NELNET FLEXIBLE BENEFIT PLAN

(Revised Effective January 1, 2019)

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NELNET FLEXIBLE BENEFIT PLAN

INTRODUCTION

The Employer has amended this Plan effective January 1, 2019, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on January 1, 2002. The Plan shall be known as Nelnet Flexible Benefit Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 10.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o), except that for purposes of adopting this Plan the term "Affiliated Employer" does not include Facts Education Corporation..

1.3 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **"Dependent"** means any individual who qualifies as a dependent of a Participant under an insured or self-funded plan for purposes of that plan or under Code Section 152. The definition of "Dependent" is modified to conform with the underlying Code section for the qualified benefit. For example, for purposes of a benefit under Code Section 105, except as otherwise provided, a "Dependent" is a dependent as defined under Code Section 152, without regard to Code Section 105(b)(1), (b)(2), and (d)(1)(B), and any child (as defined in Code Section 152(f)(1)) of a Participant who has not attained the limiting age of 26. Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

"Dependent" shall include a domestic partner of a Participant and any child of a domestic partner who is covered under a self-funded plan or under an Insurance Contract, as defined in the applicable document.

1.8 **"Effective Date"** means January 1, 2019.

1.9 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1, subject to the following:

(a) An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

(b) The following individuals shall not be eligible to participate in the Plan:

(i) Employees expected to work less than 20 hours per week;

(ii) Individuals the Employer treats as temporary associates; and

(iii) Employees of Facts Education Corporation.

1.11 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 **"Employer"** means Nelnet, Inc. and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Affiliated Employer.

1.13 **"Employer Contribution"** means the contributions made by the Employer pursuant to Section 3.1 to enable a Participant to purchase certain Benefits. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to Section 3.1 and the Participants' elections made under Article V.

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

1.15 **"Grace Period"** means, with respect to any Plan Year, the time period ending on the fifteenth day of the third calendar month after the end of such Plan Year, during which Medical Expenses and Employment-Related Dependent Care Expenses incurred by a Participant will be deemed to have been incurred during such Plan Year.

1.16 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.17 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits, the Employer.

1.18 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.19 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.20 **"Plan"** means this instrument, including all amendments thereto.

1.21 **"Plan Year"** means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.22 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the insured or self-funded Benefits described in Section 4.1.

1.23 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

1.24 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.2. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.25 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.26 **"Spouse"** means "spouse" as defined in the insured or self-funded plan for purposes of that plan or the individual to whom the Participant is lawfully married, including an individual of the same sex or opposite sex, if the marriage was validly entered into under the laws of a state or foreign jurisdiction whose laws authorize the marriage, unless legally separated by court decree.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder on his or her initial date of employment with the Employer. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

Employees who are Eligible Employees as of the Effective Date become Participants effective on the Effective Date. Any other Eligible Employee shall become a Participant effective on his or her initial date of employment.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-funded Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

2.4 TERMINATION OF PARTICIPATION

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

(a) **Termination of employment.** The Participant’s termination of employment, subject to the provisions of Section 2.6;

(b) **Change in employment status.** The end of the Plan Year during which the Participant became a limited Participant because of a change in employment status pursuant to Section 2.5;

(c) **Death.** The Participant’s death, subject to the provisions of Section 2.7; or

(d) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be eligible to participate because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made on behalf of the Participant, and, except as otherwise provided herein, all further Benefit elections shall cease, subject to the limited Participant’s right to continue coverage under any Insurance Contracts. However, any balances in the limited Participant’s Dependent Care Flexible Spending Account may be used during such Plan Year to reimburse the limited Participant for any allowable Employment-Related Dependent Care Expenses incurred during the Plan Year. Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan.

2.6 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insurance Benefit.** With regard to Benefits provided under Section 4.1, the Participant’s participation in the Plan shall cease, subject to the Participant’s right to continue coverage under any Insurance Contract or self-funded benefit for which premiums have already been paid.

(b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant’s participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred through the remainder

of the Plan Year in which such termination occurs and submitted within 90 days after the end of the Plan Year, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **Health FSA.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made. These claims must be submitted within 60 days after the Participant's termination. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 12.13 of the Plan.

2.7 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account. Claims related to Benefits which are insured will be governed by the applicable Insurance Contract.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 EMPLOYER CONTRIBUTION

The Employer shall contribute to the Plan amounts deemed necessary to meet its obligations under the Plan. The Employer shall provide an Employer Contribution for each Participant in an amount, if any, to be determined by the Employer prior to the beginning of each Plan Year. The Employer Contribution shall be converted to Cafeteria Plan Benefit Dollars and be available to purchase Benefits as described in this Section 3.1.

