

**FLEXIBLE BENEFIT PLAN FOR
UNITED CHURCH OF CHRIST
MINISTRIES**

[PROTOTYPE DOCUMENT]

Amended and Restated January 1, 2026

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INTRODUCTION

The Pension Boards – United Church of Christ, Inc. (“Pension Boards”) makes available this prototype cafeteria plan document, the Flexible Benefit Plan for United Church of Christ Ministries (“Prototype Document”) for the benefit of certain United Church of Christ employers who are otherwise participating in health and welfare benefit programs sponsored by the Pension Boards. This Prototype Document is intended to serve as written documentation for the purpose of creating a “cafeteria plan” with the meaning of Code section 125 of the Internal Revenue Code (“Code”), as amended. The purpose of a cafeteria plan is to allow the eligible employees of electing employers to choose among different types of benefits based on their own particular goals, desires, and needs, and to pay for those benefits on a pre-tax basis.

An employer who adopts this Prototype Document in the form and manner directed by the Pension Boards becomes the plan sponsor of their own cafeteria plan covering their respective eligible employees. The Pension Boards shall serve as the plan administrator for each plan so created, with the intent of administering each plan as a “cafeteria plan” within the meaning Code Section 125.

ARTICLE I DEFINITIONS

1.1 Administrator

“Administrator” means the Pension Boards or its designee for the purpose of administering a cafeteria plan created pursuant to this Prototype Document.

1.2 Benefit

“Benefit” means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.3 Cafeteria Plan Benefit Dollars

“Cafeteria Plan Benefit Dollars” means the amount available to Participants, pursuant to Article III, to purchase Benefits. Each dollar contributed to this Plan pursuant to a Salary Reduction Agreement shall be converted into one Cafeteria Plan Benefit Dollar.

1.4 Compensation

“Compensation” means the amounts received by the Participant from the Electing Employer during a Plan Year.

1.5 Dependent

“Dependent” means any individual who qualifies as a dependent under Code Section 152, as such section is modified by Code Section 105(b) or by regulation or otherwise or a Child (as such term is defined under the UCC Medical, Dental and Vision Benefits Plan) of a Participant under the age of 26 covered by the UCC Medical, Dental and Vision Benefits Plan.

1.6 Effective Date

“Effective Date” means the first date that coverage becomes effective under the Plan.

1.7 Election Period

“Election Period” generally means an Eligible Employee’s initial enrollment period or the Plan’s annual open enrollment period. An Eligible Employee’s initial enrollment period shall be determined pursuant to Section 2.1. The Plan’s annual open enrollment period shall be as determined by the Pension Boards and communicated to Participants from time to time.

1.8 Electing Employer

“Electing Employer” means the Pension Boards and any United Church of Christ affiliated employer who is otherwise a participating employer in a health and welfare benefit program sponsored by the Pension Boards that has adopted this Prototype Document in the form and manner prescribed by the Pension Boards.

1.9 Eligible Employee

“Eligible Employee” means an Employee who has satisfied the provisions of Section 2.1.

1.10 Employee

“Employee” means any person who is employed by an Electing Employer and is otherwise eligible to participate in a health and welfare benefit program sponsored by the Pension Boards; provided, however, that an individual not treated as a common law employee by the Employer on its payroll records is not an “Employee” and is excluded from Plan eligibility even if a court or administrative agency later determines that such individual is a common law employee and not an independent contractor.

1.11 Grace Period

“Grace Period” means the two and one-half month period immediately following the close of a Plan Year, which extends the period in which a Participant may incur employment-related Dependent Care Expenses for reimbursement with respect to the Plan Year to which such Grace Period applies.

1.12 Key Employee

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

1.13 Participant

“Participant” means an Eligible Employee who elects to become a Participant in this Plan pursuant to Section 2.3 and has not for any reason become ineligible.

1.14 Plan

“Plan” means the cafeteria plan created by an Electing Employer’s adoption of this Prototype Document in the form and manner directed by the Pension Boards.

