City of Jonesboro

300 S. Church Street
Jonesboro, AR 72401

Signature Copy

Resolution: R-EN-158-2018

File Number: RES-18:173

Enactment Number: R-EN-158-2018

A RESOLUTION TO ENTER INTO AN AGREEMENT WITH AMERICAN FIDELITY ASSURANCE COMPANY TO PROVIDE A FLEXIBLE COMPENSATION PLAN TO CITY OF JONESBORO EMPLOYEES

WHEREAS, The City of Jonesboro offers a flexible compensation plan as a voluntary benefit for employees; and

WHEREAS, American Fidelity Assurance Company has proposed to provide this coverage for 2019 and details of this proposal are attached as Exhibit A.

NOW THEREFORE BE IT RESOLVED BY THE CITY COUNCIL, FOR THE CITY OF JONESBORO, ARKANSAS, THAT:

SECTION 1: The coverage proposal provided by American Fidelity Assurance Company is approved.

SECTION 2: The effective dates of coverage shall be January 1, 2019 through December 31, 2019.

SECTION 3: The Mayor and City Clerk are hereby authorized to execute such documents as are necessary to effectuate this agreement.

PASSED AND APPROVED this 8th day of November, 2018.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

WG-AcctAdmin-S125@AmericanFidelity.com
Phone: (800)662-1113 ext. 8904
Fax: (800)240-0642

Thank you for giving American Fidelity the opportunity to serve as your Section 125 Plan service provider. Based on the information provided to us, we have prepared a plan document for review by you and your legal counsel. This document will supersede any previous plan document(s) that you may have in place.

After reviewing the documentation to ascertain its correctness, and if all is in order, **sign** the document(s), as required by IRS regulations. **To sign document(s), you will need to create a Docusign signature.** If someone other than you is required to sign the documents, please forward to them by clicking on "Other Actions" and select "Assign to Someone Else". Then enter the new receipients name and email address. You can download or print your documents by clicking the links in the confirmation email that you receive after the documents are signed.

As your Section 125 Plan service provider, American Fidelity will perform the following services:

- Prepare amended and restated plan documents, when necessary, based on information provided by you;
- Provide signed copies, if signatures are received, of all necessary Section 125 documentation in the case of an IRS audit of your plan;
- Provide an updated Administration Guide to assist you in the on-going administration of your plan;
- Provide an annual re-enrollment of your employees prior to the plan year anniversary date;
- Provide a 25% Key Employee discrimination test worksheet, when requested;
- Provide a 55% Average Benefits (for dependent care) discrimination test worksheet, when requested;
- Provide compliance assistance in interpreting the IRS regulations governing cafeteria plans;
- Furnish a semi-annual newsletter outlining changes to the sections of the tax code which impact cafeteria plans, as well as other pertinent information; and
- Provide copies of the laws and regulations governing cafeteria plans upon request.

As the plan sponsor/plan administrator, **it is your responsibility**, among other things, to prepare and file any required reports for the underlying welfare benefit plans, prepare and distribute a summary plan description to employees, provide COBRA, FMLA or HIPAA administration, verify that all benefits provided by other carriers in the plan are qualified for tax-exemption, assure that the plan is not discriminatory, and calculate imputed tax for employer-provided (Section 79) group term life coverage exceeding $50,000, whether outside a cafeteria plan or being salary-reduced within a cafeteria plan. A copy of the Section 79 Uniform Table Calculation is included (for questions regarding this form, please contact us by email or by phone).

Some important reminders:

- **You must have an executed written cafeteria plan document meeting the legal requirements of Internal Revenue Code Section 125 and formally adopted by the employer.** The plan must contain operating rules covering benefit descriptions, eligibility rules, manner of employer contributions, maximum amount of employer and employee contributions, the plan year, timing of participant elections and the irrevocability of participant elections. In addition, the plan cannot discriminate in favor of highly compensated employees or key employees either as to eligibility to participate or in contributions and benefits.

- **If your plan provides either eligibility requirements or contributions and benefits that are not the same for all eligible employees it may be considered to be discriminatory. Please seek advice from your tax or legal counsel.**

- **In order to avoid the doctrine of constructive receipt, elections of pre-tax benefits must be made prior to the anniversary date of the plan.** All employees should sign either an affirmative election, or a statement that they are not making any changes for the coming plan year, and if waiving participation, should sign a waiver. Mid-year election changes are only allowed if (1) a qualified event has occurred and (2) the change requested is on account of and consistent with the event. A change verification form should be signed by the employee (see the Administration Guide for further guidance).

- If your plan document requires changes, please email us at **WG-AcctAdmin-S125@americanfidelity.com.** You will then receive a corrected copy electronically to be signed using Docusign.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

- Election forms must be maintained for a period of at least three years for audit purposes, and longer if youare subject to ERISA regulations. ERISA regulations require that records be maintained for a period of at least six years plus the current year; **the plan document and any amendments thereto must be maintained permanently.**

If your Section 125 cafeteria plan includes Flexible Spending Accounts (FSAs), the following may clarify frequent areas of concern:

- Changes in the Unreimbursed Medical (Health FSA) Account – If the Employer has subscribed to American Fidelity's uniform coverage risk policy, Health FSA participants will not be allowed to make any mid-year changes to their election for any reason except for termination of employment. No other change of status will be accepted. If the Employer is assuming the uniform coverage risk, certain mid-year changes may be permitted. Please refer to the Section 125 Administration Guide for more information.

- Leave of Absence (LOA) – During an unpaid leave of absence, contributions to the Health FSA account may either be pre-taxed in advance prior to the LOA, made on an after-tax basis while out on leave, or upon returning to work, may be prorated over the remaining pay periods. Contributions must continue in order for coverage to continue.

- Options at Termination of Employment – Terminating participants in the Health FSA must be offered COBRA, as follows: if the employer makes no contributions to the Health FSA and if the employee is exempt from HIPAA (has other medical coverage), then you are only required to offer COBRA through the end of the cafeteria plan year. As of the date of termination, if the employee has taken more out of the account than he has contributed, then you do not have to offer any COBRA coverage.

If your Health FSA includes the debit card, the following may clarify frequent areas of concern:

- Once the card is elected by the employee, it will be mailed to the participant approximately two weeks before the plan year begins. The card is ready to be used once it is received (and the plan year has begun); there is no further activation required.

- The participant is responsible for providing all receipts to American Fidelity Assurance as they are requested. If the participant does not respond to our requests for receipts in a timely manner, the debit card will be deactivated and will not be reactivated until the amount of the reimbursement is paid back, offsetting receipts are sent, or until the requested receipts have been received.

- The participant must reimburse American Fidelity Assurance for any ineligible expense charged to the card. The reimbursement can be in the form of a check or money order. If the participant does not reimburse American Fidelity for the ineligible claims, the card will be deactivated until restitution is made.

- ***If the participant does not reimburse American Fidelity for any ineligible claims or for any claims for which they do not submit receipts in a timely manner, the Employer is responsible for making an after-tax deduction from the participant's paycheck or adjusting the participant's W-2 in order to make the plan whole.***

Please refer to the administration guide included on our website **https://americanfidelity.com/admin-forms** for more information. The password to access the forms is 125plan. Once again we look forward to assisting you with your Section 125 plan. Please email us at WG-AcctAdmin-S125@AmericanFidelity.com or call us at (800)662-1113 ext. 8904 any time you have a question concerning your plan.

Sincerely,

Section 125 Team
Account Administration Department
American Fidelity

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

SAMPLE PLAN DOCUMENT
SECTION 125
FLEXIBLE BENEFIT PLAN

The attached plan document and adoption agreement are being provided for illustrative purposes only. Because of differences in facts, circumstances, and the laws of the various states, interested parties should consult their own attorneys. This document is intended as a guide only, for use by local counsel.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

The undersigned Employer hereby adopts the Section 125 Flexible Benefit Plan for those Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	CITY OF JONESBORO
Address:	300 S CHURCH JONESBORO, AR 72401
Employer Identification Number:	71-6013749
Nature of Business:	MUNICIPALITY
Name of Plan:	CITY OF JONESBORO FLEXIBLE BENEFIT PLAN
Plan Number:	502

B. EFFECTIVE DATE

Original effective date of the Plan:	January 1, 2019
If Amendment to existing plan, effective date of amendment:	N/A

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable and, if different, will be listed in Item F.

Length of Service:	First day of the month following 60 days of service.
Minimum Hours:	All employees with 30 hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 18 years.