A Participant who elects coverage under one of the Employer's Consumer Driven Health Care Plans ("CDHPs", each "CDHP") may receive an Employer Contribution to the Health Savings Account Benefit in an amount to be determined by the Employer on an annual basis. The Employer Contribution to the Health Savings Account Benefits, if any, shall be made available on a quarterly basis each Plan Year.

If a Participant fails to make any election of Benefit Option, there shall be no Employer Contribution (i.e., the Employer Contribution shall not be available in cash).

3.2 SALARY REDIRECTION

If a Participant's Employer Contribution is not sufficient to cover the cost of Benefits or Premium Expenses he elects pursuant to Section 4.1, his Compensation will be reduced in an amount equal to the difference between the cost of Benefits he elected and the amount of Employer Contribution available to him. Such reduction shall be his Salary Redirection, which the Employer will use on his behalf, together with his Employer Contribution, to pay for the Benefits he elected. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.3 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Employer Contribution and Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account, Dependent Care Flexible Spending Account, or Health Savings Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.4 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

3.5 MAXIMUM CONTRIBUTIONS

The maximum contribution any individual can make under this Plan is an amount equal to the sum of the costs for the highest Health Insurance Benefit, Dental Insurance Benefit, Group-Term Life Insurance Benefit, Accident Insurance Benefit, Vision Insurance Benefit, and Accidental Death and Dismemberment Insurance Benefit offered under the Plan, plus the maximum contribution toward the Health Flexible Spending Account, Dependent Care Flexible Spending Account, and Health Savings Account. Notwithstanding anything in this Plan or the Benefits to the contrary, however, effective January 1, 2013, the Code limits the maximum benefits available under the Health Flexible Spending Account attributable to salary reduction contributions under a Salary Redirection Agreement to $2,500 for any taxable year, plus any cost-of-living adjustment provided by Code Section 125(i) or applicable Treasury Regulations for taxable years beginning after December 31, 2013.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

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

(1) Health Flexible Spending Account (General Purpose or Limited Purpose)

(2) Dependent Care Flexible Spending Account

(3) Health Savings Account Benefit

In addition, each Participant shall have a sufficient portion of his Employer Contributions and Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

(4) Health Insurance Benefit

(5) Dental Insurance Benefit

(6) Group-Term Life Insurance Benefit

(7) Accident Insurance Benefit

(8) Vision Insurance Benefit

(9) Accidental Death and Dismemberment Insurance Benefit

Participants who are employed by Great Lakes Educational Loan Services, Inc. (“GLELSI Participants”) may also elect the following Benefits unless the GLELSI Participant elects not to receive such Benefits:

(10) HMO Health Insurance Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in one of the Health Flexible Spending Account options, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Contract shall be determined therefrom, and such Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

4.6 GROUP-TERM LIFE INSURANCE BENEFIT

(a) **Coverage for Participant only.** Each Participant may elect to be covered under the Employer's group-term life Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable group-term life Insurance Contracts for use in providing this group-term life insurance benefit, which policies will provide benefits for all Participants electing this Benefit on a uniform basis.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such group-term life Insurance Contract shall be determined therefrom, and such group-term life Insurance Contract shall be incorporated herein by reference.

4.7 ACCIDENT INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer’s accident Insurance Contract. In addition, the Participant may elect either individual, individual plus spouse, individual plus children, or family coverage.

(b) **Employer selects contracts.** The Employer may select suitable accident Insurance Contracts for use in providing this accident insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such accident Insurance Contract shall be determined therefrom, and such accident Insurance Contract shall be incorporated herein by reference.

4.8 VISION INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer’s vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

4.9 ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer’s accidental death and dismemberment Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable accidental death and dismemberment policies for use in providing this accidental death and dismemberment insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such accidental death and dismemberment Insurance Contract shall be determined therefrom, and such accidental death and dismemberment Insurance Contract shall be incorporated herein by reference.

4.10 HEALTH SAVINGS ACCOUNT BENEFIT

Each Participant may elect to have a portion of his Salary Redirections contributed to a Health Savings Account, as defined in Code Section 223, in which case Article VIII shall apply. The amounts contributed shall be subject to the terms of the Health Savings Account as established.

4.11 HMO HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each GLELSI Participant may elect to be covered under an HMO health Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable HMO health Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all GLELSI Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such HMO health Contract shall be determined therefrom, and such Contract shall be incorporated herein by reference.

4.12 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits, Dependent Care Flexible Spending Account Benefits, and then the Health Savings Account Benefit, and once all these Benefits are expended, proportionately among the remaining insured and self-funded Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so within fifteen (15) days of his or her effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-funded benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which spending account Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

With regard to all Benefits available under the Plan, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits. A Participant must affirmatively elect coverage under each benefit offered under the Plan each year.

