but not limited to, adjusting the amount of future benefit payments, repaying to the Plan any overpayment, or making catch-up payments to a Participant for an underpayment. The failure to enforce any provision of the Plan does not affect the Plan's right thereafter to enforce such provision, nor does such failure affect its right to enforce any other Plan provision.

ARTICLE XI: PLAN ADMINISTRATION

11.01 Plan Administration. The operation and administration of the Plan are controlled and managed by the Employer. With respect to the Medical FSA, the Employer is the "administrator" within the meaning of ERISA section 3(16)(A). Pursuant to parts 11.03(a) and (b), the Employer has delegated certain powers and duties of plan administration to Paychex, Inc., the Recordkeeper, as specified in Item I of the Adoption Agreement.

11.02 Recordkeeper. The Recordkeeper shall perform such administrative tasks as shall be delegated to it by the Employer as described in a separate administrative services agreement.

11.03 Powers of the Employer. Subject to any limits under ERISA with respect to the Medical FSA, the Employer is authorized to take such actions as it determines to be necessary or appropriate for the management and operation of the Plan including:

(a) allocate fiduciary or other authority among any persons and delegate its powers and duties to any person, in which case the references herein to the Employer are deemed to mean or include such person, as to matters within his jurisdiction;

(b) select, employ, and compensate such benefit consultants, actuaries, accountants, attorneys, and other agents and employees as the Employer deems necessary or advisable for the proper and efficient administration of the Plan, and the Employer may rely on the advice and information provided by them;

(c) adopt rules and regulations for the administration of the Plan not inconsistent with the terms and provisions of the Plan; and

(d) exercise itself, or through its delegate, full discretionary authority to determine all questions and matters that may arise in the administration of the Plan, including the resolution of questions of fact, interpretation or application. In all cases, each decision of the Employer or its delegate is final and binding upon all parties. Benefits under the Plan are paid only if the Employer decides in its discretion that the applicant is entitled to them.

11.04 Named Fiduciaries of Medical FSA. The Named Fiduciary of the Medical FSA is the Employer, which may designate other Named Fiduciaries of the Medical FSA.

11.05 Fiduciary Liability.

(a) **For Fiduciary's Own Actions.** No Fiduciary is liable for its own act, or failure to act, unless the Fiduciary causes actual loss to the Medical FSA or to a Participant by failing properly to discharge a fiduciary duty or responsibility expressly imposed upon the Fiduciary by the Plan or by law.

(b) **For Actions of Other Fiduciaries.** No Fiduciary is liable for the act, or failure to act, of another Fiduciary unless the first Fiduciary commits one or more of the following breaches of his or her fiduciary responsibilities:

(1) if he or she participates knowingly in, or knowingly undertakes to conceal, an act or omission of another Fiduciary, knowing the act or omission is a breach;

(2) if, by his or her failure to observe applicable standards in the administration of his or her specific responsibilities which give rise to his or her status as a Fiduciary, he or she enables the other Fiduciary to commit a breach; or

(3) if he or she has actual knowledge of a breach by the other Fiduciary, unless he or she makes reasonable efforts under the circumstances to remedy the breach.

11.06 Indemnity for Liability. The Employer indemnifies each employee, officer, and director of the Employer, and all persons formerly serving in this capacity, acting on behalf of the Plan, against any and all liabilities, or expenses, including all legal fees relating thereto, arising in connection with the exercise of their duties and responsibilities to the Plan, provided however that the Employer does not indemnify any person for liabilities or expenses covered by insurance, nor due to the person's own gross negligence or willful misconduct.

11.07 Plan Interpretation.

(a) **Qualification Under the Code and ERISA.** This Plan is intended to qualify as a "cafeteria plan" within the meaning of section 125 of the Code, such that salary reductions under the Premium Payment Plan, the Medical FSA, and the Dependent Care FSA will be eligible for exclusion from Participants' taxable income. It is intended that the Medical FSA meet the requirements of ERISA, operate in accordance with the rules under section 125 of the Code, and qualify as an "accident and health plan" within the meaning of section 105(e) of the Code, such that reimbursements will be eligible for exclusion from Participants' taxable income under section 105(b) of the Code. It is intended that the Dependent Care FSA qualify as a dependent care assistance program with the meaning of section 129 of the Code, such that reimbursements will be eligible for exclusion from Participants' taxable income under section 129(a) of the Code. To the extent that a provision of this Plan relates to a requirement of the Code or ERISA, it must be interpreted to impose such requirement, but only to the extent required by law, unless the terms of the provision expressly provide otherwise.