D. PLAN YEAR

The current plan year will begin on January 1, 2019 and end on December 31, 2019. Each subsequent plan year will begin on January 1 and end on December 31.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts will not be paid to the Participant as taxable cash.

Elective Contributions (Salary Reduction):

The maximum amount available to each Participant for the purchase of elected benefits through salary reduction will be:

$15000.00 per plan year.

Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made on the benefit election form.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

F. **AVAILABLE BENEFITS:** Each of the following components should be considered a plan that comprises this Plan.

1. **Group Medical Insurance** -- The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

American Fidelity Assurance Company Accident only plan

Eligibility Requirements for Participation, if different than Item C.

2. **Disability Income Insurance** -- The terms, conditions, and limitations for the Disability Income Insurance will be as set forth in the insurance policy or policies described below: (See Section VI of the Plan Document)

N/A

Eligibility Requirements for Participation, if different than Item C.

3. **Cancer Coverage** -- The terms, conditions, and limitations for the Cancer Coverage will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

American Fidelity Assurance Company C-11 and subsequent policies

Eligibility Requirements for Participation, if different than Item C.

4. **Dental/Vision Insurance** -- The terms, conditions, and limitations for the Dental/Vision Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)

N/A

Eligibility Requirements for Participation, if different than Item C.

5. **Group Life Insurance** which will be comprised of Group-term life insurance and Individual term life insurance under Section 79 of the Code.

The terms, conditions, and limitations for the Group Life Insurance will be as set forth in the insurance policy or policies described below: (See Section VII of the Plan Document)

N/A

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, **N/A** exceed $50,000.

Eligibility Requirements for Participation, if different than Item C.

6. **Dependent Care Assistance Plan** -- The terms, conditions, and limitations for the Dependent Care Assistance Plan will be as set forth in Section IX of the Plan Document and described below:

   Minimum Contribution - $ **0.00** per Plan Year

   Maximum Contribution - $ **5000.00** per Plan Year

   Recordkeeper: **American Fidelity Assurance Company**

   Eligibility Requirements for Participation, if different than Item C.
   N/A

7. **Medical Expense Reimbursement Plan** -- The terms, conditions, and limitations for the Medical Expense Reimbursement Plan will be as set forth in Section VIII of the Plan Document and described below:

   Minimum Coverage - $ **0.00** per Plan Year

   Maximum Coverage - $ **2650.00** per Plan Year or a Prorated Amount for a Short Plan Year. In no event may the maximum exceed the limit as indicated by the IRS in accordance with the law.

   Recordkeeper: **American Fidelity Assurance Company**

   Restrictions: **As outlined in Policy G-905/R1.**

   Grace Period: The provisions in Section 8.06 of the Plan to permit a Grace Period with respect to the Medical Expense Reimbursement Plan **are not** elected.

   Carryover Provision: The provisions in Section 8.07 of the Plan to permit a Carryover with respect to the Medical Expense Reimbursement Plan are elected.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

HEART Act: The provisions in Section 8.08 of the Plan to permit the Qualified Reservist Distribution of the Heroes Earnings Assistance and Relief Tax Act (HEART) **are** elected.

Eligibility Requirements for Participation, if different than Item C.

8. **Health Savings Accounts** – The Plan permits contributions to be made to a Health Savings Account on a pretax basis in accordance with Section X of the Plan and the following provisions:

HSA Trustee – **N/A**

Maximum Contribution – As indexed annually by the IRS.

Limitation on Eligible Medical Expenses – For purposes of the Medical Reimbursement Plan, Eligible Medical Expenses of a Participant that is eligible for and elects to participate in a Health Savings Account shall be limited to expenses for:

N/A

If the Plan includes the limitation on expenses, a Participant's carryover amounts (when applicable) will be treated as an election for a limited Medical Reimbursement Plan for the carryover amounts for any plan year for which the participant has elected a Health Savings Account for that plan year.

Eligibility Requirements for Participation, if different than Item C.

a. An Employee must complete a Certification of Health Savings Account Eligibility which confirms that the Participant is an eligible individual who is entitled to establish a Health Savings Account in accordance with Code Section 223(c)(1).

b. Eligibility for the Health Savings Account shall begin on the later of (i) first day of the month coinciding with or next following the Employee’s commencement of coverage under the High Deductible Health Plan, or (ii) the first day following the end of a Grace Period available to the Employee with respect to the Medical Reimbursement Accounts that are not limited to vision and dental expenses (unless the participant has a $0.00 balance on the last day of the plan year).

c. An Employee’s eligibility for the Health Savings Account shall be determined monthly.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

The Plan shall be construed, enforced, administered, and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, (as amended) if applicable, the Internal Revenue Code of 1986 (as amended), and the laws of the State of Arkansas. Should any provision be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

This Plan is hereby adopted ____.

CITY OF JONESBORO
(Name of Employer)

By:____

Title:______________________________________

APPENDIX A

Related Employers that have adopted this Plan

Name(s):
N/A

THIS DOCUMENT IS NOT COMPLETE WITHOUT SECTIONS I THROUGH XIII
PD0717sw 119083 10/30/2018 10:13 AM

SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

The Employer is establishing this Flexible Benefit Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

SECTION II

DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

2.01 **Administrator** The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(16) of ERISA (if applicable).

2.02 **Beneficiary** Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.

2.02A **Carryover** The amount equal to the lesser of (a) any unused amounts from the immediately preceding Plan Year or (b) five hundred dollars ($500), except that in no event may the Carryover be less than five dollars ($5).

2.03 **Code** Internal Revenue Code of 1986, as amended.

2.04 **Dependent** Any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee’s income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

Code Section 152(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Student on a Medically Necessary Leave of Absence: With respect to any plan that is considered a group health plan under Michelle's Law (and not a HIPAA excepted benefit under Code Sections 9831(b), (c) and 9832(c)) and to the extent the Employer is required by Michelle's Law to provide continuation coverage, a Dependent includes a child who qualifies as a Tax Dependent (defined in Section 2.04(a)) because of his or her full-time student status, is enrolled in a group health plan, and is on a medically necessary leave of absence from school. The child will continue to be a Dependent if the medically necessary leave of absence commences while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the group health plan's benefits coverage. Written physician certification that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary is required at the Administrator's request. The child will no longer be considered a Dependent as of the earliest date that the child is no longer on a medically necessary leave of absence, the date that is one year after the first day of the medically necessary leave of absence, or the date benefits would otherwise terminate under either the group health plan or this Plan. Terms related to Michelle's Law, and not otherwise defined, will have the meaning provided under the Michelle's Law provisions of Code Section 9813.

(c) Adult Children: With respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A 'child' for purpose of this Section 2.04(c) means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adult child described in this Section 2.04(c) is only a Dependent with respect to benefits provided after March 30, 2010 (subject to any other limitations of the Plan).

Dependent for purposes of the Dependent Care Reimbursement Plan is defined in Section 9.04(a).

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

2.05	**Effective Date**	The effective date of this Plan as shown in Item B of the Adoption Agreement.
2.06	**Elective Contribution**	The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.
2.07	**Eligible Employee**	Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.
2.08	**Employee**	Any person employed by the Employer on or after the Effective Date.
2.09	**Employer**	The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan with the approval of the Employer. Related Employers who participate in this Plan are listed in Appendix A to the Adoption Agreement. For the purposes of Section 11.01 and 11.02, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.
2.10	**Employer Contributions**	Amounts that have not been actually received by the Participant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.
2.11	**Entry Date**	The date that an Employee is eligible to participate in the Plan.
2.12	**ERISA**	The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).
2.13	**Fiduciary**	The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.
2.14	**Health Savings Account**	A “health savings account” as defined in Section 223(d) of the Internal Revenue Code of 1986, as amended established by the Participant with the HSA Trustee.
2.15	**HSA Trustee**	The Trustee of the Health Savings Account which is designated in Section F.8 of the Adoption Agreement.
2.16	**Highly Compensated**	Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.
2.17	**High Deductible Health Plan**	A health plan that meets the statutory requirements for annual deductibles and out-of-pocket expenses set forth in Code section 223(c)(2).
2.18	**HIPAA**	The Health Insurance Portability and Accountability Act of 1996, as amended.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

2.19	**Insurer**	Any insurance company that has issued a policy pursuant to the terms of this Plan.
2.20	**Key Employee**	Any Participant who is a "key employee" as defined in Section 416(i) of the Code.
2.21	**Non-Elective Contribution**	A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.
2.22	**Participant**	An Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement.
2.23	**Plan**	The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.
2.24	**Plan Year**	The Plan Year as specified in Item D of the Adoption Agreement.
2.25	**Policy**	An insurance policy issued as a part of this Plan.
2.26	**Preventative Care**	Medical expenses which meet the safe harbor definition of "preventative care" set forth in IRS Notice 2004-23, which includes, but is not limited to, the following: (i) periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations); (ii) well-baby and/or well-child care; (iii) immunizations for adults and children; (iv) tobacco cessation and obesity weight-loss programs; and (v) screening devices. However, preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.
2.27	**Recordkeeper**	The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Plan and/or the Dependent Care Reimbursement Plan.
2.28	**Related Employer**	Any employer that is a member of a related group of organizations with the Employer shown in Item A of the Adoption Agreement, and as specified under Code Section 414(b), (c) or (m).