5.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

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

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. A Participant must notify the Employer of the change in status within 30 days of the event. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

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

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

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

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

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

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

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

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

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or

Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

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

(k) **Health FSA changes.** A Participant shall not be permitted to change an election to for purposes of the Health Flexible Spending Accounts.

(l) **Health Savings Account changes.** With regard to the Health Savings Account Benefit specified in Section 4.11, a Participant who has elected to make elective contributions under such arrangement may modify or revoke the election prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder. A Participant's modification or revocation of his or her election shall be effective the next payday after the Employer has had a reasonable time to process the new election.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses, as defined in Section 6.3. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly. Participants may elect to participate in either the General Purpose Health Flexible Spending Account or the Limited Purpose Health Flexible Spending Account.

6.2 ELIGIBILITY

Only Eligible Employees who (1) waive Employer Health Insurance Benefit coverage or (2) elect to participate in one of the Employer's Consumer Driven Health Care Plan ("CDHP") but are not eligible or do not desire to contribute to an HSA may participate in the General Purpose Health Flexible Spending Account.

Eligible Employees participating in one of the CDHPs with an HSA are eligible to participate in the Limited Purpose Health Flexible Spending Account.

Eligible Employees may not participate in both Health Flexible Spending Accounts at the same time.

6.3 DEFINITIONS

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

(a) **"Dependent"** for purposes of this Article VI means an individual defined in Code Section 152 without regard to Code Sections 152(b)(1), (b)(2), and (d)(1)(B) and any child (as defined in Code Section 152(f)(1)) of the taxpayer who has not attained age 26 as of the last day of the previous month. Any child to whom Code Section 152(e) applies (relating to custody of a child in the case of divorced parents) is treated as a dependent of both parents.

(b) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(c) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(d) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. Participants in the Limited Purpose Health Flexible Spending Account may only seek reimbursement for medical expenses that are for dental care or vision care, as defined in Code Section 223(c).

"Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents (as defined under this Article VI). "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin. A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent. A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

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

6.4 HEALTH FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Health Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefits Dollars to Health Flexible Spending Account benefits pursuant to Salary Redirection or who is eligible to receive an Employer Contribution to a Health Flexible Spending Account pursuant to Section 3.1.

6.5 INCREASES IN HEALTH FLEXIBLE SPENDING ACCOUNTS

A Participant's Health Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Health Flexible Spending Account pursuant to elections made under Article V hereof or that he is eligible to receive as an Employer Contribution to a Health Flexible Spending Account pursuant to Section 3.1.

6.6 DECREASES IN HEALTH FLEXIBLE SPENDING ACCOUNTS

A Participant's Health Flexible Spending Account shall be reduced by the amount of any reimbursements for Medical Expenses paid or incurred on behalf of a Participant pursuant to Section 6.12 hereof.

6.7 ALLOWABLE MEDICAL EXPENSES REIMBURSEMENT

Subject to the limitations contained in Section 6.9, and to the extent of the amount contained in the Participant's Health Flexible Spending Account, a Participant who incurs Medical Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year and Grace Period or portion thereof during which he is a Participant.

6.8 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Grace Period (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 9.2.

6.9 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary reduction contributions that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $2,500, as adjusted for increases in the cost of living in accordance with Code Section 125(i)(2).

(b) **Cost of Living Adjustment.** In no event shall the amount of salary redirections on the Health Flexible Spending Account exceed $2,500 as adjusted by law. Such amount shall be adjusted for increases in the cost-of-living in accordance with Code Section 125(i)(2). The cost-of-living adjustment in effect for a calendar year applies to any Plan Year beginning with or within such calendar year. The dollar increase in effect on January 1 of any calendar year shall be effective for the Plan Year beginning with or within such calendar year. For any short Plan Year, the limit shall be an amount equal to the limit for the calendar year in which the Plan Year begins multiplied by the ratio obtained by dividing the number of full months in the short Plan Year by twelve (12).

(c) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the $2,500 limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to $2,500 (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to $2,500 (as adjusted) under each Employer's Health Flexible Spending Account.

(d) **Grace Period.** The Plan allows a Participant to submit claims for expenses incurred during the Grace Period. The limits above apply to the Plan Year including the Grace Period. Amounts carried into the next Plan Year as part of the Grace Period shall not affect the limit for that next Plan Year.

6.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.11 COORDINATION WITH FLEXIBLE BENEFIT PLAN

All Participants under the Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Plan.

6.12 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year including the Grace Period shall be reimbursed during the Plan Year subject to Section 2.6, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year and/or attributable to Employer Contributions. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Grace Period.** Notwithstanding anything in this Section to the contrary, Medical Expenses incurred during the Grace Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Grace Period relates.

