TOWN OF CONCORD

SECTION 125 CAFETERIA PLAN - FLEXIBLE SPENDING PLAN
ADOPTION AGREEMENT

Effective Date: 1/1/2017

Item I: Adoption

The Employer hereby establishes a Qualified "Cafeteria Plan" as set forth pursuant to Section 125 of the Internal Revenue Code. The Benefit Package Options listed in Item VI below have been incorporated into this Plan by reference. Nothing in this Adoption Agreement shall be intended to override the terms of the Plan Document to which this Adoption Agreement is attached.

Item II: Employer Organization

Name of Organization:	TOWN OF CONCORD
Federal Employer ID Number:	04-6001121
Street Address:	22 MONUMENT SQUARE
City, State, Zip:	CONCORD, MA 01742
Nature of Business:	MUNICIPALITY
Employer Affiliates:	NONE

Item III: Plan Information

Plan No.:	502
Plan Name:	TOWN OF CONCORD CAFETERIA PLAN
Plan Year Runs*:	JANUARY 1 – DECEMBER 31

*This Plan is designed to run on a 12-month Plan Year period as stated above. A Short Plan Year may occur when the Plan is first established, when the Plan Year period changes, or at the termination of a Plan.

Plan Administrator:	CAFETERIA PLAN ADVISORS, INC
Street Address:	420 WASHINGTON STREET, SUITE 100
City, State, Zip:	BRAINTREE, MA 02184
Phone:	781-848-9848

Item IV: Eligibility Requirements

(a) Except as provided in (b) below, the Classification of eligible Employees consists of All Employees.

(b) Employees excluded from this classification group are those individual Employees who fall into one or more of the following categories below:

Employees who are not eligible for coverage under group medical plan.

Employees who work less than 20 hours per week.

Item V - Service Period Requirement

An Employee meeting the eligibility requirements shall be allowed to participate in the Flexible Spending plan on the first day of employment and has up to 30 days from date of hire to enroll.

Item VI - Benefit Package Options

The following Benefit Package Options are offered under this Plan:

FSA HEALTH CARE ACCOUNT (with Debit Card)

FSA DEPENDENT CARE ACCOUNT

Item VII - Flexible Spending Account Elections

Health FSA

(a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is **$2,600.**

(b) The maximum annual reimbursement amount that a Participant may receive during the year is the annual reimbursement amount elected by the Employee on the Salary Reduction Agreement for Health FSA coverage, not to exceed the amount set forth in (a) above.

(c) Minimum Contribution for this Benefit per Plan Year per Employee is: NONE

(d) In order to receive reimbursement under the Health FSA, the claim or claims must equal or exceed the Minimum Payment Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Payment Amount, except that claims submitted for reimbursement during the last month of the Plan Year, the Run-Out Period, or the Claims Submission Grace Period, whichever is applicable, will not be subject to the Minimum Payment Amount. The Minimum Payment Amount under this Plan is hereby set as $1.00.

For the Health FSA account a debit card will be issued to Participants. Using the debit card for eligible expenses will debit the Participants account accordingly.

Dependent Care Assistance Plan

(a) The maximum annual reimbursement amount a Participant may elect under the Dependent Care Assistance Plan for any Plan Year is the lesser of the maximum established by the Plan described in (b) below or the statutory maximum specified in Code Section 129.

(b) The maximum annual reimbursement amount established by the Dependent Care Assistance Plan is as follows: **$5,000** for married filing jointly or single and $2500 for married filing separately.

(c) The maximum annual reimbursement that a Participant may receive during the year is the annual reimbursement amount elected by the Participant on the Salary Reduction Agreement, not to exceed the amount in (a) above.

(d) Minimum Contribution for the Benefit per Plan Year per Employee is: NONE

(e) In order to receive reimbursement under the Dependent Care Assistance Plan, the claim or claims must equal or exceed the Minimum Payment Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Payment Amount, except that claims submitted for reimbursement during the last month of the Plan Year, during the Run-Out Period, or Claims Submission Grace Period, whichever is applicable, will not be subject to the Minimum Payment Amount. The Minimum Payment Amount under this Plan is hereby set as $1.00.

Item VIII: Plan Entry Date

The Plan Entry Date is the date when an Employee who has satisfied the Eligibility Requirements may commence participation in the Plan. Each year each Participant may elect in writing on a form filed with the plan administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any Plan Year thereafter, to be reimbursed from the Plan for Unreimbursed Medical Expenses incurred during that year by him to the extent described and defined in the Plan Documents.

Item IX: Run-Out Period, Grace Period, Roll-Over Option

Run-Out Period

A. The Active Employee Run-Out is the period of time that begins the day after the Plan Year ends during which the Employee can submit claims for payment of Qualified Expenses incurred during the Plan Year. See Item X for Run-Out information.