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date of the Plan, whichever is later. Dependent eligibility to receive benefits under any of the plans listed in Item F of the Adoption Agreement will be described in the documents governing those benefit plans. To the extent a Dependent is eligible to receive benefits under a plan listed in Item F, an Eligible Employee may elect coverage under this Plan with respect to such Dependent.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

Notwithstanding the foregoing, life insurance coverage on the life of a Dependent may not be elected under this Plan.

3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during an enrollment period, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's Election Form shall be completed prior to the beginning of the Plan Year, and shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Internal Revenue Code and the regulations thereunder.

3.03 TERMINATION OF PARTICIPATION: A Participant shall continue to participate in the Plan until the earlier of the following dates:

(a) The date the Participant terminates employment by death, disability, retirement or other separation from service; or
(b) The date the Participant ceases to work for the Employer as an eligible Employee; or
(c) The date of termination of the Plan; or
(d) The first date a Participant fails to pay required contributions while on a leave of absence.

3.05 SEPARATION FROM SERVICE: The existing elections of an Employee who separates from the employment service of the Employer shall be deemed to be automatically terminated and the Employee will not receive benefits for the remaining portion of the Plan Year.

3.06 QUALIFYING LEAVE UNDER FAMILY LEAVE ACT: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant’s existing coverage under the Plan with respect to benefits under Section V and Section VIII of the Plan on the same terms and conditions as though he were still an active Employee. If the Employee opts to continue his coverage, the Employee may pay his Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his Elective Contribution for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave compensation (including unused sick days or vacation) by making a special election to that effect prior to the date such compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee’s return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

4.02 IRREVOCABILITY OF ELECTIONS: A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(1) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;
(2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;
(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;
(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and
(5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

(b) Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f) or Section 2701(f) of the Public Health Service Act, then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances: (i) a Participant or his or her spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted, or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; (ii) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; (iii) the Participant's or his or her spouse's or Dependent's coverage under a Medicaid plan or under a children's health insurance program (CHIP) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage; or (iv) the Participant, his or her spouse or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than 60 days after the date the Participant, his or her spouse or Dependent is determined to be eligible for such assistance. An election change under (iii) or (iv) of this provision must be requested within 60 days after the termination of Medicaid or state health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

(c) Certain Judgments, Decrees or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

(e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

(f) COBRA Qualifying Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

(g) Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.04(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan to add coverage for the Adult Child and to make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

(h) Cancellation due to reduction in hours of service. A Participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the cancellation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is cancelled.

(i) Cancellation due to enrollment in a Qualified Health Plan. A participant may cancel group health plan (as that term is defined in Code Section 9832(a)) coverage, except Health FSA coverage, under the Employer's Plan if both of the following conditions are met:

(i) The Participant is eligible for a Special Enrollment Period (as defined in Code Section 9801(f)) to enroll in a Qualified Health Plan(as described in section 1311 of the Patient Protection and Affordable Care Act (PPACA)) through a competitive marketplace established under section 1311(c) of PPACA (Marketplace), pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the cancellation in a Qualified Health Plan 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 cancelled.

Notwithstanding anything to the contrary in this Section 4.02, the change in election rules in this Section 4.02 do not apply to the Medical Expense Reimbursement Plan, or may not be modified with respect to the Medical Expense Reimbursement Plan if the Plan is being administered by a Recordkeeper other than the Employer, unless the Employer and the Recordkeeper otherwise agree in writing

4.03 OTHER EXCEPTIONS TO IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year election changes and apply to all qualified benefits except for Medical Expense Reimbursement Plans, as follows:

(a) Change in Cost. If the cost of a benefit package option under the Plan significantly increases during the plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage option in order to elect the benefit package option that has decreased in cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i) With no loss of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage.

(ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

(c) Addition or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

(e) Loss of coverage under other group health coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.

4.05 PAYMENT FROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

5.01 PURPOSE: These benefits provide the group medical insurance benefits to Participants.

5.02 ELIGIBILITY: Eligibility will be as required in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Items F(1), F(3), and F(4) of the Adoption Agreement.

5.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 COBRA: To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% of the applicable premium.

5.06 SECTION 105 AND 106 PLAN: It is the intention of the Employer that these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 CONTRIBUTIONS: Contributions for these benefits will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

5.08 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT: Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

SECTION VI

DISABILITY INCOME BENEFIT PLAN

6.01 PURPOSE: This benefit provides disability insurance designated to provide income to Participants during periods of absence from employment because of disability.

6.02 ELIGIBILITY: Eligibility will be as required in Item F(2) of the Adoption Agreement.

6.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(2) of the Adoption Agreement.

6.04 TERMS, CONDITIONS AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

6.05 SECTION 104 AND 106 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections 104 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

7.01 PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.

7.03 DESCRIPTION OF BENEFITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.

7.04 TERMS, CONDITIONS, AND LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.

7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

7.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement. Any individual policies purchased by the Employer for the Participant will be owned by the Participant.

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

8.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

(a) Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

(b) Maximum benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.

(c) Claim Procedure. In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the last day of the third month following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

(d) Funding. The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.

(e) Forfeiture. Subject to Section 8.06 and 8.07, any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

(f) COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ('COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

(g) Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section 105(h) of the Code and regulations promulgated thereunder.

(h) Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan (increased by any Carryover to the Plan Year), shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Participant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

(i) Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

(j) Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum Coverage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

(k) Continuation Coverage for Certain Dependent Children. In the event that benefits under the Medical Expense Reimbursement Plan does not qualify for the exception from the portability rules of HIPAA, then, effective for Plan Years beginning on or after October 9, 2009, notwithstanding the foregoing provisions, coverage for a Dependent child who is enrolled in the Medical Expense Reimbursement Plan as a student at a post-secondary educational institution will not terminate due to a medically necessary leave of absence before a date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the Plan.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

For purposes of this paragraph, "medically necessary leave of absence" means a leave of absence of the child from a post-secondary educational institution, or any other change in enrollment of the child at the institution, that: (i) commences while the child is suffering from a serious illness or injury; (ii) is medically necessary; and (iii) causes the child to lose student status for purposes of coverage under the terms of the Plan. A written certification must be provided by a treating physician of the dependent child to the Plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

8.04 ELIGIBLE MEDICAL EXPENSES:

(a) (a) Eligible Medical Expense in General. The phrase 'Eligible Medical Expense' means any expense incurred by a Participant or any of his Dependents (subject to the restrictions in Sections 8.04(b) and (c)) during a Plan Year that (i) qualifies as an expense incurred by the Participant or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Code Section 125, (ii) is excluded from gross income of the Participant under Code Section 105(b), and (iii) has not been and will not be paid or reimbursed by any other insurance plan, through damages, or from any other source. Notwithstanding the above, capital expenditures are not Eligible Medical Expenses under this Plan. Further, notwithstanding the above, effective January 1, 2011, only the following drugs or medicines will constitute Eligible Medical Expenses:

(i.) Drugs or medicines that require a prescription;
(ii.) Drugs or medicines that are available without a prescription ("over-the-counter drugs or medicines") and the Participant or Dependent obtains a prescription; and
(iii.) Insulin.

(b) Expenses Incurred After Commencement of Participation. Only medical care expenses incurred by a Participant or the Participant's Dependent(s) on or after the date such Participant commenced participation in the Medical Expense Reimbursement Plan shall constitute an Eligible Medical Expense.

(c) Eligible Expenses Incurred by Dependents. For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.04(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.04(a) and (b) are eligible for reimbursement if incurred either before or after March 30, 2010 (subject to the restrictions of Section 8.04(b)).

(d) Health Savings Accounts. If the Employer has elected in Item F.8 of the Adoption Agreement to allow Eligible Employees to contribute to Health Savings Accounts under the Plan, then for a Participant who is eligible for and elects to contribute to a Health Savings Accounts, Eligible Medical Expenses shall be limited as set forth in Item F.8 of the Adoption Agreement.