(b) **Applicable Law.** The Plan and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA and the Code to the extent applicable, and to the extent not preempted by ERISA, the laws of the state specified in Item VIII of the Adoption Agreement. The Plan may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

(c) **Severability.** If a provision of the Plan is held illegal or invalid, the illegality or invalidity does not affect the remaining parts of the Plan and the Plan must be construed and enforced as if the illegal or invalid provision had not been included in the Plan.

(d) **Gender and Number.** In order to shorten and to improve the readability of the Plan Document, phrases such as "his or her," "he or she," and "Employee or Employees," are used sparingly. Except where otherwise indicated by the context, any gender may be construed to include all genders and the singular or plural may be construed to include the plural or singular, respectively.

(e) **Exclusive Benefit.** The Plan has been established for the exclusive benefit of the Participants. The Plan must be interpreted in a manner consistent with this intent.

(f) **Other Interpretive Principles.** When a reference is made in the Plan to ARTICLES, parts, or appendices, such reference is to an ARTICLE, or section of, or APPENDIX to this Plan unless otherwise indicated. The table of contents and headings contained in the Plan are for reference purposes only and shall not affect the meaning or interpretation of the Plan. Whenever the words "include," "includes," or "including" are used in this Plan, they are deemed to be followed by the words "without limitation."

11.08 Required Information.

(a) A Participant must furnish the Employer with such information or proof as requested.

(b) The Employer may rely on any information furnished by a Participant and this information is conclusively binding upon the Participant furnishing the evidence, but is not binding upon the Employer.

(c) If a Participant claiming benefits under the Plan makes a false statement that is material to the Participant's claim for benefits, the Employer may adjust the benefits payable to the Participant or require that the payments be returned to the Plan, or take any other action as deemed reasonable.

(d) Failure on the part of a Participant to comply with a request by the Employer for information or proof within a reasonable period of time is sufficient grounds for delay in the payment of any benefits that may be due under the Plan until information or proof is received.

11.09 Notice.

(a) Communications from Participants or Beneficiaries. Any notice, election, application, instruction, designation, or other form of communication required to be given or submitted by any Eligible Employee or Participant will be in the form and delivery method as is prescribed from time-to-time by the Employer, including electronic form and is deemed to be duly given only upon actual receipt thereof.

(b) Communications from the Employer. Any notice, statement, report, and other communications from the Employer to any Eligible Employee or Participant required or permitted by the Plan will be deemed to have been duly given when delivered by hand to such person, mailed to such person at the address last appearing on the records of the Employer, or delivered electronically to such person.

(c) Mailing Address. Each Participant entitled to receive a payment under the Plan must file with the Employer his or her completed mailing address and each change therein. A check or communication mailed to any Participant at the address on file with the Employer is deemed to have been received by such person for all purposes of the Plan, and no Employee or agent of the Employer is obliged to search for or ascertain the location of any such Participant except as required by ERISA. If the Employer is in doubt as to whether payments are being received by the Participant entitled thereto, it may, by registered mail addressed to such person at the address last known to the Employer, notify such Participant that all future payments will be withheld until such person submits to the Employer the proper mailing address and such other information as the Employer may reasonably request.

(d) Electronic Administration. In its rules and procedures for the administration of the Plan (including, without limitation, procedures covering any directions, elections, or other action by Participants, and the delivery of statements and other disclosure materials to such individuals), the Employer may provide for the use of electronic communications and other media.