1.15 Plan Year

“Plan Year” means the 12-month period beginning January 1 and ending December 31, except that an Electing Employer may initially adopt this the Plan during a Plan Year (that is, on a date other than January 1), and with respect to that Electing Employer and its Eligible Employees, the first Plan Year (i.e., a “short plan year”) will begin on the date on which the Plan becomes effective for the Electing Employer and its Eligible Employees and will end on the following December 31. All subsequent Plan Years will begin on January 1 and end on December 31. The Plan Year shall be the coverage period for the Benefits provided under the Plan. In the event the Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant’s date of entry and ending on the last day of such Plan Year.

1.16 Salary Redirection

“Salary Redirection” means the salary reduction contributions made by the Electing Employer on behalf of Participant pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participant’s elections made under Article V. Except as otherwise authorized by the Plan, all Salary Redirection contributions shall be paid to the Pension Boards for the provision of Benefits.

1.17 Salary Redirection Agreement

“Salary Redirection Agreement” means the agreement pursuant to which the Participant agrees to reduce his Compensation in order to have such amounts contributed by the Electing Employer to the Plan on the Participant’s behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking the Plan and Code Section 125 into account) and, subsequently, does not become currently available to the Participant.

1.18 Spouse

“Spouse” means the person legally married to a Participant, as evidenced by a marriage license valid under the laws of the jurisdiction of issuance, unless legally separated by court decree.

ARTICLE II ENROLLMENT & PARTICIPATION

2.1 Eligibility & Enrollment

An Eligible Employee must enroll to become a Participant in the Plan. An Eligible Employee shall be eligible to enroll in the Plan during the individual’s initial enrollment period or during the Plan’s annual open enrollment period. For most Benefits, an Eligible Employee’s initial enrollment period is the 90 day period beginning on the date of hire.

2.2 Effective Date Of Participation

An Eligible Employee shall become a Participant effective as of the first day of the month coinciding with or next following the later of the date on which the individual makes an application to participate pursuant to Section 2.3.

2.3 Application To Participate

An Eligible Employee shall, during the applicable Election Period, complete an application to participate and election of Benefits in the form and manner prescribed by the Pension Boards. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change Benefit elections pursuant to Article V hereof.

A Participant's election for Benefits under the Premium Payment Plan shall continue from year to year to the extent the underlying benefit remains in effect. A Participant must make a new election and execute a new Salary Redirection Agreement during each annual Election Period in order to continue participation in the Health Care Reimbursement Plan or the Dependent Care Assistance Program.

2.4 Termination Of Participation

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

- (a) Termination of employment, subject to the provisions of Section 2.5;
- (b) Death, subject to the provisions of Section 2.6; or
- (c) Termination of the Plan, the Prototype Document or the Electing Employer's participation in benefits through the Pension Boards, subject to the provisions of Section 11.2.

2.5 Termination Of Employment

If a Participant's employment with the Electing Employer is terminated for any reason other than death, their participation in the Plan shall automatically terminate, subject to the following:

- (a) With regard to the Dependent Care Assistance Program, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related Dependent Care Expense reimbursements for up to 60 days following the last day of the month in which such termination occurs, provided that the expenses were incurred during the portion of the Plan Year preceding his date of termination.
- (b) With regard to the Health Care Reimbursement Plan, the Participant may elect to continue his participation in the Plan as and to the extent provided in this subsection (b).
 - (i) If the Participant elects to continue participation in the Health Care Reimbursement Plan for the remainder of the Plan Year in which such termination

occurs, the Participant may continue to seek reimbursement from the Health Care Reimbursement Fund. The Participant shall be required to make contributions to the fund based on the elections made prior to the beginning of the Plan Year.

(ii) If the Participant does not elect to continue participation in the Health Care Reimbursement Plan for the remainder of the Plan Year in which such termination occurs, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for reimbursement for up to 60 days following the last day of the month in which such termination occurs, provided that the expenses were incurred during the portion of the Plan Year preceding his date of termination.

2.6 Death

If a Participant dies, their participation in the Plan shall automatically terminate, subject to the rules that otherwise apply to a termination of employment as set forth in Section 2.5. In addition, such Participant's beneficiaries, or the representative of their estate, may submit eligible claims for expenses, subject to the rules of Section 2.5.