(e) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

6.13 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year plus any Employer Contributions, if applicable. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.9 plus any Employer Contributions, if applicable.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

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

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

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

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

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

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

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

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

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

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

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

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee, who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

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

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

7.11 COORDINATION WITH FLEXIBLE BENEFIT PLAN

All Participants under the Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

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

(a) The Qualifying Dependent or Qualifying Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Qualifying Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) **Grace Period.** Notwithstanding anything in this Section to the contrary, Employment-Related Dependent Care Expenses incurred during the Grace Period, up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Grace Period relates.

(j) **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

ARTICLE VIII
HEALTH SAVINGS ACCOUNT

8.1 IN GENERAL

A Participant may elect to make salary reduction contributions to a Health Savings Account under this Plan in accordance with this Article and the terms of the trust governing the Participant's Health Savings Account, as well as Code Section 223 and the guidance thereunder.

8.2 DEFINITIONS

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

(a) **"Health Savings Account"** ("HSA") means an account intended to qualify under Code Section 223.

(b) **"High Deductible Health Plan"** ("HDHP") means a health plan –

(1) which has an annual deductible which is greater than or equal to the applicable amount found in Code Section 223(c)(2)(A)(i) ($1,350 for self-only coverage and $2,700 for family coverage in 2019); and

(2) for which the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed the applicable amount found in Code Section 223(c)(2)(A)(ii) ($6,750 for self-only coverage and $13,500 for family coverage in 2019).

An HDHP does not include a health plan if substantially all of its coverage is coverage for any benefit provided by permitted insurance and coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

In the case of a plan using a network of providers, an HDHP can have an out-of-pocket limitation for services provided outside of the network that exceeds the applicable limitation of subsection (b)(i). The plan's annual deductible for services provided outside of the network is not taken into account for purposes of subsections (b)(i) and (b)(ii). Family coverage under this definition means any coverage that is not self-only coverage.

(c) **"Highly Compensated Employee"** means any Employee who is highly compensated, an officer, or a 5-percent shareholder. A Spouse or dependent of a Highly Compensated Employee is also a Highly Compensated Employee.

"Highly compensated" means any employee who for the preceding plan year (or current plan year in the case of the first year of employment) had compensation from the Employer in excess of the amount specified in Code Section 414(q)(1)(B) ($125,000 in 2019), and, if elected by the Employer, was also in the top-paid group of employees for such preceding plan year (or for the current plan year in the case of the first year of employment).

An "officer" means any individual or participant who for the preceding Plan Year (or the current Plan Year in the case of the first year of employment) was an officer. Generally, an officer means an individual or participant who was an administrative executive in regular and continued service of the Employer. An individual's status as an officer depends on the source of the individual's authority, the term of his or her election or appointment, and the nature and extent of his or her duties. An individual who merely has the title of an officer, but not the authority, is not an officer. An individual who has the authority of an officer, but not the title, is an officer.

8.3 ELIGIBILITY TO PARTICIPATE

A Participant may contribute to an HSA for any month under the Plan if he or she is an individual covered under an HDHP as of the first day of the month, and is not, while covered under an HDHP, covered under any health plan that is not an HDHP that provides coverage for any benefit covered under the HDHP.

Participation in this HSA shall terminate on the date the Employee is no longer eligible to participate in the Plan. The Participant may continue to maintain his or her HSA even after he or she is no longer eligible to participate in the Plan.

8.4 ELECTION TO PARTICIPATE

A Participant may elect to make salary reduction contributions to an HSA under this Article. A Participant may revoke or modify his or her election to contribute to an HSA for any reason by completing a new Salary Redirection Agreement. The new Salary Redirection Agreement will be effective as of the next payday after the Employer has a reasonable time to process it. The new Salary Redirection Agreement applies prospectively only.

If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy, for such Plan Year, any requirement imposed by the Code or any limitation on Highly Compensated Employee, the Plan Administrator shall take such action(s) as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation.

8.5 CONTRIBUTIONS TO AN HSA

A Participant must enter into a Salary Redirection Agreement with the Employer to make contributions to their HSA through the Plan. If the Employer elects in writing and pursuant to Section 3.1, the Employer will contribute to a Participant's HSA an amount the Employer specifies in writing.