11.10 HIPAA Compliance. The Medical FSA is subject to the HIPAA Compliance provisions set forth in this section.

(a) Disclosures to Company. The Plan may disclose Participant information to the Employer, as permitted under the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 ("HIPAA Privacy Regulations"). In addition, the Plan may disclose protected health information to the Employer as necessary to allow the Employer to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

(b) Access to Medical Information. The following Employees or individuals under the control of the Employer shall have access to the Plan's protected health information to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

(1) Benefits personnel at the Plan's claims processing locations;

(2) Paychex, Inc.;

(3) Members of the Legal, Finance, Information System, Audit, Accounting, and Human Resources departments to the extent they perform functions with respect to the Plan; and

(4) Such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

(c) Employer Agreement to Restrictions. The Plan will not disclose protected health information to the Employer until the Employer has certified to the Plan that it agrees to:

(1) Not use or disclose protected health information other than as permitted or required by law or as specified above;

(2) Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or benefit plan;

(3) Report to the Plan any use of disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law, specified above, of which the Employer becomes aware;

(4) Make protected health information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;

(5) Allow the subject individuals to amend or correct their protected health information in accordance with the HIPAA Privacy Regulations;

(6) Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;

(7) Make its internal practices, books, and records available to the Secretary of Health and Human Services for determining compliance;

(8) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information, or if not feasible, restrict access and uses as required by the HIPAA Privacy Regulations;

(9) Ensure that any agents, including a subcontractor, of the Employer to whom the Employer provides protected health information shall also agree to these same restrictions;

(10) Ensure that adequate separation between the Employer and Plan is established as required under the HIPAA Privacy Regulations and restrict access to protected health information to those classes of associates or individuals identified above; and

(11) Restrict the use of protected health information by those Employees identified above for Plan administration functions within the meaning of the HIPAA Privacy Regulations.

(d) Noncompliance. In the event of noncompliance with the restrictions of part 11.10(a) - (c) by a designated Employee or other individual receiving protected health information on behalf of the Employer, the Employee, or other individual shall be subject to discipline in accordance with the Employer's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's privacy official.

(e) HIPAA Security Standards.

(1) **Safeguards.** The Employer shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Standards.

(2) **Agents**. The Employer shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate safeguards to protect such information.

(3) **Security Incidents.** The Employer shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

(4) **Adequate Separation.** The Employer shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Employer, in support of the requirements described in this section.

(f) Application. The provisions of this section shall only apply with respect to any health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

11.11 Agent for Service of Legal Process. The name and address of the person designated as agent for the service of legal process with respect to this Plan shall be the name and address specified in Item I of the Adoption Agreement.

11.12 Bonding and Fiduciary Insurance. To the extent required under ERISA section 412, fidelity bonds covering Fiduciaries and other parties having authority to handle Plan funds must be purchased by the beginning of each Plan Year. Unless paid by the Employer or a funding agent, Plan funds may be applied, in accordance with ERISA section 410(b), to the purchase of lawful insurance covering the fiduciary obligations of persons who are Fiduciaries respecting the Plan and the Fiduciaries may purchase, with funds other than Plan funds, waivers of subrogation.

ARTICLE XII: AMENDMENT AND TERMINATION

12.01 Amendment.

(a) **Amendment Authority.** Subject to part 12.01(b), the Employer has the right to amend or modify the Plan in whole or in part, prospectively or retroactively, at any time and for any reason. The Employer's right to amend or modify the Plan may be exercised by Paychex, Inc., provided the Employer does not object within 30 days following Paychex' issuance of written notice to the Employer of the amendment or modification.

(b) **Limits on Right to Amend.** A purported amendment to the Plan is not effective to the extent it deprives a Participant of a right to receive benefits to which he has already become entitled.

12.02 Termination.

Employer's Right to Terminate. Although the Employer intends to continue this Plan indefinitely, the Employer reserves the sole and exclusive right at any time to terminate the Plan by action of the Employer. The Employer's right of termination is not subject to the consent or concurrence of any Participant or any other interested party. Any termination will be evidenced by a written instrument duly executed by an officer of the Employer.

APPENDIX A - DEFINITIONS

Whenever used in this Plan, the following terms, when capitalized, have the respective meanings set forth below unless otherwise expressly provided herein.