ARTICLE III CONTRIBUTIONS TO THE PLAN

3.1 Salary Redirection

Benefits under the Plan shall be paid by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 2.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury, which are incorporated by reference into the Plan. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of the Plan and incorporated by reference herein.

Except as otherwise authorized by the Plan, all Salary Redirection contributions shall be paid to the Pension Boards for the provision of Benefits hereunder.

3.2 Application Of Contributions

As soon as reasonably practical after each payroll period, the Electing Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants and shall send the Salary Redirection contributions to the Pension Boards in the form and manner prescribed by the

Pension Boards. Any contribution made or withheld for the Health Care Reimbursement Fund or Dependent Care Assistance Account shall be credited to such fund or account.

ARTICLE IV BENEFITS

4.1 Benefit Options

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

- (a) Health Care Reimbursement Plan
- (b) Dependent Care Assistance Program
- (c) Premium Payment Plan

4.2 Health Care Reimbursement Plan Benefit

Each Participant may elect coverage under the Health Care Reimbursement Plan option, in which case Article VI shall apply.

4.3 Dependent Care Assistance Program Benefit

Each Participant may elect coverage under the Dependent Care Assistance Program option, in which case Article VII shall apply.

4.4 Premium Payment Plan Benefit

Each Participant may elect coverage under the Premium Payment Plan option, in which case Article VIII shall apply.

4.5 Nondiscrimination Requirements

- (a) It is the intent of the Plan to comply with the nondiscrimination provisions of the Code, including Code Sections 125, 129 and 105(h), as applicable.
- (b) It is the intent of the Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.
- (c) If the Electing Employer or the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with applicable nondiscrimination requirements. Any act taken by the Electing Employer or Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Electing Employer or Administrator decides to reject

any election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an Employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have their non-taxable benefits reduced until the discrimination tests set forth in this Section 4.5 are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section 4.5 are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Care Reimbursement Plan Benefits and Dependent Care Assistance Program Benefits, and once all these Benefits are expended, proportionately among Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

ARTICLE V PARTICIPANT ELECTION CHANGES

5.1 Change Of Elections

(a) A Participant may change a Benefit election after the Plan Year has commenced and make new elections with respect to the remainder of such Plan Year only if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the U.S. Department of the Treasury, the provisions of which are incorporated into this Plan by reference as if fully set forth herein. Notwithstanding anything herein to the contrary, if the rules and regulations adopted by the U.S. Department of the Treasury conflict with the terms of this Plan, then the rules and regulations adopted by the U.S. Department of the Treasury shall control.

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

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form, including the Salary Redirection Agreement, is completed and returned to the Administrator, subject to any special enrollment right for the birth or adoption of a child. For the purposes of the Plan, a change in status shall only include the following events or other events permitted by rules and regulations adopted by the U.S. Department of the Treasury, which are fully incorporated into the Plan by reference:

- (i) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, 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, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of 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 subsection;
- (iv) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and
- (v) Residency: A change in the place of residence of the Participant, Spouse or Dependent.

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

(b) Notwithstanding subsection (a), a Participant may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f). Such change shall take place on a prospective basis, subject to the right of retroactive enrollment with respect to the birth or adoption of a child.

(c) Notwithstanding subsection (a), in the event of 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 ERISA Section 609, if applicable) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

- (i) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or
- (ii) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires another individual to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under this Plan provides similar coverage.

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

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

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

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

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

A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) this Plan or other benefits plan of the Spouse's, former

Spouse's or Dependent's employer permits its participants to make a change; or (2) this Plan permits participants to make an election for a period of coverage that is different from the period of coverage under this Plan of a Spouse's, former Spouse's or Dependent's employer.

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

A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a cost or coverage change under this subsection (e).