(a) **Contribution Limits**. A Participant may contribute an amount to an HSA under this Plan that is not greater than the limitation on deductions under Code Section 223(b). The following rules govern a Participant's contributions:

(1) If a Participant has coverage under an HDHP for the entire taxable year, he or she may contribute any amount up to the limitation in Code Section 223(b)(2), adjusted for inflation by Code Section 223(g);

(2) If a Participant establishes an HSA after the first month of the taxable year, and remains an eligible individual during the last month of that year, his or her annual deductible limit is the full-year amount provided in subsection (a)(i);

(3) If a Participant does not maintain his or her status as an Eligible Participant during the last month of the taxable year, the limitation is 1/12 of the limit in subsection (a)(i), multiplied by the number of months he or she was an eligible individual;

(4) A Participant may make a one-time rollover contribution from an qualifying Individual Retirement Account, as provided by Code Section 408(d)(9), up to the amount provided in subsection (a)(i) as limited by the individual's eligibility in subsection (a)(iii). The amount an individual may contribute under subsection (a)(i) is reduced for by the amount of the rollover.

If a Participant attains age 55 before the close of the taxable year, the applicable limitation under subsection (a)(i) is increased by the Additional Contribution Amount, which for years 2009 and following is $1,000.

(b) **Contributions while on FMLA Leave**. A Participant may continue his or her contributions to the HSA while on FMLA Leave. The Employer may continue to provide Employer Contributions, if applicable, to a Participant who has elected to participate in an HDHP who is on FMLA Leave in the same manner as a Participant not on FMLA Leave. The Participant may continue to seek reimbursement from his or her HSA while on FMLA leave.

(c) **Trustees or Custodians**. The Employer will provide a list of eligible trustees or custodians to Participants wanting to make contributions to an HSA by salary reduction contributions under this Plan. Participants must adopt an HSA according to the trustee's or custodian's requirements. A Participant's HSA will be governed by the terms of the eligible trustee's or custodian's document.

(d) **Contribution following Termination of Employment**. If a Participant terminates employment with the Employer or dies while employed by the Employer, salary reduction contributions and employer contributions to the HSA will cease as of the date of termination or death. The Participant or his or her beneficiary will be entitled to the HSA in accordance with the terms of such account

(e) **Participant in Limited Purpose Health Flexible Spending Account**. A Participant may participate in a Limited Purpose Health Flexible Spending Account and an HSA at the same time. A Limited Purpose Health Flexible Spending Account only allows a Participant to seek reimbursement for eligible medical expenses that are dental expenses or vision expenses.

A Participant may not contribute to an HSA if he or she participates in a Health Flexible Spending Account that reimburses all types of eligible medical expenses (a "General Purpose Health Flexible Spending Account"). A Participant may contribute to an HSA during the Grace Period for the General Purpose Health Flexible Spending Account if his or her balance in the General Purpose Health Flexible Spending Account is $0 as of the end of the Plan Year (e.g., December 31). This means that the General Health Flexible Spending Account balance must be $0 on a cash basis, taking into account only those expenses that have been incurred and paid as of the end of the Plan Year. Thus, pending claims, claims submitted, claims received, or claims under review that have not been paid are not considered.

8.6 ADMINISTRATION

(a) **Employer Role**. The Employer's role with respect to a Participant's HSA is solely to:

(1) Provide Participants with a list of eligible trustees or custodians sponsoring HSAs;

(2) Forward, within a reasonable time after salary reduction, a Participant's HSA contributions to the trustee or custodian elected by the Participant;

(3) Determine whether a Participant is covered under an HDHP of the Employer; and

(4) Determine a Participant's age for purposes of catch-up contributions.

(b) **Limitations on Employer Administration**. The Employer's role with respect to a Participant's HSA is

limited to facilitating elections to contribute to the HSA and contributions to the account. The Employer has no role concerning the investments in the HSA or distributions from the account. The Employer will not –

(1) Limit the ability of eligible individuals to move their funds to another HSA beyond restrictions imposed by the Code;

(2) Impose conditions on utilization of HSA funds beyond those permitted under the Code;

(3) Make or influence the investment decisions with respect to funds contributed to an HSA;

(4) Represent that the HSAs are an employee welfare benefit plan established or maintained by the Employer; and

(5) Receive any payment or compensation in connection with an HSA. Participants must execute and deliver such documents to the HSA provider as it requires to adopt an HSA.

If an Employee makes any contribution to an HSA under the Employer's program that does not qualify under Code Section 223, he or she must indemnify and reimburse the Employer for any liability it may incur for the failure to withhold federal and state income tax or social security tax from such payments or reimbursements. However, such indemnification and reimbursement will not exceed the amount of additional federal and state income tax that the Employee would have owed if the contributions had been made to him or her as regular cash compensation, plus the Employee's share of any social security tax that would have been paid on such compensation, less any such additional income and social security tax actually paid by the Employee, plus any penalties or interest assessed against the Employer.

(c) **Records**. The Plan Administrator shall keep or cause to be kept accurate and complete books and records with respect to the salary reduction and employer contributions (if any) under the HSA component of the Plan.