B. The Terminated Employee/Coverage Run-Out is the period of time after an Employee terminates employment (or loses eligibility to participate in the Plan) during which the Employee can submit claims for expenses incurred while the Employee remained a Participant. See Item X for Run-Out information.

Grace Period

As indicated in Item X below, the Employer has the option to adopt a grace period for your benefits. View this section to determine if the grace period is included.

If a grace period has been adopted, it will begin on the first day of the next Plan Year and (depending on the benefit) will end up to two (2) months and fifteen (15) days later. To view a list of benefits and associated grace information, see Item X.

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- (for Health FSA) A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period:

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Because Run-Out claims may be submitted after Grace Period claims, claims may be reordered to maximize reimbursement; as a result, grace claims and/or payments may be reassigned to the current Plan Year.

  For example, assume that $200 remains in your Health FSA account at the end of the 2013 Plan Year, and further assume that you have elected to allocate $2400 to the Health FSA for the 2014 Plan Year. If you submit for reimbursement an Eligible Medical Expense of $500 that was incurred on January 15, 2014, $200 of your claim will be paid out of the unused amounts remaining in your Health FSA from the 2013 Plan Year and the remaining $300 will be paid out of amounts allocated to your Health FSA for 2014.

- Expenses incurred during a grace period must be submitted before the end of the Run-out Period described in Item X. The run-out period applies to claims, incurred both during the previous Plan Year and the grace period, that are reimbursable from the previous Plan Year. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the Run-out Period. To see a list of benefits and associated Run-Out information, see Item X.

You may not use Health FSA amounts to reimburse Eligible Day Care Expenses (and if the grace period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse Eligible Medical Expenses).

Roll-Over Option

As indicated in Item X below, the Employer has the option to adopt a roll-over, allowing participants to roll up to $500 of unused/unclaimed funds for the Health FSA accounts to the succeeding plan year.

The Employer has the option to set the roll-over amount, up to $500 maximum. View this section to determine if the Health FSA account includes this option and the amount.

In order to take advantage of the roll-over option, you must be:

- A Participant in the applicable Flex Spending account(s) on the last day of the Plan Year to which the roll-over applies, or
- (for Health FSA) A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the roll-over applies.

The following additional rules will apply to the roll-over:

- If a roll-over option has been adopted, the rolled funds become available after the run out period has expired for the current Plan Year.

  For example, assume that $200 remains in your Health FSA account at the end of the 2013 Plan Year and after the run out period. Further assume that you have elected to allocate $2500 to the Health FSA for the 2014 Plan Year. The $200 will roll to the 2014 Plan Year making the total amount available for Plan Year 2014 of $2700 ($2500 election plus the $200 amount rolled).

- The roll-over amount does not affect the maximum amount of salary reduction contributions that a Participant is permitted to make.

The roll-over option cannot be adopted to a Plan Year for which the Grace Period option is in effect. The Employer would need to cancel the grace period and opt for the roll-over.

Item X: Rollover Option, Grace Period and Run-Out Summary Information

Benefit	Roll Over Option	Roll Over Amount	Grace Period Adopted	Grace Period Days	Grace End Date	Active Employee Run-Out	Terminated Employee / Coverage Run-Out
FSA Health Care	**YES**	**$500**	**NO**			**90 days after plan yr ends**	**90 days after termination**
FSA Dependent Care	N/A	N/A	NO			90 days after plan yr ends	90 days after termination

Item XI: Administration Fee

Administration Fees:

Administrative fees paid by employee: $5.00 pppm
$1.00 pppm for debit card

Item XII: Contacts

Benefits Coordinator

Employer Name:	TOWN OF CONCORD
Street Address:	22 MONUMENT SQUARE
City, State, Zip:	CONCORD, MA 01742

Plan Administrator:	CAFETERIA PLAN ADVISORS, INC
Street Address:	420 WASHINGTON STREET, SUITE 100
City, State, Zip:	BRAINTREE, MA 02184
Phone:	781-848-9848
Web Site:	www.CPA125.COM

Item XIII - Incorporation by Reference

The actual terms and conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Cafeteria Plan adopted through this Agreement as to substantive content. To that end, each such separate document, including the Plan Document and the Summary Plan Description as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

CAFETERIA PLAN

FLEXIBLE SPENDING ACCOUNTS

PLAN DOCUMENT

TOWN OF CONCORD

1/1/2017

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PREAMBLE

Effective as of the date set forth in the Adoption Agreement, the Employer identified in the Adoption Agreement has established the Flexible Spending Plan (the "Plan") for its Employees for purposes of providing eligible Employees with the opportunity to choose from the Benefit Package Options available under the Plan. The Plan is intended to qualify as a Cafeteria Plan under the provisions of Code Section 125.