8.05 USE OF DEBIT CARD: In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses (other than over-the-counter drugs or medicines) under the Medical Expense Reimbursement Plan, the provisions described in this Section shall apply. However, beginning January 1, 2011, a Debit Card may not be used to purchase drugs or medicines over-the-counter.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

(a) Substantiation. The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card to pay the claimed Eligible Medical Expense:

(i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.

(ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

(b) Status of Charges. All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (a) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.

(c) Correction Procedures for Improper Payments. In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:

(i) First, upon the Recordkeeper's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.

(iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

(d) Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of such cards set forth in

Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

8.06 GRACE PERIOD: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.06 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. For purposes of this Section, 'Grace Period' shall mean the period extending to the 15th day of the third calendar month after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.

8.07 Carryover: If the Employer elects in Section F.7 of the Adoption Agreement to permit a Carryover with respect to the Medical Reimbursement Plan, the provisions of this Section 8.07 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2013-71, the Carryover for a Participant who has an amount remaining unused as of the end of the run-off period for the Plan Year, may be used to pay or reimburse Eligible Medical Expenses during the following entire Plan Year. The Carryover does not count against or otherwise affect the Maximum benefit set forth in Section 8.03 (b). Eligible Medical Expenses incurred during a Plan Year shall be reimbursed first from unused contributions for the current Plan Year, and then from any Carryover carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense (a) reduce the amounts available to pay prior Plan Year expenses during the run-off period, (b) must be counted against any Carryover amount from the prior Plan Year, and (c) cannot exceed the maximum Carryover from the prior Plan Year. If the Employer elects to apply Section 8.06 in Section F.7 of the Adoption Agreement, this Section 8.07 shall not apply.

8.08 QUALIFIED RESERVIST DISTRIBUTIONS: Notwithstanding anything in the Plan to the contrary, an individual who, by reason of being a member of a reserve component (as defined in 37 U.S.C. § 101), is ordered or called to active duty for a period in excess of 179 days or for an indefinite period may elect to receive a distribution of all or a portion of the unused Elective Contributions in his or her Account relating to the Medical Expense Reimbursement Plan if the distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year that includes the date of such order or call. If the distribution is for the entire amount of unused Elective Contributions available in the Medical Expense Reimbursement Plan, then no additional reimbursement requests will be processed for the remainder of the Plan Year.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

9.01 PURPOSE: The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 ELIGIBILITY: The eligibility provisions are set forth in Item F(6) of the Adoption Agreement.

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

(a) Accounts. The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

(b) Maximum Benefit. The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item F(6) of the adoption agreement.

(c) For purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents.

(d) Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the ninetieth (90th) day following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

(e) Funding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.

(f) Forfeiture. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.

(g) Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

(a) "Dependent" (for purposes of this Section IX) means any individual who is:

(i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or
(ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

(b) "Dependent Care Center" (for purposes of this Section IX) shall be a facility which:

(i) provides care for more than six individuals (other than individuals who reside at the facility);
(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and
(iii) satisfies all applicable laws and regulations of a state or unit of local government.

(c) "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:

(i) incurred for the care of a Dependent of the Participant or for related household services;
(ii) paid or payable to a Dependent Care Service Provider; and
(iii) incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

(d) "Dependent Care Service Provider" (for purposes of this Section IX) means:

(i) a Dependent Care Center, or

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

(ii) a person who provides care or other services described in Section 9.04(b) and who is not a related individual described in Section 129(c) of the Code.

SECTION X

HEALTH SAVINGS ACCOUNTS

10.01 PURPOSE: If elected by the Employer in Section F.8 of the Adoption Agreement, the Plan will permit pre-tax contributions to the Health Savings Account, and the provisions of this Article X shall apply.

10.02 BENEFITS: A Participant can elect benefits under the Health Savings Accounts portion of this Plan by electing to pay his or her Health Savings Account contributions on a pre-tax salary reduction basis. In addition, the Employer may make contributions to the Health Savings Account for the benefit of the Participant.

10.03 TERMS, CONDITIONS AND LIMITATION:

(a) Maximum Benefit. The maximum annual contributions that may be made to a Participant's Health Savings Account under this Plan is set forth in Section F.8 of the Adoption Agreement.

(b) Mid-Year Election Changes. Notwithstanding any to the contrary herein, a Participant election with respect to contributions for the Health Savings Account shall be revocable during the duration of the Plan Year to which the election relates. Consequently, a Participant may change his or her election with respect to contributions for the Health Savings Account at any time.

10.04 RESTRICTIONS ON MEDICAL REIMBURSEMENT PLAN: If the Employer has elected in Section F.8 of the Adoption Agreement both Health Savings Accounts under this Plan and the Medical Expense Reimbursement Plan, then the Eligible Medical Expenses that may be reimbursed under the Medical Reimbursement Plan for Participants who are eligible for and elect to participate in Health Savings Accounts shall be limited as set forth in Section F.8 of the Adoption Agreement.

10.05 NO ESTABLISHMENT OF ERISA PLAN: It is the intent of the Employer that the establishment of Health Savings Accounts are completely voluntary on the part of Participants, and that, in accordance with Department of Labor Field Assistance Bulletin 2004-1, the Health Savings Accounts are not "employee welfare benefit plans" for purposes of Title I of ERISA.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

SECTION XI

AMENDMENT AND TERMINATION

11.01 AMENDMENT: The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.

11.02 TERMINATION: The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

12.01 NAMED FIDUCIARIES: The Administrator shall be the fiduciary of the Plan.

12.02 APPOINTMENT OF RECORDKEEPER: The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

(a) General. The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any questions arising in the administration (including all questions of eligibility and determination of amount, time and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

(b) Recordkeeping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such reports and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.

(c) Inspection of Records. The Administrator shall, during normal business hours, make available to each Participant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

12.06 DELEGATIONS OF RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

12.07 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to this Plan under which the Participant claims a benefit.

12.09 GENERAL CLAIMS REVIEW PROCEDURE: This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.

(a) Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special

circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon 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, and (d) the claimant's rights to seek review of the denial.

(b) Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review , unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

(c) Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

12.10 SPECIAL CLAIMS REVIEW PROCEDURE: The provisions of this Section 12.10 shall be applicable to claims under the Group Medical Reimbursement Plan and the Group Medical Insurance Plan, effective on the first day of the first Plan Year beginning on or after July 1, 2002, but in no event later than January 1, 2003, provided such plans are subject to ERISA.

(a) Benefit Denials: The Administrator is responsible for evaluating all claims for reimbursement under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan.

The Administrator will decide a Participant's claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Participant will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Administrator is expected to be made. The Participant will be given 45 days in which to complete an incomplete claim. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

If the Administrator denies the claim, in whole or in part, the Participant will be furnished with a written notice of adverse benefit determination setting forth:

1. the specific reason or reasons for the denial;

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

2. reference to the specific Plan provision on which the denial is issued;

3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and

4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

(b) Appealing Denied Claims: If the Participant's claim is denied in whole or in part, he may appeal to the Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Administrator's initial notice of adverse benefit determination, or else the participant will lose the right to appeal the denial. If the Participant does not appeal on time, he will also lose his right to file suit in court, as he will have failed to exhaust his internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Participant's written appeal should state the reasons that he feels his claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his claim. The Participant may also ask additional questions and make written comments, and may review (on request and at no charge) documents and other information relevant to his appeal. The Administrator will review all written comment the Participant submits with his appeal.

(c) Review of Appeal: The Administrator will review and decide the Participant's appeal within a reasonable time not longer than 60 days after it is submitted and will notify the Participant of its decision in writing. The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with the Participant's appeal will be provided.) If the decision on appeal affirms the initial denial of the Participant's claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based,

3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,

4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request," and

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

5. A statement of the Participant's right to bring suit under ERISA § 502(a).

12.11 <u>PAYMENT TO REPRESENTATIVE</u>: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

12.12 <u>PROTECTED HEALTH INFORMATION</u>. The provisions of this Section will apply only to those portions of the Plan that are considered a group health plan for purposes of 45 CFR Parts 160 and 164. The Plan may disclose PHI to employees of the Employer, or to other persons, only to the extent such disclosure is required or permitted pursuant to 45 CFR Parts 160 and 164. The Plan has implemented administrative, physical, and technical safeguards to reasonably and appropriately protect, and restrict access to and use of, electronic PHI, in accordance with Subpart C of 45 CFR Part 164. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Employer will:

- not use or disclose PHI other than as permitted or required by the plan documents and permitted or required by law;
- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by it on behalf of the Plan, in accordance with Subpart C of 45 CFR Part 164;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents including a subcontractor~~s~~ to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- make available PHI in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services or his designee upon request for purposes of determining compliance with 45 CFR Section 164.504(f);
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which ~~the~~ disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and,
- ensure that the adequate separation required in paragraph (f)(2)(iii) of 45 CFR Section 164.504 is established.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

For purposes of this Section, “PHI” is “Protected Health Information” as defined in 45 CFR Section 160.103, which ~~is~~ means individually identifiable health information, except as provided in paragraph (2) of the definition of “Protected Health Information” in 45 CFR Section 160.103, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium by a covered entity, as defined in 45 CFR Section 164.104.