"Adoption Agreement" means the written agreement that the Employer completes to adopt the Plan as its own. The Adoption Agreement shall constitute part of the Plan.

"Benefit Option" means any of the following benefits that the Employer specifies in Item IV of the Adoption Agreement, which Employees can elect and pay for with pretax salary reduction contributions: the Medical Plan, the Dental Plan, the Accidental Death and Dismemberment Plan, the Group Term Life Insurance Plan, the Disability Plan, the Medical FSA, the Dependent Care FSA, and Health Savings Account contributions.

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

"Contribution" means the amount contributed to pay for the cost of Benefit Options (including self-funded Benefit Options as well as those that are insured).

"Dental Plan" means, the stand-alone dental benefit option offered to Participants by the Employer as elected under Item IV of the Adoption Agreement.

"Dependent" means for the purposes other than part 5.06, any individual who qualifies as a Dependent under section 152 of the Code (as modified by section 105(b) of the Code). In addition, a child of divorced parents is treated as a dependent of both parents if section 152(e) of the Code applies (regarding a child of divorced or separated parents who receives over half of his or her support from the parents and lives in the custody of one or both parents for more than one-half of the calendar year).

"Dependent Care Flexible Spending Arrangement" or **"Dependent Care FSA"** means the Employer's Dependent Care FSA as described in ARTICLE V.

"Dependent Care Account" means the individual account established under the Plan in the name of each Participant for the purpose of accounting for credits and benefits for Qualifying Dependent Care Expenses paid for or on behalf of the Participant.

"Dependent Care Service Provider" means a person who provides Qualifying Dependent Care Services, but shall not include (a) a dependent care center (as defined in section 21(b)(2)(D) of the Code), unless the requirements of section 21(b)(2)(C) of the Code are satisfied, or (b) a related individual described in section 129(c) of the Code.

"Effective Date" means the effective date specified in Item II of the Adoption Agreement.

"Election" means the elections a Participant makes for the Plan Year in his or her Enrollment Form or alternativ ely, for the flexible spending account, an Employee may complete the Enrollment Form by calling Paychex Emp loyee Services at 1-877-244-1771 or through the Participant website at **www.paychexflex.com.**

"Eligible Employee" means an Employee who satisfies the requirement of part 2.01.

"Employee" means a common law employee of the Employer on its U.S. payroll, subject to the exclusions set forth in Item III of the Adoption Agreement. For any and all purposes under this Plan, "Employee" shall not include a leased employee or a person otherwise designed by the Employer at the time of hire as not eligible to participate in the Plan or receive benefits under the Plan, even if such ineligible person is subsequently determined to be an "employee" by any government or judicial authority.

"Employer" means the entity identified as the Employer in the Adoption Agreement and, as the context requires, any entity affiliated with the Employer under the rules of Section 414 of the Code that adopts the Plan for the benefit of its employees. Unless other procedures are required by the Employer, authorization by the Employer's authorized representative to the Plan's recordkeeper for an entity affiliated with the Employer under the rules of Section 414 of the Code to participate in the Plan shall constitute conclusive proof of adoption and consent. Employer shall also include any successors that assume the obligations created under the Plan.

"Enrollment Form" means the Flexible Spending Account enrollment form that the Employer provides to the Eligible Employee to elect benefits under the Plan and specify salary reduction amounts.

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

"Fiduciary" means a person who has discretionary authority over the administration of the Medical FSA within the meaning of ERISA section 3(21).

"FMLA Leave" means leave under The Family and Medical Leave Act of 1993.

"Group Term Life Insurance Plan" means group term life insurance benefit option offered to Participants by the Employer as elected under Item IV of the Adoption Agreement.

"Health Savings Account" or **"HSA"** means a health savings account as described in section 223 of the Code that a Participant establishes with a custodian or trustee who has entered into an arrangement with the Employer to receive contributions directly from the Employer's payroll.
"High Deductible Health Plan" means the high-deductible health plan that is intended to qualify as a high-deductible health plan under Code section 223(c)(2) of the Code, as described in materials provided separately by the Employer or another third party.