(f) A Participant may prospectively revoke an election of family coverage under a group health plan that is not a health flexible spending account and that provides minimum essential coverage (as defined in Code section 5000A(f)(1)) provided the following conditions are satisfied:

- (i) One or more of a Participant's related individuals are eligible for a special enrollment period to enroll in a qualified health plan ("QHP") through a federal or state exchange ("Marketplace") pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or one or more already-covered related individuals seeks to enroll in a QHP during the Marketplace's annual open enrollment period;
- (ii) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the related individual or related individuals in a QHP through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked; and
- (iii) If the Participant does not enroll in a QHP through a Marketplace, the Participant must elect self-only coverage (or family coverage including one or more of the already-covered related individuals) under the group health plan.

The Plan Administrator may rely on the reasonable representation of a Participant that the Participant and/or related individuals have enrolled or intend to enroll in a QHP through an Exchange for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked. A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of an event described in this subsection (f).

ARTICLE VI HEALTH CARE REIMBURSEMENT PLAN

6.1 Establishment Of Plan

This Health Care Reimbursement Plan is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted and administered accordingly. Participants who elect to participate in this Health Care Reimbursement Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed under this Health Care Reimbursement Plan shall be periodically paid from amounts allocated to the Health Care Reimbursement Fund. Periodic payments reimbursing Participants from the Health Care Reimbursement Fund shall in no event occur less frequently than monthly.

6.2 Definitions

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

- (a) “Health Care Reimbursement Fund” means the fund established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars shall be allocated and from which all allowable Medical Expenses shall be reimbursed.
- (b) “Health Care Reimbursement Plan” means the plan of benefits contained in this Article, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant or their Dependents.
- (c) “Highly Compensated Participant” means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:
 - (i) One of the 5 highest paid officers;
 - (ii) A shareholder who owns (or is considered to own) more than 10 percent in value of the stock of the Electing Employer; or
 - (iii) Among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).
- (d) “Medical Expenses” means any expense for medical care within the meaning of the term “medical care” or “medical expense” as defined in Code Section 213 and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. However, a Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant’s spouse or individual policies maintained by the Participant or his Spouse or Dependent. Furthermore, a Participant may not be reimbursed for “qualified long-term care services” as defined in Code Section 7702B(c). A prescription shall not be required for an expense incurred for a medicine or drug to be treated as a Medical Expense. An expense incurred for menstrual care products (as defined in section 223(d)(2)(D) of the Code) shall also be treated as a Medical Expense.

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Plan.

6.3 Forfeitures

Except as otherwise provided in Section 6.5 hereof, amounts in the Health Care Reimbursement Fund as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.8 hereof) shall be forfeited. In the event of forfeiture, the Participant shall have no further claim to such amount for any reason.

6.4 Limitation On Allocations

No more than the dollar limitation under section 125(i) of the Code and any regulations thereunder, as annually adjusted for inflation, may be allocated to the Health Care Reimbursement Fund by a Participant in or on account of any Plan Year. This allocation limitation does not include any annual carryover made in accordance with Section 6.5 hereof.

6.5 Annual Carryover

The unused amount remaining in a Participant's Health Care Reimbursement Fund at the end of a Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.8 hereof) will not be forfeited and will remain in the Participant's Health Care Reimbursement Fund for use during the following Plan Year, provided that such amount is not more than the maximum allowable amount as determined by the IRS.

6.6 Nondiscrimination Requirements

(a) It is the intent that this Health Care Reimbursement Plan not discriminate in violation of the Code and the Treasury regulations thereunder.

(b) If the Administrator or the Electing Employer deems it necessary to avoid discrimination under this Health Care Reimbursement Plan, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section 6.6. Any act taken by the Administrator or the Electing Employer under this Section 6.6 shall be carried out in a uniform and nondiscriminatory manner. If the Electing Employer decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Care Reimbursement Fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section 6.6 or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Care Reimbursement Fund for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section 6.6 or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited. In such event, the Participant shall have no further claim to such amount for any reason.

6.7 Coordination With Plan

All Plan Participants are eligible to elect Benefits under this Health Care Reimbursement Plan. The designation or cessation of designation of Cafeteria Plan Benefit Dollars to the Health Care Reimbursement Plan shall constitute enrollment or termination of enrollment under this Health Care Reimbursement Plan. All other matters shall be governed by the general provisions of this Plan.