SECTION XIII

MISCELLANEOUS PROVISIONS

13.01 INABILITY TO LOCATE PAYEE: If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

13.02 FORMS AND PROOFS: Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

13.03 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant’s or Dependent’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 or Dependent.

13.04 PLAN NOT CONTRACT OF EMPLOYMENT: The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.

13.05 NON-ASSIGNABILITY: No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

13.06 SEVERABILITY: If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.

13.07 CONSTRUCTION:

(a) Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

(b) Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

13.08 NONDISCRIMINATION: In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

13.09 ERISA. The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERISA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.

PD 0217sw

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

CITY OF JONESBORO
EMPLOYER

FLEXIBLE SPENDING ACCOUNT RECORDKEEPING AGREEMENT

Rev. 08/18

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

TABLE OF CONTENTS

PREAMBLE

ARTICLE I DEFINITIONS

1.01 Account
1.02 Plan Administrator
1.03 Agreement
1.04 Code
1.05 Employer
1.06 Participant
1.07 New Participant
1.08 Plan
1.09 Policy
1.10 Recordkeeper

ARTICLE II POWERS AND DUTIES OF RECORDKEEPER

2.01 Recordkeeper
2.02 Powers of the Recordkeeper
2.03 Claim Procedure
2.04 Debit Card Procedure
2.05 Duties of the Recordkeeper

ARTICLE III RESPONSIBILITIES OF EMPLOYER AS PLAN ADMINISTRATOR

3.01 Responsibilities Concerning Recordkeeper
3.02 Indemnification of Recordkeeper

ARTICLE IV ESTABLISHMENT OF ACCOUNTS

4.01 Account to Hold Contributions
4.02 Account to Remain Property of Employer
4.03 Status of Recordkeeper
4.04 Account Not to Earn Interest

ARTICLE V TERM OF AGREEMENT

5.01 Termination
5.02 Termination Upon Written Notice

ARTICLE VI FEES FOR SERVICES

6.01 Fees

ARTICLE VII EXCEPTION TO ELECTION CHANGES

7.01 Exception to Election Changes

ARTICLE VIII COMPLIANCE WITH HIPAA REQUIREMENTS AS A BUSINESS ASSOCIATE OF THE EMPLOYER

8.01 Recordkeeper as Business Associate
8.02 Definitions
8.03 Use and Disclosure
8.04 Further Limitations or Restrictions
8.05 Use for Management and Administration
8.06 Other Services
8.07 Safeguards
8.08 Assignment
8.09 Standard Transactions
8.10 Available Copies
8.11 Amendment of PHI
8.12 Accounting
8.13 Breach of Obligations
8.14 Return of PHI
8.15 Compliance by Employer
8.16 Amendments to HIPAA
8.17 Effective Date
8.18 ARRA Compliance
8.19 Compliance with Breach Notification Rule

ARTICLE IX MISCELLANEOUS

9.01 Action by the Employer
9.02 Notices
9.03 Applicable Law
9.04 Amendment
9.05 Titles
9.06 Severability
9.07 Controlling Agreement

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

PREAMBLE

This RECORDKEEPING AGREEMENT to be effective as of January 1, 2019 is made by and between CITY OF JONESBORO, an entity duly organized and existing under the laws of the State of AR and having its principal place of business in Jonesboro, Arkansas (hereinafter referred to as the "Employer") and American Fidelity Assurance Company, a corporation (the "Recordkeeper"), for the Employer's Section 125 Flexible Benefit Plan (the "Plan").

ARTICLE I

DEFINITIONS

Capitalized terms used herein and not otherwise defined herein shall have the same meaning as set forth in the Plan. The masculine gender shall include both sexes; the singular shall include plural and the plural the singular, unless the context otherwise requires.

1.01 "Account" shall mean the account established by the Recordkeeper on behalf of the Employer from which benefits are to be paid in accordance with the terms of the Plan and this Agreement.

1.02 "Plan Administrator" shall mean the Employer or its appointed delegate, which includes the person, persons or group appointed to act as Administrator under the Plan.

1.03 "Agreement" shall mean this Recordkeeping Agreement, as set forth herein, with any and all further supplements and amendments thereto, which supplements and amendments shall be effective as to Employer upon written notice to Employer.

1.04 "Code" shall mean the Internal Revenue Code of 1986, as amended from time to time, and successor tax laws.

1.05 "Employer" shall mean the Plan Sponsor/Employer and its successors.

1.06 "Participant" shall mean an Employee of an Employer who participates in the Plan under the participation provisions thereof. For purposes of the medical expense reimbursement account, "Participant" does not include Employees who participated during the current plan year, left the plan by discontinuing contributions to the plan, and who then are rehired.

1.07 "New Participant" shall mean an Employee newly hired during the plan year and who has not previously participated in the flexible spending accounts during the current plan year.

1.08 "Plan" shall mean the Employer's Section 125 Flexible Benefit Plan as hereafter amended from time to time.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

1.09 "Policy" shall mean the medical expense reimbursement insurance risk coverage contract issued to the Employer by American Fidelity Assurance Company. The Employer has either (a) applied for coverage under the Policy and the Trust Subscription Agreement, as required by the Recordkeeper, has been submitted to the Recordkeeper (See Article VII for limitations of election), (b) not applied for the Policy and will assume the uniform coverage risk for the medical expense reimbursement and has signed and submitted a Flexible Spending Account Agreement, or (c) has not submitted any signed Agreement because the Plan either does not include medical expense reimbursement and only includes dependent daycare reimbursement.

1.10 "Recordkeeper" shall mean American Fidelity Assurance Company as duly appointed by the Employer pursuant to the terms of the Plan.

ARTICLE II

POWERS AND DUTIES OF THE RECORDKEEPER

2.01 Recordkeeper. The Recordkeeper shall provide the recordkeeping and other ministerial services as the Recordkeeper appointed by the Employer as such under the terms of the Plan. The duties of the Recordkeeper shall be only as provided under this Agreement, the Policy or as otherwise agreed to, in writing, by the Recordkeeper.

2.02 Powers of the Recordkeeper. The Recordkeeper shall have such powers as are necessary for the proper payment of claims for medical expense reimbursement and dependent care expense reimbursement benefits under the Plan, including, but not limited to, the following:

(a) To prescribe procedures to be followed by Participants in filing applications for benefits under the Plan and for furnishing evidence necessary to establish their rights to benefits under the Plan;

(b) To apply the provisions of the Plan (including the provision allowing no election changes by participants for the medical expense reimbursement account during the plan year unless otherwise agreed to in writing by the Employer and the Recordkeeper) as interpreted by the Plan Administrator in determining the rights of any Participant who applies for benefits under the Plan and to notify any such Participant of any such determination;

(c) To obtain from the Employer, Participants and others information as shall be necessary for proper accounting of expense reimbursement benefit payments made pursuant to the terms of the Plan, the Policy, and the directions of the Plan Administrator; and

(d) To receive from and hold on behalf of the Plan Administrator those sums of monies in the Account as determined by the Plan Administrator which (i) represent contributions made under the Plan (by Participants or the Employer) and (ii) will be held and administered in accordance with the Plan, the Policy and this Agreement to pay benefits (or to be returned to the Employer).

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

Provided, the foregoing notwithstanding, the Recordkeeper shall have no power to add to or subtract from or to modify any of the provisions of the Plan, or to change or add to any benefit provided in the Plan.

2.03 Claim Procedure. The Recordkeeper shall pay or deny claims for reimbursement of medical expenses and dependent care expenses in accordance with the terms of the Plan, where applicable. The Recordkeeper shall refer to the Plan Administrator any request for review of a denial of benefits pursuant to the provisions of the claim procedures set forth in the Plan. In accordance with the terms of the Plan, the Plan Administrator (and not the Recordkeeper) shall have the final and absolute authority to determine the validity of claims and whether claims should be paid or denied. Claims will be retained by the Recordkeeper for a period of six years plus the current year, after which they will be purged. No reimbursement will be made to the participant under the dependent day care and/or medical expense reimbursement account until the first contribution is received from the employer and posted to the participant's account.