"Highly Compensated Employee" means an Employee who:

(a) performs services for the Employer during the determination year;

(b) for the look-back year received compensation (as defined in section 415(c)(3) of the Code, including elective deferrals as defined in section 402(g) of the Code and amounts excludible from salary under sections 125, 132(f)(4), or 457 of the Code) in excess of $105,000 (for 2008), as adjusted to reflect cost-of-living increases; and

(c) was a Participant of the top 20% of Employees during the look-back year when ranked on the basis of compensation received during the year.

For purposes of this definition of Highly Compensated Employee, the "determination year" is the Plan Year, and the "look-back year" is the 12-month period immediately preceding the determination year.

"Highly Compensated Individual" means with respect to section 125 of the Code, a Participant who is (a) an officer, (b) a Highly Compensated Employee, (c) a more-than five percent owner, or (d) a Spouse or Dependent of an individual described in (a), (b), or (c) above. With respect to section 105(h) of the Code, Highly Compensated Individual means an individual who is (a) one of the five highest paid officers, (b) a more-than 10 percent owner of the employer's stock, or (c) among the highest paid 25 percent of all Employees.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

"HSA-Eligible Individual" means an individual who is eligible to contribute to an HSA under Code section 223 and who has elected qualifying High Deductible Health Plan coverage and who has not elected any disqualifying non-High Deductible Health Plan coverage.

"Key Employee" means an employee of the Employer who is a "key employee" within the meaning of section 416(i)(1) of the Code.

"Leased Employee" means a person described in section 414(n) of the Code who performs services under the primary direction or control of the Employer and who is not classified as a common law employee on the Employer's payroll records.

"Long-term Disability Plan" means long-term disability benefits offered to Participants by the Employer as elected under Item IV of the Adoption Agreement.

"Medical Flexible Spending Arrangement" or **"Medical FSA"** means the Employer's Medical Flexible Spending Arrangement as described in ARTICLE IV.

"Medical FSA Account" means an account established under the Plan in the name of each Participant for the purpose of accounting for credits and for benefits for Qualifying Medical Expenses paid for or on behalf of the Participant.

"Medical Plan" means, separately or collectively, the medical and associated dental benefit options, plans and arrangements, other than the Dental Plan, provided to Participants by the Employer as elected under Item IV of the Adoption Agreement.

"Named Fiduciary" means a named fiduciary within the meaning of ERISA section 402(a)(2) of the Code and part 11.04.

"Participant" means each Eligible Employee who participates in the Plan.

"Plan" means the Section 125 Plan as set forth in this Plan and as amended from time-to-time thereafter. The term includes all documents associated with this Plan, including the Adoption Agreement signed by the Employer, the Enrollment Form, any amendments to any such documents, and such uniformly applicable rules, regulations, and standards promulgated by the Employer or its delegate consistent and in accordance with the terms hereof, the Adoption Agreement, and ERISA and other legal requirements, to the extent that such requirements may apply to the Plan.

"Plan Year" means a 12 consecutive month period beginning and ending on the dates specified it Item II of the Adoption Agreement.

"Premium Only Plan" means the portion of the Plan described in ARTICLE III, which allows each Participant to pay Qualifying Premium Expenses on a pretax salary reduction basis.

"Prior Plan" means a predecessor plan that was in existence as of the effective date of the Plan as specified in Item II of the Adoption Agreement.

"Qualifying Dependent Care Expenses" means expenses that are eligible to be reimbursed from the Dependent Care Account, as described in part 5.06.

"Qualifying Medical Expenses" means expenses that are eligible to be reimbursed from the Medical FSA Account, as described in part 4.07.

"Qualifying Premium Expenses" means costs that a Participant must pay to participate in the Employer's Benefit Options, as described in part 3.03.

"Recordkeeper" means the person or entity to which the Employer delegates purely administrative functions otherwise exercisable by the Employer as plan sponsor.

"Short-term Disability Plan" means short-term disability benefits offered to Participants by the Employer as elected under Item IV of the Adoption Agreement.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law, and who is treated as a spouse under the Code. However, for purposes of the Dependent Care FSA, the term "Spouse" does not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.