6.8 Health Care Reimbursement Plan Claims

- (a) Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.
- (b) The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Reimbursement Fund for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.
- (c) Claims for reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim by the March 31 immediately following the end of a Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.
- (d) Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Reimbursement Fund, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

ARTICLE VII DEPENDENT CARE ASSISTANCE PROGRAM

7.1 Establishment Of Program

This Dependent Care Assistance Program is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with that Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related

Dependent Care Expenses. All amounts reimbursed under this Dependent Care Assistance Program shall be paid from amounts allocated to the Participant's Dependent Care Assistance Account.

7.2 Definitions

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

(a) "Dependent Care Assistance Account" means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed.

(b) "Dependent Care Assistance Program" means the program of benefits contained in this Article, which provides for the reimbursement of eligible expenses for the care of the Qualifying Dependents of Participants.

(c) "Earned Income" means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(d) "Employment-Related Dependent Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment-related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(i) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent who is (i) a "qualifying child" (as such term is defined under Code Section 152) of the Participant that has not attained age 13, or (ii) the Spouse or other dependent of the Participant who is physically or mentally incapable of self care, who has the same principal residence as the Participant for more than one-half of the taxable year, and who regularly spends at least 8 hours per day in the Participant's household;

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

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

(e) "Qualifying Dependent" means, for Dependent Care Assistance Program purposes, a person described in Code Section 21(b), incorporating Code Section 152 as it may be modified by statute, regulation or otherwise.

(f) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Program.

7.3 Dependent Care Assistance Accounts

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

7.4 Increases In Dependent Care Assistance Accounts

A Participant's Dependent Care Assistance Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that they have elected to apply toward his Dependent Care Assistance Account pursuant to elections made under Article V hereof.

7.5 Decreases In Dependent Care Assistance Accounts

A Participant's Dependent Care Assistance Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid on behalf of a Participant pursuant to Section 7.11 hereof.

7.6 Allowable Dependent Care Assistance Reimbursement

Subject to limitations contained in Section 7.8 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Assistance Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Administrator full reimbursement for the entire amount of such expenses incurred during the Plan Year, including the Grace Period, or portion thereof during which they are a Participant.

7.7 Forfeitures

The amount in a Participant's Dependent Care Assistance Account as of the end of any Plan Year, including the Grace Period and after the processing of all claims for such Plan Year pursuant to Section 7.11 hereof, shall be forfeited. In such event, the Participant shall have no further claim to such amount for any reason.

7.8 Limitation On Payments

Notwithstanding any provision contained in this Article or in this Plan to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code

Section 129(b) or \$7,500 (\$3,750 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)), or any higher amount as may be permitted by Code Section 129(a)(2).

7.9 Nondiscrimination Requirements

(a) It is the intent that this Dependent Care Assistance Program not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

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

(c) If the Administrator or Electing Employer deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section 7.9. Any act taken by the Administrator or Electing Employer under this Section 7.9 shall be carried out in a uniform and nondiscriminatory manner. If the Administrator or Electing Employer decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Assistance Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section 7.9 are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Assistance Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section 7.9 are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.10 Coordination With Plan

All Participants under this Plan are eligible to elect Benefits under this Dependent Care Assistance Program. The designation or cessation of designation of Cafeteria Plan Benefit Dollars to the Dependent Care Assistance Program shall constitute enrollment or termination of enrollment under this Dependent Care Assistance Program. All other matters shall be governed by the general provisions of this Plan.

7.11 Dependent Care Assistance Program Claims

The Administrator shall direct the payment of all such Dependent Care Assistance claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be