The Adoption Agreement is incorporated by reference and is made a part of this plan document. In addition, there are appendices attached to these documents that describe the terms of the Health Flexible Spending Account and the Dependent Care Flexible Spending Account. To the extent adopted by the Employer (as set forth in the Adoption Agreement), each appendix is incorporated into and made a part of this Plan Document.

ARTICLE I
DEFINITIONS

1.01 "Affiliated Employer" means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m).

1.02 "After-Tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan.

1.03 "Anniversary Date" means the first day of any Plan Year.

1.04 "Benefit Credits" means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the Benefit Package Option(s) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Package Option(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time at the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the Summary Plan Description or enrollment material, the Employer may make Benefit credits available to Participants and allow Participants to allocate the Benefit credits among the various Benefit Package Options offered under the Plan in a manner set forth in the Summary Plan Description or enrollment material. In no event will any Nonelective Contribution be disbursed to a Participant in the form of additional, taxable Compensation except as otherwise provided in the Summary Plan Description or enrollment material.

1.05 "Benefit Package Option(s)" means those Qualified Benefits available to a Participant under this Plan as set forth in the Adoption Agreement.

1.06 "Board of Directors" means the Board of Directors or other governing body of the Employer (the "Board"). The Board of Directors, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

1.07 "Change in Status" means any of the events described in the Summary Plan Description, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year. Note: See the Summary Plan Description for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

1.08 "Code" means the Internal Revenue Code of 1986, as amended.

1.09 "Compensation" means the cash wages or salary paid to an Employee by the Employer.

1.10 "Dependent" means any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a); however, that in the case of health benefits, a Dependent shall be defined as set forth in Code Section 105(b) and the regulations issued under Code Section 106. For purposes of Dependent Care FSA (if offered under the Plan) a Dependent shall also be defined as in Code Section 21(e)(5) (i.e., Dependent of the parent with custody for the greatest portion of the year).

1.11 "Effective Date" of the Plan means the date specified in the Adoption Agreement that this Plan was established**.** If this Plan is Amended and Restated, the Amended and Restated effective date will be the date of this document as set forth below.

1.12 "Employee" means an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any of the following: (a) any leased employee (including, but not limited to, those individuals defined in Code § 414(n)); (b) an individual classified by the Employer as a contract worker or independent contractor; (c) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll; and (d) any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement, except as otherwise provided for in the collective bargaining agreement.

1.13 "Employer" means the Employer identified in the Adoption Agreement as the sponsoring employer and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Employer. Notwithstanding the previous sentence when the Plan provides that the Employer has a certain power (e.g., the appointment of a third party administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only the Employer identified as the Plan Sponsor. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

1.14 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.15 "Highly Compensated Individual" means an individual defined under Code Section 125(e), as amended, as a "highly compensated individual" or a "highly compensated Employee."

1.16 "Key Employee" means an individual who is a "key Employee" as defined in Code Section 125(b)(2), as amended.

1.17 "Participant" means an Employee who becomes a Participant pursuant to Article II.

1.18 "Plan" means this Cafeteria Plan, as set forth herein.

1.19 "Plan Administrator" means the person(s) or Committee identified in the Summary Plan Description that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.20 "Plan Year" shall be the period of coverage set forth in the Summary Plan Description.

1.21 "Pre-Tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.22 "Qualified Benefit" means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 124, 127, or 132 and any other benefit permitted by the Income Tax Regulations (i.e., any group-term life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Sec. 79). Notwithstanding the previous sentence, long-term care insurance is not a "Qualified Benefit."

1.23 "Salary Reduction Agreement" means the actual or deemed agreement pursuant to which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Package Options with Pre-Tax or After-Tax Contributions and/or Benefit Credits (if offered under the Plan) in accordance with Article III herein. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the Salary Reduction Agreement may be maintained on an electronic database in accordance with all applicable federal and/or state laws.

1.24 "Spouse" means an individual who is legally married to a Participant (and who is treated as a spouse under the Code).

1.25 "Summary Plan Description" or "SPD" means the Flexible Benefits Plan SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and attached to this Plan Document as Attachment I, as amended from time to time. The SPD and appendices are incorporated hereto by reference.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

2.01 Eligibility to Participate. Each Employee who satisfies the eligibility requirements set forth in the Adoption Agreement shall be eligible to participate in this Plan as of the Plan Entry Date set forth in the Adoption Agreement. Eligibility to participate in this Plan means only that the Eligible Employee is entitled to contribute his share of the cost of applicable Benefit Package Options for which he is eligible with Pre-Tax Contributions. The provisions of this Article are not intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Package Options and the terms of eligibility and participation for the Benefit Package Option(s) offered under the Plan shall be subject to the requirements specified in the governing documents of the Benefit Package Options.