2.04 Debit Card procedure. The Recordkeeper shall pay or deny claims in the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses under the Medical Expense Reimbursement Plan, in accordance with Section 8.05 of the Plan.

2.05 Duties of the Recordkeeper. The Recordkeeper shall provide the following recordkeeping services to the Plan Administrator:

(a) At the direction of the Plan Administrator, make expense reimbursement benefit payments from the Account to or for the benefit of Participants entitled to such benefits under the Plan;

(b) Provide to the Plan Administrator by January 15 of each year, if requested, annual statements of monies from Participants received and posted who participated in the Dependent Care Expense Plan as set forth in the Plan during the preceding calendar year;

(d) Prepare a monthly reconciliation of allocations and expense reimbursement benefit payments made from the Account, if requested;

(e) Return unused reimbursement amounts which may be due to the Employer under the terms of the Plan and the Policy on a timely basis following the runoff period after the end of the Plan year.

ARTICLE III

RESPONSIBILITIES OF EMPLOYER AS PLAN ADMINISTRATOR

3.01 Responsibilities Concerning Recordkeeper. The Employer shall take the following actions in connection with its delegation of recordkeeping duties to the Recordkeeper:

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

(a) Deliver to the Recordkeeper all contributions (both by Participants and the Employer) received by the Employer under the Plan;

(b) Provide any and all cost, claims, contribution and participation information in the format and frequency that the Recordkeeper determines is necessary to perform its recordkeeping duties;

(c) Interpret the Plan and provide written directions to the Recordkeeper concerning (i) the proper interpretation of the terms of the Plan or any expense reimbursement provision thereunder and (ii) payment of benefits; and

(d) Complete and file an annual 5500 report, if necessary.

3.02 Indemnification of Recordkeeper. Notwithstanding any other provision of this Agreement or the Policy, the Employer agrees to indemnify and hold the Recordkeeper harmless from and against any liability, damage, expense (including attorney fees) or cost that it may incur in serving as Recordkeeper under this Agreement, including but not limited to any claim arising from damage experienced by the Employer, the Plan Administrator or a Participant in connection with the adoption or maintenance or administration of the Plan, unless arising from the Recordkeeper's own negligent or willful breach of the provisions of this Agreement.

ARTICLE IV

ESTABLISHMENT OF ACCOUNTS

4.01 Account to Hold Contributions. Pursuant to the Plan and Policy, the Employer is required to collect contributions. The Employer does not desire to retain physical custody of such contributions and has requested that the Recordkeeper hold and administer such contributions as agent of the Employer, for the benefit of the Participants in the Plan. Accordingly, the Employer hereby requests the Recordkeeper to establish the Account for and on behalf of the Employer and the Participants in the Plan. In accordance with the terms and provisions of the Plan, the Employer shall collect and remit to the Recordkeeper all amounts collected by it under the Plan. All amounts received by the Recordkeeper will be credited to the Account which has been established in the name of the Employer by the Recordkeeper. The Employer will deliver all such contributions as soon as reasonably possible following receipt by the Employer in accordance with the terms of the Plan in order that such amounts may be available to pay benefits. No credits for adjustments on previous billings are allowed; any necessary adjustment will be resolved separately from the monthly contributions upon written agreement between Employer and Recordkeeper.

4.02 Account to Remain Property of the Employer. All contributions to the Account (and the Account itself) shall be deemed to be and remain the exclusive property of the Employer until payment of benefits has occurred. The Recordkeeper shall have no proprietary interest in or title to any amounts held in the Account, its duties hereunder being solely to administer the Account for and on behalf of the Employer and the Participants in accordance with the terms

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

and provisions of the Plan and this Agreement. Further, the Account shall in no manner whatsoever be considered as a trust or other similar entity.

4.03 Status of Recordkeeper. The duties of the Recordkeeper hereunder shall be performed in its capacity as the agent of the Employer for the purposes of administering the Account. Due solely to the fact that the Recordkeeper is administering the Account for and on behalf of the Employer, this fact in no manner whatsoever should be considered as a guarantee to either the Employer or the Participants that all funds which need to be made available for the payment of benefits under the plan are in the Account. The Recordkeeper does not warrant payment of any amounts otherwise due to be paid under the Plan except with respect to those amounts which the Employer has delivered to the Recordkeeper for payment of benefits as provided under the Plan and the Policy. The maximum amount of reimbursement elected by a Participant under the medical expense reimbursement account is available at all times during the period of coverage, as required in Internal Revenue Code Section 125-2 (Q/A-7).

4.04 Account Not to Earn Interest. The Employer has specifically requested of and the Recordkeeper has agreed that the contributions will not be maintained in interest bearing accounts or investments; accordingly, the contributions held in the Account will be held only in non-interest bearing accounts and investments.

ARTICLE V

TERM OF AGREEMENT

5.01 Termination. Unless earlier terminated pursuant to the provisions of 5.02, this Agreement shall remain in effect for one Plan year following the effective date. At the end of one Plan year, this Agreement will continue in full force and effect until terminated. Further, this Agreement will automatically terminate upon termination of the Plan if the Employer certifies to the Recordkeeper that no further benefits are to be paid to Participants. In the event of termination of this Agreement, any and all amounts held in the Account will be returned to the Employer in accordance with the terms of the Policy, and the Employer will then be solely responsible for the performance of the duties otherwise required to be performed by the Recordkeeper hereunder or under the Plan.

5.02 Termination Upon Written Notice. This Agreement may be terminated with or without cause by either party upon no less than ninety (90) days written notice to the other party. In addition, this Agreement may be terminated immediately by written notice specifying a termination date by any party should any of the following events occur: (a) a party fails to comply with this Agreement, or (b) an act of dishonesty or fraud is committed by any party, or (c) any other reason deemed by American Fidelity to be a legitimate business reason. If American Fidelity insures the uniform coverage risk, the risk policy will also terminate and all risk reverts back to the Employer. This would include instances where the Employer consolidates with another entity during the plan year and does not allow the flexible spending accounts to run the full length of the plan year. If American Fidelity's recordkeeping services are terminated, or if Employer terminates either the Section 125 Plan or the flexible spending accounts, a runoff period will only be honored if Employer immediately provides funds to pay any outstanding claims.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

ARTICLE VI

FEES FOR SERVICES

6.01 Fees. In consideration of the Recordkeeper performing the services described herein for the Employer, the Employer will pay a fee of $0 per month for participation in one or both flexible spending accounts for each Participant in the Plan during such month. Payment of all required fees will be made each month during the term of this Agreement following the month in which such services are performed. If the debit card is allowed by the employer in the Medical Expense Reimbursement Account, there will be an additional fee of $0.00 per month per participant electing the debit card.

ARTICLE VII

EXCEPTION TO ELECTION CHANGES

7.01 Exception to Election Changes. If the employer applies for the Medical Expense Reimbursement Policy, Participants may not make election changes under said Policy except in the case of termination of employment unless otherwise agreed to in writing by Employer and Recordkeeper, or otherwise stipulated by amendment to this Agreement. This stipulation does not affect election changes under a dependent care account.

ARTICLE VIII

COMPLIANCE WITH HIPAA REQUIREMENTS AS A BUSINESS ASSOCIATE OF THE EMPLOYER

8.01 Recordkeeper as Business Associate. In connection with Recordkeeper's performance of services pursuant to this Agreement, Recordkeeper may create, receive or have access to Protected Health Information ("PHI"). Since HIPAA regulates the use and disclosure of Protected Health Information, Employer and Recordkeeper want to address and ensure in this Article VIII their respective compliance with HIPAA's applicable business associate provisions and requirements in connection with the services performed under this Agreement. Wherever the term "Employer" is used in this Article VIII, it shall mean "Plan Administrator" and "Employer", as those terms are defined in Paragraphs numbered 1.02 and 1.05 of this Agreement.

8.02 Definitions. When used in this Article VIII, the following terms shall have the meanings specified adjacent to them:

(a) "ARRA" means the American Recovery and Reinvestment Act of 2009.

(b) "Breach" means the acquisition, access, use, or disclosure of PHI in a manner not permitted under 45 C.F.R., Part 164, Part E, which compromises the security or privacy of the PHI.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

(c) "Breach Notification Rule" means the regulations set forth at 45 C.F.R. Part 164, Subpart D, as hereafter amended, which implement the Breach notification requirements set forth in HIPAA.