8.7 CLAIMS PROCEDURE

The Participant should refer to the materials provided by the trustee or custodian of his or her HSA for information on how to submit claims for processing. The HSA Plan is not subject to ERISA. If the trustee or custodian denies the Participant's claim for benefits, the Participant should follow any appeals process it has established**.**

ARTICLE IX
ERISA PROVISIONS

9.1 CLAIM FOR BENEFITS

(a) **Insurance claims.** Any claim for Benefits underwritten by the self-funded plan shall be made to the Employer. If the Employer denies any claim, the Participant or beneficiary shall follow the Employer's claims review procedure. Any claim for Benefits underwritten by an Insured plan shall be made to the Insurer.

(b) **Dependent Care Flexible Spending Account claims.** Upon any event that will entitle a Participant or beneficiary to make a claim under the Plan for Dependent Care Flexible Spending Account Benefits, the Participant, his or her representative or beneficiary will make application to the Plan Administrator or its designee. The Plan Administrator or its designee will accept, reject or modify the request and notify the Participant, his or her representative or beneficiary in writing setting forth the response according to the claims procedure described in the Plan's Summary Plan Description (the "Claims Procedure"). This Section of the Plan document specifically incorporates the Claims Procedure, as amended from time to time. In the event the request is rejected or modified, the Participant, his or her representative or beneficiary must submit a written request for review by the Plan Administrator or its designee of the decision pursuant to the Claims Procedure.

(c) **Health FSA claims.** Upon any event that will entitle a Participant or beneficiary to make a claim under the Plan for Health Flexible Spending Account Benefits, the Participant, his or her representative or beneficiary will make application to the Plan Administrator or its designee. The Plan Administrator or its designee will accept, reject or modify the request and notify the Participant, his or her representative or beneficiary in writing setting forth the response according to the claims procedure described in the Plan's Summary Plan Description (the "Claims Procedure"). This Section of the Plan document specifically incorporates the Claims Procedure, as amended from time to time. In the event the request is rejected or modified, the Participant, his or her representative or beneficiary must submit a written request for review by the Plan Administrator or its designee of the decision pursuant to the Claims Procedure.

(d) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year and Grace Period (if applicable) shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.8 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above

have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

9.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan. No amounts attributable to the Health Savings Account shall be subject to the benefit plan surplus.

9.3 NAMED FIDUCIARY

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

9.4 GENERAL FIDUCIARY RESPONSIBILITIES

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

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

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

9.5 NONASSIGNABILITY OF RIGHTS

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

ARTICLE X
ADMINISTRATION

10.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer or be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Act, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator’s interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant’s rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and

(i) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

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

10.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

10.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

10.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

10.5 INDEMNIFICATION OF ADMINISTRATOR

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

ARTICLE XI
AMENDMENT OR TERMINATION OF PLAN

11.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

11.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Contract shall be paid in accordance with the terms of the Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XII
MISCELLANEOUS

12.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 12.11.

12.2 GENDER AND NUMBER

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

12.3 WRITTEN DOCUMENT

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

12.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

12.5 PARTICIPANT'S RIGHTS

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

12.6 ACTION BY THE EMPLOYER

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

12.7 NO GUARANTEE OF TAX CONSEQUENCES

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

12.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

12.9 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

12.10 GOVERNING LAW

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

12.11 SEVERABILITY

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

12.12 CAPTIONS

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

12.13 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

12.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

12.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

12.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

12.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

Application. If any benefits under this Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply. The applicable requirements of HIPAA and all amendments thereto including the Health Information Technology for Economic and Clinical Health Act ("HITECH") enacted as part of the American Recovery and Reinvestment Act of 2009 ("ARRA") (collective "HIPAA") shall apply. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Employer, provided the Employer requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage, or modifying, amending, or terminating the Plan. The Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations as set forth below.

(a) **Certification of Plan Sponsor**. The Plan (or a health insurance issuer or HMO with respect to the benefit offered under the Plan) shall disclose Protected Health Information ("PHI") to the Employer only upon receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in subsection (b). The Plan shall not disclose and may not permit a health insurance issuer or HMO to disclose PHI to the Employer as otherwise permitted herein unless the statement required by 45 CFR § 164.520(b)(1)(iii)(C) is included in the appropriate notice.

(b) **Conditions of Disclosure**. The Employer agrees that with respect to any PHI disclosed to it by the Plan, a health insurance issuer or an HMO, the Employer shall:

(i) Not use or further disclose the PHI other than as permitted or required by the Plan documents or as required by law.

(ii) Ensure that any agents, including a subcontractor, 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 PHI.