2.02 Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD.

2.03 Qualifying Leave Under the Family and Medical Leave Act. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Package Options that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Employer (as described above), will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.04 Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Package Options chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD and implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Package Options chosen by the Participant, the election change rules in Section 3.04 will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

ARTICLE III
ELECTIONS

3.01 Election of Contributions. A Participant may elect any combination of Pre-Tax Contributions (to the extent set forth in the enrollment material) to fund any Benefit Package Option available under the Plan, provided that only Qualified Benefits may be funded with Pre-Tax Contributions. The Employer may, but is not required to, allocate Benefit credits to one or more Benefit Package Options offered under the Plan and to the extent set forth in the SPD or enrollment material, may allow the Participants to allocate his allotted share of Benefit credits among the various Benefit Package Options in a manner set forth in the SPD or enrollment material.

3.02 Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Plan as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Agreement shall be effective, subject to Section 3.04, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Plan's Waiting Period**. An Employee who becomes eligible to become a Participant in this Plan after the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Plan as set forth in the SPD. Coverage under the component Benefit Package Options will be effective in accordance with the governing provisions of such Benefit Package Options.

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.03 or 3.04.

3.03 Annual Election Period. Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the Annual Election Period. The date on which the Annual Election Period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

3.04 Change of Elections. A Participant shall not make any changes to the Pre-Tax Contribution amount or, where applicable, to the Participant's elected allocation of Benefit credits except under the circumstances set forth in the SPD and for changes made during the Annual Election Period, changes caused by termination of employment or cessation of eligibility, and changes pursuant to the Family and Medical Leave Act. Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later.

3.05 Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3.05, no new election with respect to Pre-Tax Contributions may be made by such Participant during the remainder of the Plan Year except as set forth in the SPD.

ARTICLE IV
CREDITS AND DEBITS TO ACCOUNTS

4.01 Source of Benefit Funding. The cost of coverage under the component Benefit Package Options shall be funded by Participant's Pre-Tax and/or any Benefit credits provided by the Employer.

4.02 Reduction of Certain Elections to Prevent Discrimination. 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 Pre-tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

ARTICLE V
BENEFITS

5.01 Qualified Benefits. The maximum benefit a Participant may elect under this Plan shall not exceed the sum of the aggregate maximum contribution for all Benefit Package Option(s) set forth in the Adoption Agreement.

5.02 Cash Benefit. To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as a Pre-Tax Contribution or After-tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Benefit credits may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment material.

ARTICLE VI
PLAN ADMINISTRATION

6.01 Allocation of Authority. The Board of Directors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;

(d) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan. Such entity will be referred to as a third party administrator and shall be identified in the SPD;

(e) To keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan;

(f) To do all things necessary to operate and administer the Plan in accordance with its provisions.

6.02 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons, as it may deem necessary or desirable, in connection with the operation of the Plan, and may rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Such entity will be identified in the SPD as a third party administrator. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

6.03 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

6.04 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but the Employer shall pay all reasonable expenses incurred in the performance of their duties.

6.05 Bonding. Unless otherwise determined by the Employer, or unless required by any federal or state law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

6.06 Payment of Administrative Expenses. Administrative expenses shall be paid as described in the Plan Adoption Agreement and Summary Plan Description.

ARTICLE VII
CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Plan and those claims review procedures are set forth in the SPD. The Plan's claim review procedures set forth in the SPD shall only apply to issues germane to the Pre-Tax benefits available under this Plan (i.e., such as a determination of: a Change in Status; change in cost or coverage; or eligibility and participation matters under this Cafeteria Plan document), and to the extent offered under the Plan, claims for benefits under the Reimbursement Accounts.

ARTICLE VIII
AMENDMENT OR TERMINATION OF PLAN

8.01 Permanency. While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 8.02 and 8.03, below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

8.02 Employer's Right to Amend. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business (e.g., by approval by the Board of Directors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Package Option shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

8.03 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

8.04 Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine.

ARTICLE IX
GENERAL PROVISIONS

9.01 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

9.02 Applicable Laws. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State of the Employer's primary domicile to the extent not preempted.

9.03 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

9.04 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

9.05 Tax Effects. Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any Pre-Tax Contributions made to, or on behalf of, any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated as a "Cafeteria Plan" under Section 125 of the Code.

9.06 Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

9.07 Headings. The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

9.09 Severability. Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder thereof shall be given effect to the maximum extent possible.