(d) "Data Aggregation," "Designated Record Set," "Secretary" and "Standard Transaction" shall each have the meaning provided for that term in HIPAA.

(e) "Electronic PHI" means any PHI that comes within or satisfies the definition of "protected health information" at 45 C.F.R. 160.103(1)(i) and (ii), and is disclosed to, or created, obtained, maintained or received by, Business Associate in connection with, or in any manner related to, Recordkeeper's performance of services pursuant to this Agreement, or otherwise for or on behalf of Employer or any Plan.

(f) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, and all rules and regulations promulgated thereunder, as either or both are amended and revised from time to time.

(g) "Law" means any and all statutes, legislation, rules, regulations, codes, laws, orders, decrees, decisions, and ordinances enacted, issued or promulgated by any federal, state or local governmental authority, agency, body, commission, board, court or legislature.

(h) "Person" means any natural person, corporation, limited liability company, partnership, trust, or other legal entity or organization.

(i) "Plan" means all individual or group health plans, cafeteria plans, and similar employee benefit plans sponsored by the Employer that provide, reimburse or pay the cost of medical care or similar services and to which Recordkeeper now or hereafter provides services.

(j) "Privacy Rule" means the regulations set forth at 45 C.F.R. Part 160 and Part 164, subparts A and E, as hereafter amended, which implement the privacy requirements set forth in the Administrative Simplification provisions of HIPAA.

(k) "Protected Health Information" or "PHI" means any and all information constituting "protected health information," as that term is defined in HIPAA, that is disclosed to, or created, obtained, maintained or received by, Recordkeeper in connection with this Agreement.

(l) "Secretary" means the Secretary of the Department of Health and Human Services, or his or her duly designated designee.

(m) "Security Incident" has the same meaning as the term "security incident" in 45 C.F.R. 164.304.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

(n) "Security Rule" means the regulations set forth at 45 C.F.R. Part 164, subpart C, as hereafter amended, which implement the security requirements set forth in the Administrative Simplification provisions of HIPAA.

8.03 Use and Disclosure. Recordkeeper shall neither use nor disclose PHI except as provided in this Article or permitted under applicable law. Except as otherwise specified in this Article, Recordkeeper may make any and all uses of PHI that are reasonably necessary to perform its undertakings with respect to the services under this Agreement. Neither Employer nor any Plan shall request Recordkeeper to use or disclose PHI in any manner that would violate HIPAA.

8.04 Further Limitations or Restrictions. Recordkeeper shall also comply with all further limitations and restrictions on the privacy or any use or disclosure of PHI agreed by Employer or any Plan in accordance with 45 C.F.R. 164.522 to the extent they may affect Recordkeeper's use or disclosure of PHI provided that Recordkeeper has received prior written notification of those limitations and restrictions from Employer or the applicable Plan. Neither Employer nor any Plan will commit Recordkeeper to any such limitations or restrictions, including, but not limited to, restrictions on the use or disclosure of PHI as provided for or limitations in 45 C.F.R. 164.522, unless those limitations or restrictions are required by applicable Law or, in all other instances, without first obtaining Recordkeeper's written approval, which approval will not be unreasonably withheld or delayed. Employer shall immediately notify Recordkeeper of any changes in, or revocation of, any authorization or consent of any participant of or beneficiary under any Plan with respect to the use or disclosure of PHI, to the extent same may affect Recordkeeper.

8.05 Use for Management and Administration. Recordkeeper may use PHI as necessary for the proper management and administration of Recordkeeper or to carry out the legal responsibilities of Recordkeeper. Recordkeeper may disclose PHI as necessary for the proper management and administration of Recordkeeper or to carry out the legal responsibilities of Recordkeeper if (a) the disclosure is required by Law or (b) prior to the disclosure, Recordkeeper obtains a binding written agreement from each Person to whom Recordkeeper will disclose the PHI which provides that such Person will (i) hold the PHI in confidence and use or further disclose the PHI only as required by law or for the lawful purpose for which Recordkeeper disclosed it to the Person, and (ii) notify Recordkeeper of each instance of which the Person becomes aware in which the confidentiality of the PHI is breached and/or a Security Incident occurs.

8.06 Other Services. Recordkeeper may use PHI, as permitted by HIPAA, to provide Data Aggregation services relating to the health care operations of Employer or any Plan as permitted under HIPAA. Recordkeeper may use PHI to report a violation of Law to the Secretary in accordance with HIPAA.

8.07 Safeguards. Recordkeeper will use appropriate, commercially reasonable safeguards to ensure the confidentiality of PHI permitted under this Agreement. Recordkeeper will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that Recordkeeper creates, receives, maintains or transmits on behalf of Employer or any Plan. Recordkeeper shall promptly notify Employer in writing after Recordkeeper has actual knowledge of any use or disclosure of PHI

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

not permitted by this Article. Recordkeeper's obligation to protect the privacy of the PHI it created or received for or from Employer will be continuous and survive the termination of Agreement. Recordkeeper will report to the applicable Plan and Employer any Security Incident of which it becomes aware.

8.08 Assignment. In each instance that Recordkeeper provides PHI to any agent, subcontractor, assignee or delegatee and/or assigns or delegates (if such assignment or delegation is permitted hereunder) any of its undertakings with respect to the services under this Agreement to any other Person, then Recordkeeper shall obtain a binding written agreement from each such agent, subcontractor, assignee and delegatee requiring that Person to comply with the provisions of this Article with respect to the use, disclosure and safeguarding of PHI including, without limitation, the implementation of reasonable and appropriate safeguards to protect Electronic PHI and the reporting of Security Incidents involving such Person of which such Person becomes aware.

8.09 Standard Transactions. If Recordkeeper conducts in whole or in part any Standard Transaction for or on behalf of Employer or any Plan, Recordkeeper will comply, and Recordkeeper will require any of its subcontractors or agents involved with the conduct of such Standard Transaction to comply, with each applicable requirement of HIPAA as respects that Standard Transaction, as follows:

(a) When either party provides, transmits or exchanges data and information electronically to the other party with respect to any Plan, that party shall transfer the data and information in the code sets, data elements, and formats reasonably specified by Recordkeeper. To the extent required by HIPAA, Recordkeeper shall only specify and use the code sets, data elements and formats that comply with HIPAA. All electronic transmissions between the parties shall be to the address provided by the receiving party to the transmitting party. Plan Administrator authorizes Recordkeeper to submit such data and information to Plan Administrator in the specified electronic format after completion of successful testing thereof. If Plan Administrator is unable or unwilling to transfer data in the specified legal electronic format proposed by Recordkeeper, then Recordkeeper shall be under no obligation to receive or transmit data in any other format.

(b) Recordkeeper shall use its reasonable efforts to provide Plan Administrator with at least sixty (60) days prior written notice of any proposed change by Recordkeeper to any code sets, data elements or segments, and formats then being used by the parties for purposes of the electronic exchange of data and information concerning any Plan.

(c) Each party will take reasonable measures to ensure that its data transmissions concerning the Policy or containing any PHI are timely, accurate, complete, and secure, and will take reasonable precautions to prevent unauthorized access to the other party's data transmission or operating system. If either party receives data from the other party that was not intended for it, the receiving party will immediately notify the sender to arrange for, at the sender's sole election, the return, re-transmission or destruction of that data.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

(d) Each party will obtain and maintain, at its own expense, its own operating system necessary for timely, complete, accurate, and secure data transmission pursuant to this Agreement. Each party will pay its own costs related to data transmission under this Agreement, including, without limitation, charges for the party's own operating system equipment, software and services, maintaining an electronic mailbox, connection time, terminals, connections, telephones, internet service providers, modems, and applicable minimum use charges, except as otherwise provided in this Agreement or any other agreement between the parties. Each party will be responsible for its own expenses incurred in connection with translating, formatting, and sending or receiving communications over the electronic network to any electronic mailbox of the other party, except as otherwise provided in this Agreement or any other agreement between the parties.

(e) Each party will provide the other party with all information (including, without limitation, access and security codes) reasonably necessary to allow access to the other party's operating system in order to successfully complete data transmissions and satisfy the transmission and security requirements provided in Agreement. Each party shall test, and cooperate with the other party in testing, each party's operating system to reasonably ensure the accuracy, timeliness, completeness, and confidentiality of each data transmission made in connection with any Plan.