(iii) Not use or disclose the PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(iv) Report to the Plan any access, use or disclosure of PHI that is inconsistent with this Section or the Privacy Rule or Security Rule, including, without limitation, any access, use, or disclosure of Unsecured PHI which could reasonably require the Plan to undertake an analysis to determine whether a "breach" has occurred (as that term is defined in the regulations and the Secretary's guidance promulgated with respect to HITECH and HIPAA generally), immediately upon becoming aware of an inconsistent use or disclosure. The Employer agrees to provide all information reasonably requested by the Plan in order for the Plan to fully comply with its obligations under 45 C.F.R. Part 164 including breach notification and security incident obligations. The Employer agrees, to the extent practicable, to mitigate the harmful effects of a breach or security incident known to the Employer and to document any breach or security incident and the outcome of the same. The Employer agrees to reimburse the Plan for all costs incurred by the Plan in complying with the breach notification procedures in 45 C.F.R. § 164 Subpart D, provided such costs arise out of a breach for which the Employer is required to give the Plan notice under this Section.

(v) To provide individuals with access to PHI in accordance with 45 CFR § 164.524 and 42 U.S.C. § 17935(e). The Employer agrees to provide access to PHI in a Designated Record Set, as that term is defined in 45 C.F.R. § 164.501, to the Plan or, as directed by the Plan, to an individual at the written request of the Plan within 10 calendar days to allow the Plan to meet the requirements of 45 C.F.R. § 164.524. If an individual requests access to PHI in a Designated Record Set in an electronic format, the Employer agrees to permit such access and to direct a secure transmission of such PHI to the entity or person designated by the individual, provided that the direction from the individual is clear, conspicuous and specific.

(vi) Make available PHI for amendment and incorporate any amendments to PHI in a Designated Record Set in accordance with 45 CFR § 164.526. The Employer agrees to make said amendments within 10 calendar days of a written request by the Plan.

(vii) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528 and 42 U.S.C. § 17935(c). The Employer acknowledges that for purposes of 45 C.F.R. § 164.528, effective as of the applicable date set forth in 42 U.S.C. § 17935(c)(4), to the extent the Employer makes a disclosure of an electronic health record containing PHI from a Designated Record Set, the Employer will maintain such information as required by the Secretary in regulations promulgated pursuant to section 42 U.S.C. § 17935(c)(2) notwithstanding the status of such disclosures as "treatment," "payment," or "health care operations" disclosures.

(viii) 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 for purposes of determining compliance by the Plan with HIPAA.

(ix) If feasible, return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such

return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(x) Ensure that the adequate separation between Plan and Employer, required in 45 CFR § 164.504(f)(2)(iii) and described in this Section, is established.

(xi) Implement administrative, physical, and technical safeguards to the extent required by sections 164.308, 164.310, and 164.316 of title 45, Code of Federal Regulations and HITECH that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI or PHI the Employer creates, receives, maintains or transmits on behalf of the Plan (other than enrollment/disenrollment information) and it will ensure that any agents or subcontractors to whom it provides such electronic PHI agrees to implement reasonable and appropriate safeguards to protect the information.

(xii) Comply with the other provisions of HIPAA, HITECH and any implementing regulations promulgated thereunder to the extent the same apply to the Employer.

(xiii) Limit its uses and disclosures of PHI to the "minimum necessary" amount of information to accomplish the intended purpose of the use, disclosure, or request for information. The Employer acknowledges that for purposes of this Section, it will be deemed to meet the "minimum necessary" requirement if it discloses only such information within the definition of a "limited data set" as described in 45 C.F.R. § 164.514(e)(2), or if it discloses only such information consistent with guidance required to be provided by the Secretary under 42 U.S.C. § 17935(b)(1)(B).

(xiv) To the extent the Plan is required to restrict the use or disclosure of PHI pursuant to 42 U.S.C. § 17935(a), or otherwise agrees to a restriction on the disclosure of PHI, the Employer agrees to abide by such requested restriction to the extent the Employer is made aware of the same via written notice from the Plan and to immediately implement the restriction as requested.

(c) **Adequate Separation Between Plan and Employer**. In compliance with HIPAA, the Employer will designate persons entitled to access to PHI. The Employer shall only allow those persons so identified to be given access to PHI. Those Employees who have access to PHI from the Plan are listed in the Privacy Notice, either by name or individual position. The Employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI to the extent necessary to perform the Plan Administration Functions that the Employer performs for the Plan, including but not limited to: quality assurance, claims processing, auditing, and monitoring. In the event that any of these specified persons do not comply with the provisions of this Article, that person, if an employee of the Employer, shall be subject to disciplinary action by the Employer for noncompliance pursuant to the Employer's employee discipline and termination procedures. If that person is a non-employee, the Employer shall take appropriate action with the entity involved, to ensure that appropriate discipline or sanctions are imposed and that non-compliance does not recur.