9.10 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

APPENDIX

Health and Dependent Care Account
Flexible Spending Accounts

If identified as a Benefit Package Option in the Adoption Agreement, the Employer identified in the Adoption Agreement has established this Health Flexible Spending Account (the Health FSA) to help provide full and complete medical care for those Employees who participate in the Employer's Cafeteria Plan ("Plan") and who, pursuant to the election procedures set forth in the Plan, choose to contribute to a Health FSA established pursuant to this document. This Health FSA is intended to provide reimbursement of certain Eligible Medical Expenses incurred by the Participant and his eligible Dependents. The Employer intends that the Health FSA qualify as a Code Section 105 self-insured medical reimbursement plan, and that the benefits provided under the Health FSA be eligible for exclusion from the Participant's income for federal income tax purposes under Section 105(b) of the Code. This Health FSA is a component of, and incorporated by reference into, the Cafeteria Plan and Articles VI, VIII and IX of the Cafeteria Plan document apply also to this Health FSA.

If identified as a Benefit Package Option in the Adoption Agreement, the Employer identified in the Adoption Agreement has established this Dependent Care Flexible Spending Account (the Dependent Care FSA) to help provide dependent care assistance for those Employees who participate in the Employer's Cafeteria Plan ("Plan") and who, pursuant to the election procedures set forth in the Plan, choose to make contributions to a Dependent Care Reimbursement Account established pursuant to this Dependent Care FSA. This Dependent Care FSA is intended to provide reimbursement of certain Eligible Employment Related Expenses incurred by the Participant for care of a Qualifying Individual. The Employer intends that the Dependent Care FSA qualify as a Code Section 129 dependent care assistance plan, and that the benefits provided under the Dependent Care FSA be eligible for exclusion from the Participant's income for federal income tax purposes under Section 129 of the Code. This Dependent Care FSA is a component of, and incorporated by reference into, the Cafeteria Plan **("**Cafeteria Plan") and Articles VI, VIII and IX of the Cafeteria Plan document applying also to this Dependent Care FSA.

This Flexible Spending Account Appendix only applies to the extent Health FSA and Dependent Care Spending Account have been identified as a Benefit Package Options in the Adoption Agreement.

ARTICLE I-A
DEFINITIONS

Unless otherwise specified, terms that are capitalized in this Appendix have the same meaning as the defined terms in the Cafeteria Plan. The definitions of terms defined in this Appendix, but not defined in the Cafeteria Plan, shall be applicable only with respect to this Appendix. To the extent a term is defined both in the Cafeteria Plan and in this Appendix, the term as defined in the Cafeteria Plan shall govern the interpretation of the Cafeteria Plan and the term as defined in this Appendix shall govern the interpretation of the Health and Dependent Care FSA.

1.01-A "Dependent" means any individual who is a tax dependent of the Participant as defined in Code Sections105(b) and 152 except that a child with respect to whom Code Section 21(e)(5) applies who is in the custody of the parent for the longest period during the year shall be considered a dependent of such custodial parent for purposes of the Dependent Care FSA.

1.02-A "Dependent Care Reimbursement" shall have the meaning assigned to it by Section 4.02 of this Appendix.

1.03-A "Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code Section 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

1.04-A "Eligible Employment Related Expenses" means those expenses that would be considered to be employment-related expenses under Section 21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services other than amounts paid to:

(a) an individual with respect to whom a Dependent deduction is allowable under Code Sec. 151(c) to the Participant or his Spouse;

(b) the Participant's Spouse; or

(c) a child (as defined in Code Section 152(f)(1)) of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

1.05-A "Eligible Medical Expenses" means those expenses that are eligible for reimbursement under this Health FSA as set forth in the SPD.

1.06-A "Health Care Reimbursement" shall have the meaning assigned to it by Section 4.01 of this Health FSA.

1.07-A "Highly Compensated Individual" means an individual defined under Code Sections105(h) and 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.08-A "Qualifying Individual" means:

(a) a Qualifying Child as defined in Code Section 152(a)(1) who is under the age of thirteen (13) and except that a child of divorced parents will be considered a Qualifying Individual of the parent with whom the child resides with for the longest portion of the year without regard to who is entitled to the exemption;

(b) a Dependent of a Participant who is mentally or physically incapable of caring for himself or herself, and who has the same principal place of abode as the employee for more than half the year; or

(c) the Spouse of a Participant who is mentally or physically incapable of caring for himself or herself and who has the same principal place of abode as the employee for more than half the year.