(f) Each party shall use its reasonable efforts in accordance with prudent business practices to provide uninterrupted access to the operating system of the other party for purposes of electronic transmissions concerning any Plan.

(g) The parties shall use their good faith efforts to incorporate herein such applicable requirements of HIPAA that are hereafter adopted concerning the privacy, security, standardization or encryption of electronic data transmissions involving any Plan.

8.10 Access. Upon Employer's reasonable written request, Recordkeeper will make available to Employer or, at Employer's direction, to an individual participant in any Plan (or the individual's personal representative) any PHI (in its possession or under its reasonable control) concerning the individual in a Designated Record Set for his or her inspection and obtaining copies for so long as the PHI is so maintained by Recordkeeper. The PHI shall be made available in the format requested by the individual, unless the PHI is not readily producible in such format, in which case it shall be produced in a readable hard copy format. Recordkeeper shall have the right to charge the individual a reasonable cost-based fee, as permitted by 45 C.F.R. 164.524. Recordkeeper does not assume any obligation to coordinate access to PHI maintained by other business associates of Employer or any Plan. Recordkeeper shall make its internal policies, procedures, practices, books and records relating to its safeguarding, use or disclosure of PHI available to the Secretary, in a time and manner reasonably designated by the Secretary for purposes of determining Employer or any Plan's compliance with HIPAA.

8.11 Amendment of PHI. Upon Employer's request, Recordkeeper will promptly amend, or provide Employer with reasonable access to promptly amend, any portion of the PHI or any record in a Designated Record Set in accordance with 45 C.F.R. 164.526 for as long as the PHI

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

is maintained in a Designated Record Set in the possession or under the reasonable control of Recordkeeper.

8.12 Accounting. Recordkeeper will maintain a record for each disclosure of PHI, which is not excepted from disclosure accounting under HIPAA, including, without limitation, 45 C.F.R. 164.528, that Recordkeeper makes to any Person. That record shall include all information that Employer would be required under HIPAA to respond to a request by a participant in any Plan (or his or her personal representative) for an accounting of disclosures of PHI in accordance with HIPAA, including, without limitation, the information required by 45 C.F.R. 164.528(b)(2).

8.13 Breach of Obligations. If Employer determines that Recordkeeper has breached the provisions of this Article in any material respect and Recordkeeper has not remedied or cannot remedy that breach within fifteen (15) days after its receipt of written notification thereof from Employer, Employer may terminate the recordkeeping arrangement and this Agreement; if termination is not feasible, report the breach to the Secretary.

8.14 Return of PHI. Upon termination of the recordkeeping arrangement or this Agreement and as to the extent permitted by applicable law and as consistent with its other obligations and undertakings provided in this Article, Recordkeeper will, if feasible, return to Employer or destroy all PHI that Recordkeeper still maintains in any form, including all copies of any data or compilations derived from and allowing identification of any individual who is a subject of the PHI. Recordkeeper will complete such return or destruction as promptly as possible. Recordkeeper will identify the conditions that make the return or destruction of any PHI infeasible and any PHI that Recordkeeper cannot feasibly return to Employer or destroy. Recordkeeper will limit its further use or disclosure of that PHI to those purposes that make its return or destruction infeasible, and extend the safeguards and protections of this Agreement to that PHI.

8.15 Compliance By Employer. As between Employer and Recordkeeper, Employer shall be solely responsible for compliance with the applicable plan sponsor disclosure rules of 45 C.F.R. 164.504(f) and other requirements of HIPAA applicable to Employer as the sponsor and/or administrator of any Plan. As between a Plan and Recordkeeper, such Plan shall be solely responsible for its compliance with the applicable obligations and requirements under HIPAA applicable to that Plan as a covered entity. To the extent that Recordkeeper provides PHI (other than “summary health information,” within the meaning of 45 C.F.R. 164.504(a), or enrollment information) to Employer in connection with the services performed under this Agreement or otherwise, Employer will ensure compliance with the requirements of HIPAA including 45 C.F.R. 164.504(f) with respect to that PHI. To the extent that Employer is relying upon the “summary health information” exception to the foregoing plan sponsor disclosure requirements, Employer will ensure, consistent with the provisions of 45 C.F.R. 164.504(f)(ii), that the information in question meets the requirements of that definition and that the information is sought for the purpose of obtaining premium bids or for modifying, amending or terminating the group health plan or any other legally permissible purpose.

8.16 Amendments to HIPAA. Upon the effective date of any final regulation or amendment to HIPAA that conflicts with any term of this Article or which imposes any

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

requirement, condition or obligation upon Recordkeeper, Employer or any Plan concerning the subject matter hereof that is not imposed by this Article, then this Article will be automatically amended to incorporate the applicable terms and conditions of that regulation or amendment such that this Article contractually imposes those terms upon the party or parties to which they apply. Any ambiguity in this Article shall be resolved in favor of a meaning that results in the parties complying with HIPAA.

8.17 Effective Date. This Article shall be effective on the effective date of this Agreement, except with respect to the applicable requirements of the HIPAA security standards for the protection of Electronic PHI set forth at Subpart C of Part 164 of Title 45 of the Code of Federal Regulations, which shall be effective on the later of the effective date of Agreement or April 20, 2005. The Employer or any Plan's engagement of Recordkeeper to perform any services during which Recordkeeper may create or have access to PHI shall constitute Employer and that Plan's acceptance of, and agreement to, all the terms and provisions of this Article.

8.18 ARRA Compliance. Recordkeeper acknowledges and agrees, as of the applicable effective dates for such provisions, Recordkeeper shall comply with each provision of the American Recovery and Reinvestment Act of 2009 ("ARRA") that extends HIPAA Privacy or Security Rule requirements to Business Associates of Covered Entities. The term "Business Associate" and "Covered Entity" shall have the meanings given such terms at 45 C.F.R. § 160.103.

8.19 Compliance with Breach Notification Rule. Recordkeeper shall report any Breach to Employer and Plan as soon as possible, but in no event later than 30 days after Recordkeeper becomes aware of any Breach. Recordkeeper shall, at the direction of the Plan, cooperate and assist in investigating the Breach, performing a risk assessment, determining whether the Breach is reportable under the Breach Notification Rule, and taking steps to minimize any adverse consequences resulting from the Breach. Recordkeeper shall take appropriate disciplinary action against any of its employees that were involved in the Breach. Recordkeeper shall not report the Breach to any individual, the Secretary or the media and shall keep the investigation strictly confidential. The Plan shall make the determination of whether the Breach is a reportable Breach under the Breach Notification Rule and shall comply with applicable reporting requirements.

SECTION IX

MISCELLANEOUS

9.01 Action by the Employer. Whenever under this Agreement the Employer is permitted or required to do or perform any act or thing, it shall be done and performed by an officer or a proper authority of the Employer.

9.02 Notices. All notices, advice, direction or reports required or permitted to be given under this Agreement shall be in writing and shall be mailed postage prepaid or delivered by hand and acknowledged by signed receipt, addressed as follows:

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

To Recordkeeper:

American Fidelity Assurance Company
Section 125 Administration
9000 Cameron Parkway
Oklahoma City OK 73114
P O Box 25510
Oklahoma City OK 73125

To Employer at last known address

9.03 Applicable Law. The provisions of this Agreement shall be construed, administered, and enforced according to the laws of the State of Oklahoma.

9.04 Amendment. This Agreement may be amended by Recordkeeper by written notice to Employer.

9.05 Titles. The title of the Articles and Paragraphs hereof are included for convenience only and shall not be construed as a part of this Agreement or in any respect affecting or modifying its provisions.

9.06 Severability. If any provision or provisions of this Agreement shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining provisions of this Agreement, but shall be fully severable and the Agreement shall be construed and enforced as if said illegal or invalid provisions had never been inserted herein.

9.07 Controlling Agreement. This Agreement supersedes and replaces any prior agreement between the parties with respect to the subject matter contained herein.

DocuSign Envelope ID: C895D918-FEB7-422C-8315-CC4B7F395DC7

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed on this date______________________________.

CITY OF JONESBORO
(Name of Employer)

Signature:_______________________________________

Title:_______________________________________

American Fidelity Assurance Company,
a corporation

Signature:____________________________________

Title: _________Recordkeeper______________

THIS AGREEMENT IS NULL AND VOID IF ALTERED IN ANY WAY

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed on this date 11/8/18.

American Fidelity Assurance Company,
a corporation

Signature: Shauna Sparks

Title: Recordkeeper

THIS AGREEMENT IS NULL AND VOID IF ALTERED IN ANY WAY