(d) **Permitted and Non-permitted Uses and Disclosure of PHI**. Unless otherwise permitted by law, and subject to obtaining a written certification pursuant to subsection (a), the Plan may disclose PHI to the Employer, provided the Employer uses or discloses such PHI only for the purpose of carrying out Plan Administration Functions that the Employer performs for the Plan, consistent with the provisions of subsection (b). Notwithstanding the provisions of this Section to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f). The Plan may not permit a health insurance issuer or HMO with respect to the Plan to disclose PHI to the Employer except as permitted by 45 CFR § 164.504(f). The Plan may not disclose PHI to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer. The Plan shall not use or disclose PHI that is genetic information for underwriting purposes

(e) **Information Regarding Participation**. Notwithstanding subsection (d), the Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to the Employer information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(f) **Privacy and Security Official**. The Plan shall designate a Privacy and Security Official, who will be responsible for the Plan's compliance with HIPAA's Privacy and Security Rules. The Privacy Official and the Security Official may be the same individual. The Privacy and Security Official is responsible for ensuring the Plan's compliance with HIPAA's Privacy and Security Rules. The Privacy and Security Official may contract with, or otherwise utilize, the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy and Security Official deems necessary or advisable

(g) **Definitions**. The following definitions apply for purposes of this Section:

(i) HITECH means the Health Information Technology for Economic and Clinical Health Act enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5 (Feb. 17, 2009) ("ARRA"), including final regulations promulgated pursuant thereto.

(ii) Health Information means any information, including genetic information, whether oral or recorded in any form or medium, that: is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearing house; and relates to the past, present or future physical or mental health or

condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

(iii) Health Plan means an individual or group plan that provides or pays the cost of medical care (as defined in Section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. § 300gg-91(a)(2)).

(iv) Individually Identifiable Health Information means a subset of Health Information including demographic information collected from an individual, and which: is created or received by a health care provider, Health Plan, employer, or health care clearing house; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(v) Plan Administration Functions means administration functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

(vi) Privacy Notice means the notice of the Plan's privacy practices distributed to Plan participants in accordance with 45 C.F.R. § 164.520, as amended from time to time.

(vii) Protected Health Information (PHI) means Individually Identifiable Health Information that is: transmitted by electronic media; maintained in any media described in the definition of electronic media at 42 CFR § 162.103; or transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S. C. § 1232g; records described at 20 U.S.C. § 1232g(a)(4)(B)(iv); employment records held by a Covered Entity in its role as employer; and records regarding a person who has been deceased for more than 50 years.

(viii) Secretary means the Secretary of the U.S. Department of Health and Human Services or his or her designee.

(ix) Summary Health Information means information that: summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Health Plan; and from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

(x) Unsecured PHI means protected health information that has not been secured through the use of technology or by a methodology specified by the Secretary in guidance issued pursuant to 42 U.S.C. § 17932(h)(2). In the absence of guidance from the Secretary, "unsecured PHI" means protected health information that is not secured by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized persons and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

(xi) Terms used, but not otherwise defined in this Section, Use and Disclosure of Protected Health Information: HIPAA Security, shall have the same meaning as those terms in HIPAA and regulations promulgated thereunder.

(h) **Certification of Employer for Security and Conditions of Disclosure**. The certification of the Employer required pursuant to subsection (a) shall also certify that the Employer will comply with the Security Standards as set forth at 45 CFR Parts 160, 162, and 164 (the "Security Rule").

(i) The Employer agrees that with respect to any PHI, as defined above, disclosed to it by the Plan, a health insurance issuer or an HMO, the Employer shall:

(i) Ensure that any business partner to whom it provides PHI received from the Plan, agrees to the same privacy and security restrictions and conditions that apply to the Employer with respect to such PHI.

(ii) Report to the Plan any security incident as that term is defined in 45 CFR § 164.304.

(iii) Ensure that electronic "firewalls" are in place to secure electronic PHI.

(iv) Implement reasonable and appropriate safeguards for electronic PHI as defined in 45 CFR § 164.103, created, received, maintained, or transmitted to or by the Employer on behalf of the Plan, in accordance with the Security Rule.

12.18 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

12.19 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

12.20 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

12.21 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

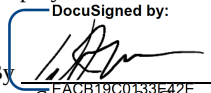
Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

WHEREAS, Nelnet, Inc. has authorized the Secretary and General Counsel to execute amendments to the Plan to assure the Plan's continued compliance with applicable law.

IN WITNESS WHEREOF, this Plan document has been adopted by the Employer.

Nelnet, Inc., Plan Sponsor, and on behalf of the Affiliated Employers

DocuSigned by:

By 
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Secretary & General Counsel

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