1.09-A "Qualifying Services" means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed which are performed:

(a) in the Participant's home; or

(b) outside the Participant's home for (1) the care of a Qualifying Child (as defined in Code Section 152(c)(1)) of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

1.10-A "Reimbursement Account" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Reimbursement (as defined in Section 4.01 herein) and Dependent Care Reimbursement as defined in Section 4.01. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

ARTICLE II-A
ELIGIBILITY AND PARTICIPATION

2.01-A Eligibility to Participate. Each Employee who satisfies the eligibility requirements set forth in the Adoption Agreement shall be eligible to participate in this Health and Dependent Care FSA as of the Plan Entry Date set forth in the Adoption Agreement.

2.02-A Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD.

2.03-A Qualifying Leave Under the Family and Medical Leave Act. Notwithstanding any provision to the contrary in this FSA, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA,

the Participant will be entitled to continue the Participant's coverage under this FSA on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.04-A Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Health FSA, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD and implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Health FSA, the election change rules in Section 3.03A of this Health FSA will apply.

ARTICLE III-A
ELECTION TO PARTICIPATE

3.01-A Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this FSA as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the FSA in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Agreement shall be effective, subject to Section 3.02, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Health FSA's Waiting Period**. An Employee who becomes eligible to become a Participant in this Health FSA after the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this FSA as set forth in the SPD (but in no event prior to the election).

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.02 or 3.03.

3.02-A Annual Election Period. Each Employee who is a Participant in this FSA or who is eligible to become a Participant in this FSA shall be notified, prior to each Anniversary Date of this FSA, of his right to become a Participant in this FSA, to continue participation in this FSA, or to modify or to cease participation in this FSA, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the Annual Election Period. The date on which the Annual Election Period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the Annual Election

Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

3.03-A Change of Elections. A Participant shall not make any changes to his or her election except for election changes permitted under the SPD, and for changes made during the Annual Election Period, changes caused by termination of employment or cessation of eligibility and changes pursuant to the Family and Medical Leave Act. Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later.

3.04-A Impact of Termination of Employment or Cessation of Eligibility on Election. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3.04, no new election with respect to the FSA may be made during the remainder of the Plan Year except as set forth in the SPD.

3.05-A Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the FSA may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation.

ARTICLE IV-A
REIMBURSEMENTS

4.01-A Health Care Reimbursement. Each Participant's Health FSA will be credited for Health Care Reimbursement with amounts withheld from the Participant's Compensation and any Benefit credits allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with Article V of this document. The entire amount elected by the Participant on the Salary Reduction Agreement as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed to the Participant for Expenses incurred during the Plan Year shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Account (provided that the periodic contributions have been made). Thus, the maximum amount of Health Care Reimbursement at any particular time during the Plan Year will not relate to the amount that a Participant has had credited to his Health FSA. In no event will the amount of Health Care Reimbursements in any Plan Year exceed the annual amount specified for the Plan Year in the Salary Reduction Agreement for Health Care Reimbursement. Any amount credited to the Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied by the end of the Run-out period set forth in the SPD to provide Health Care Reimbursement for expenses incurred during the Plan Year. Notwithstanding the foregoing, the Employer has the discretion to establish a grace period following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Eligible Medical Expenses incurred during the grace period. In no event can the grace period exceed two (2) months and fifteen (15) days following the end of the Plan Year. If adopted, all amounts allocated to the Health FSA during a Plan Year that are not used to reimburse Eligible Medical

Expenses incurred during the Plan Year and/or the Grace Period shall be forfeited. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor ("DOL") or Internal Revenue Service ("IRS") regulations. The maximum annual reimbursement under the Health FSA shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

4.02-A Dependent Care Reimbursement. To the extent offered under the Plan, each Participant's Dependent Care FSA will be credited for Dependent Care Reimbursement with amounts withheld from the Participant's Compensation, and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Dependent Care Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with Article V of this document. In the event that the amount in the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months within the same Plan Year, to be paid out as the Dependent Care Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Account for any Plan Year. Any amount allocated to the Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied by the end of the Run-out Period set forth in the SPD to provide Dependent Care Reimbursement for Eligible Day Care Expenses incurred during the Plan Year. The Employer has the discretion to establish a grace period following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Eligible Day Care Expenses incurred during the grace period. In no event can the grace period exceed two (2) months and fifteen (15) days following the end of the Plan Year. All amounts allocated to the Dependent Care FSA that are not used to reimburse Eligible Day Care Expenses incurred during the Plan year and/or the Grace Period shall be forfeited. Amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law. The maximum annual reimbursement amount shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

4.03-A Receiving Reimbursement. Payment shall be made to the Participant in cash as reimbursement for Eligible Expenses incurred by the Participant or his Dependents while he is a Participant during the Plan Year (or during the grace period to the extent adopted by the Employer) for which the Participant's election is effective provided that the substantiation requirements of Section 4.03 herein are satisfied. However, if available and if the Employer so chooses, the participant may choose to make payment for eligible expense with an electronic payment card arrangement. The terms of the electronic payment card arrangement, if applicable, will be set forth in the SPD.