made directly to the service provider. In its discretion in administering this Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- (a) The Dependent or Dependents for whom the services were performed;
- (b) The nature of the services performed for the Participant, and the cost for which reimbursement is requested;
- (c) The relationship, if any, of the person performing the services to the Participant;
- (d) If the services are being performed by a child of the Participant, the age of the child;
- (e) A statement as to where the services were performed;
- (f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
- (g) If the services were being performed in a day care center, a statement:
 - (i) That the day care center complies with all applicable laws and regulations of the state of residence,
 - (ii) That the day care center provides care for more than 6 individuals (other than individuals residing at the center), and
 - (iii) Of the amount of fee paid to the provider.
- (h) If the Participant is married, a statement containing the following:
 - (i) The Spouse's salary or wages if they are employed, or
 - (ii) If the Participant's Spouse is not employed, that
 - (A) They are incapacitated, or
 - (B) They are a full-time student attending an educational institution and the months during the year which they attended such institution.
- (i) If a Participant fails to submit a claim by the March 31 immediately following the end the Plan Year, the claim shall not be considered for reimbursement by the Administrator; provided, however, that for any claim incurred during a Grace Period, the claims filing deadline shall be the April 30 following the close of the Plan Year to which the Grace Period relates.

ARTICLE VIII PREMIUM PAYMENT PLAN

8.1 Establishment Of Plan

The purpose of this Premium Payment Plan is to provide Eligible Employees with a choice between taxable Compensation and nontaxable qualified benefits in the form of health and welfare benefit premium payments. This Plan is intended to qualify as a cafeteria plan under Code Section 125 and shall be interpreted in a manner consistent with that Code section. Premium payments will be made under the Plan on behalf of a Participant only with respect to health, dental, vision and other qualifying premiums incurred for coverage of the Participant and the Participant's spouse and dependents while the Participant, the Participant's Spouse and Dependents are participating in the Plan. Participants who elect to participate in this Plan must agree to have premiums paid on a pre-tax basis under this Plan instead of being paid on an after-tax basis.

8.2 Definitions

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

- (a) "Insurer" means the insurance company or companies providing health insurance maintained by the Electing Employer for the benefit of its Employees during the term of the Plan.
- (b) "Premium Payments" means the Participant's share of the cost of premiums to provide the elected coverage.

8.3 Nondiscrimination Requirements

The intent is to maintain the Plan in a nondiscriminatory manner and for the exclusive benefit of the Participants, in accordance with the terms of the Plan and the requirements of the law.

ARTICLE IX BENEFITS AND RIGHTS

9.1 Claim For Benefits

(a) Any claim for Benefits shall be made to the Administrator. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim, but in no event later than 180 days after such receipt. If the Administrator does not notify the Participant of the denial of the claim within the period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

- (i) Specific references to the pertinent Plan provisions on which the denial is based;

- (ii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and
 - (iii) An explanation of this Plan's claim procedure.
- (b) Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:
- (i) Request a review upon written notice to the Administrator;
 - (ii) Review pertinent documents; and
 - (iii) Submit issues and comments in writing.
- (c) A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.
- (d) Notwithstanding the foregoing, in the case of a claim for Medical Expenses under the Health Care Reimbursement Plan, the following timetable for claims and rules below apply:

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

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

- (i) The specific reason or reasons for the denial.
- (ii) Reference to the specific Plan provisions on which the denial was based.
- (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(iv) A description of this Plan's review procedures and the time limits applicable to such procedures.

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

(vi) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 90 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

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

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

(A) Was relied upon in making the claim determination;

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

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

(D) Constituted a statement of policy or guidance with respect to this Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by an individual who is neither the individual who made the adverse determination nor a subordinate of that individual.

ARTICLE X ADMINISTRATION

10.1 Plan Administration

The operation of this Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that this Plan is carried out in accordance with its terms, and for the exclusive benefit of Plan Participants. The Administrator shall have full power to administer this Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to, the following authority, in addition to all other powers provided by this Plan:

- (a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of this Plan;
- (b) To interpret this Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of this Plan;
- (c) To decide all questions concerning this Plan and the eligibility of any person to participate in this Plan and to receive benefits provided by operation of this Plan;
- (d) To reject elections or to limit contributions or Benefits for certain highly compensated Participants and Key Employee Participants if it deems such to be desirable in order to avoid discrimination under this Plan in violation of applicable provisions of the Code;
- (e) To provide Employees with a reasonable notification of their benefits available by operation of this Plan;
- (f) To approve reimbursement requests and to authorize the payment of benefits; and
- (g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering this Plan.