4.04-A Substantiation of Expenses. Each Participant must submit an expense for reimbursement in accordance with the terms of the SPD and provide the required substantiation set forth in the SPD or as otherwise requested by the Plan Administrator (or its designee).

4.05-A Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this FSA that exceed the amount of Eligible Expenses that have been substantiated by such Participant during the Plan Year as required by Section 4.03 herein or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator shall recoup the excess reimbursements in one or more of the following ways: (i) The Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to

the Employer within sixty (60) days of receipt of such notification. (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Expenses submitted for reimbursement (regardless of the Plan Year in which submitted) (iii) withhold such amounts from the Participant's pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement through the means set forth in (i) – (iii), the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt.

4.06-A Reimbursement Following Cessation of Participation. Participants in the FSA may submit claims for reimbursement for Eligible Expenses incurred during the Plan Year and before the date of participation in the FSA ceases so long as the claim is submitted prior to the end of the run out period set forth in the SPD. Unless a COBRA election is made as set forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment and/or eligibility ceases under this Section. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) shall be treated in accordance with Section 4.01.

4.07-A Coordination of Benefits Under the Health FSA. The Health FSA is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

4.08-A Disbursement Reports. The Plan Administrator shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the FSA.

4.09-A Timing of Reimbursements. Reimbursements shall be made as soon as administratively feasible after the Plan Administrator or its designee has received the required forms.

4.10-A Statements. The Plan Administrator, or its designated third party administrator, may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Reimbursements under the FSA Accounts.

4.11-A Post-Mortem Payments. Any benefit payable under the FSA after the death of a Participant shall be paid to his surviving Spouse, or if no spouse, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

4.12-A Non-Alienation of Benefits. Except as expressly provided by the Administrator, no benefit under the FSA shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to do so shall be void. No benefit under the FSA shall in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person.

4.13-A Mental or Physical Incompetency. Every person receiving or claiming benefits under the FSA shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator, or other person legally vested with the care of his estate has been appointed.

4.14-A Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant, or other person to whom a payment is due under the FSA, because he cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to locate such person, such payment and all subsequent payments otherwise due to such Participant, or other person, shall be forfeited after a reasonable time after the date any such payment first became due.

4.15-A Tax Effects of Reimbursements. Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any reimbursements made under the FSA will be treated as excludable from gross income for local, state, or federal income tax purposes. If, for any reason, it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Health FSA is designed, and is intended to be operated, as a self-insured medical reimbursement plan under Section 105 of the Code.

4.16-A Forfeiture of Unclaimed Reimbursement Account Benefits. Any FSA Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred (or such earlier period established by the Employer) shall be forfeited.

ARTICLE V-A
FUNDING AGENT

The FSA shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements, and/or Benefit credits provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and to the extent applicable, shall comply with all applicable regulations promulgated by the DOL, taking into consideration any enforcement procedures adopted by the DOL.

ARTICLE VI-A
CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this FSA, and those claims review procedures are set forth in the SPD.

ARTICLE VII-A
CONTINUATION COVERAGE UNDER COBRA

The SPD includes COBRA continuation of coverage provisions that shall be applicable to the Health FSA to the extent the plan sponsor is subject to COBRA (as it amended ERISA, the Code, and the Public Health Service Act).

ARTICLE VIII-A
HIPAA PRIVACY AND SECURITY

8.01-A Scope and Purpose. The Health FSA (the "Plan") will use protected health information ("PHI") to the extent of, and in accordance with, the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, 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.

8.02-A Effective Date. This Article VIII is effective on April 14, 2003 (or such later effective date of the Privacy Rules with respect to the client).

8.03-A Use and Disclosure of PHI.

(a) **General.** The Plan will use PHI to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA, including, but not limited to, health care treatment, payment for health care, health care operations, and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plan.

(b) **Disclosure to the Employer.** The Plan will disclose PHI to the Employer, or where applicable, an Affiliate only upon receipt of written certification from the Employer that:

(i) The Plan document has been amended to incorporate the provisions in this Article VIII; and

(ii) The Employer agrees to implement the provisions in Section 8.04A herein.

8.04-A Conditions Imposed on Employer. Notwithstanding any provision of the Plan to the contrary, the Employer agrees:

(a) Not to use or disclose PHI other than as permitted or required by this Article VIII or as required by law;

(b) To ensure that any agents, including a subcontractor to whom the Employer provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Employer with respect to PHI received or created on behalf of the Plan;

(c) Not use or disclose an individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual;

(d) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Employer unless authorized by the Individual;

(e) To report to the Plan any use or disclosure of PHI that is inconsistent with this Article VIII, if it becomes aware of an inconsistent use or disclosure;

(f) To provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;

(g) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

(h) To make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

(i) To make 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 the Plan's compliance with HIPAA;

(j) If feasible, to 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. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

(k) To ensure adequate separation between the Plan and Employer as required by 45 C.F.R. § 164.504(f)(2)(iii) and described in this Article VIII.