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

10.2 Indemnification Of Administrator

The Electing Employer agrees to indemnify and to defend to the fullest extent permitted by law the Administrator or any member of a committee designated as Administrator against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with this Plan, if such act or omission is in good faith.

ARTICLE XI AMENDMENT OR TERMINATION OF PLAN

11.1 Amendment

The Pension Boards may amend any or all of the provisions of this Prototype Document without the consent of any Electing Employer or Participant, at any time and for any reason, including to comply with any applicable Federal, state or local laws, statutes or regulations. Any such amendment shall have immediate effect and application to this Plan; provided, however, that no amendment shall have the effect of modifying any Participant's Benefit election in effect at the time of such amendment, unless necessary to comply with Federal, state or local laws, statutes or regulations.

11.2 Termination

The Pension Boards established this Prototype Document with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Pension Boards reserves the right to terminate this Prototype Document, in whole or in part, at any time. In the event this Prototype Document terminates, so shall this Plan.

ARTICLE XII MISCELLANEOUS

12.1 Plan Interpretation

This Prototype Document and any cafeteria plan created hereunder, including this Plan, shall be interpreted and applied in a uniform, nondiscriminatory manner by the Administrator. This Plan shall be read in its entirety and not severed except as provided in Section 12.11.

12.2 Gender And Number

Wherever any words are used herein in the masculine, feminine or gender neutral, they shall be construed to refer to all genders. Singular and plural words shall each refer to both the singular and plural as appropriate.

12.3 Written Document

This Prototype Document and any cafeteria plan document created hereunder, including this Plan, is intended to satisfy the written cafeteria plan requirement of Code Section 125 and any U.S. Department of Treasury rules and regulations relating to Code Section 125 and to cafeteria plans.

12.4 Exclusive Benefit

Each Plan administered pursuant to this Prototype Document shall be maintained for the exclusive benefit of its Participants.

12.5 Participant's Rights

The Electing Employer's adoption of this Prototype Document and creation of this Plan shall not be deemed to constitute an employment contract between the Electing Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in the Prototype Document or this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Electing Employer or to interfere with the right of the Electing Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon the individual as a Participant of the Plan.

12.6 Action By The Electing Employer

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

12.7 No Guarantee Of Tax Consequences

Neither the Administrator nor the Electing Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Administrator or Electing Employer if the Participant has reason to believe that any such payment is not so excludable.

12.8 Governing Law

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Administrator or Electing Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of New York.

12.9 Severability

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

12.10 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of this Plan, nor in any way shall affect this Plan or the construction of any provision thereof.

12.11 Family And Medical Leave Act

Notwithstanding anything in this Plan to the contrary, in the event the Electing Employer becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be administered in accordance with Regulation 1.125-3.

12.12 Health Insurance Portability And Accountability Act

Notwithstanding anything in this Plan to the contrary, the Plan shall be operated in accordance with HIPAA and regulations thereunder shall be administered in accordance with the applicable regulations. With respect to the Health Care Reimbursement Plan, the Electing Employer (in its capacity as plan sponsor) agrees to the following:

- (a) not use or further disclose the information 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 Electing Employer provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Electing Employer with respect to such information;
- (c) not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Electing Employer unless authorized by an individual;
- (d) report to the Plan any protected health information use or disclosure that is inconsistent with the uses or disclosures provided for which it becomes aware;
- (e) make available protected health information to an individual in accordance with HIPAA's access requirements and 45 C.F.R. § 164.524;
- (f) make available protected health information for amendment and incorporate any amendments to protected health information in accordance with HIPAA and 45 C.F.R. § 164.526;
- (g) make available the information required to provide an accounting of disclosures in accordance with HIPAA and 45 C.F.R. § 164.528;
- (h) make its internal practices, books and records relating to the use and disclosure of protected health information received from Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;
- (i) if feasible, return or destroy all protected health information received from the Plan that the Electing Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible); and

- (j) ensure that adequate separation between the Plan and Electing Employer (as described in HIPAA) is established.

12.13 Uniform Services Employment And Reemployment Rights Act

Notwithstanding any provision of this Plan to the contrary, the Plan shall be administered in accordance with any applicable requirements USERRA and the regulations thereunder.