(l) To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI (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.

8.05-A Designated Employees Who May Receive PHI. In accordance with the Privacy Rules, only certain Employees who perform Plan administrative functions may 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.

8.06-A Restrictions on Employees with Access to PHI. The Employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI for Plan Administration functions that the Employer performs for the Plan, as set forth in the Privacy Notice, including but not limited to: quality assurance, claims processing, auditing, and monitoring.

8.07-A Policies and Procedures. The Employer will implement Policies and Procedures setting forth operating rules to implement the provisions hereof.

8.08-A Organized Health Care Arrangement. The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Employer.

8.09-A Privacy and Security Official. The Plan shall designate a Privacy and a 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 Officials are 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.

8.10-A Noncompliance. The Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Article VIII.

8.11-A Definitions. As used in this Article VIII, each of the following capitalized terms shall have the respective meaning given below:

"Individual" means the person who is the subject of the Heath information created, received or maintained by the Plan or Employer.

"Organized Health Care Arrangement" means the relationship of separate legal entities as defined in 45 C.F.R. §160.103.

"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.

"Privacy Rules" means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164.

"Protected Health Information or PHI" means individually identifiable health information as defined in 45 C.F.R. § 160.103.

8.12-A Interpretation and Limited Applicability. This Article VIII serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Article VIII nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the Benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Article VIII are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

8.13-A Services Performed for the Employer. Notwithstanding any other provision of this Plan to the contrary, all services performed by a business associate for the Plan in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plan and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the Plan. If a business associate of the Plan performs any services that relate to eligibility and enrollment to the Plan, these services shall be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Plan.

CAFETERIA PLAN
FLEXIBLE SPENDING ACCOUNTS

SUMMARY PLAN DESCRIPTION

TOWN OF CONCORD

1/1/2017

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SUMMARY PLAN DESCRIPTION

PART 1. GENERAL INFORMATION ABOUT THE PLAN

Your employer identified in the Plan Information Summary (Part 5) (the "Employer") is pleased to sponsor an employee benefit program known as the Cafeteria Plan (the "Plan") for you and your fellow employees. It is so-called because it allows you to choose from several different benefit programs (which we refer to as "Benefit Options") according to your individual needs, and allows you to reduce your pay before taxes are deducted ("Pre-Tax Contributions") to pay for the Benefit Options that you choose by entering into a Salary Reduction Agreement with your Employer. This Plan helps you because the Benefit Options you elect are nontaxable (i.e., you save Social Security and income taxes on the amount of your salary reduction). However, you may choose to pay for any of the available benefits with after-tax payroll deductions to the extent set forth in your enrollment materials.

This SPD describes information relating to the Plan that is specific to your Employer as described in the Plan Information Summary. For example, you can find the identity of the Plan Service Provider, the Employer, and the Plan Administrator in the Plan Information Summary as well as the Plan Number and any applicable contact information. Each summary and the attached Appendices constitute the Summary Plan Description for the Cafeteria Plan. The SPD (collectively, the Summary Plan Description or "SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a Plan Document into which the SPD has been incorporated. However, if there is a conflict between the official Plan Document and the SPD, the Plan Document will govern. Certain terms in this Summary are capitalized. Capitalized terms reflect important terms that are specifically defined in this Summary or in the Plan Document into which this SPD is incorporated. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under this Plan.

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator (who is identified in the Plan Information Summary).

PART 2. CAFETERIA PLAN SUMMARY

Q-1. What is the purpose of the Cafeteria Plan?

The purpose of the Cafeteria Plan is to allow eligible employees to pay for Benefit Options with Pre-Tax Contributions. The Benefit Options to which you may contribute with Pre-tax Contributions under this Cafeteria Plan are described in the Plan Information Summary. Rules regarding Pre-Tax Contributions are described in more detail below.

Q-2. Who can participate in the Cafeteria Plan?

Each Employee of the Employer (or an Affiliated Employer identified in Part 5, the Plan Information Summary) who satisfies the Plan's Eligibility Requirements will be eligible to participate in this Plan. If you meet these requirements, you may become a Participant on the Plan Entry Date. The Eligibility Requirements and the Plan Entry Date are described in the Plan Information Summary. Those employees who actually participate in the Plan are called "Participants". (See below for instructions on how to become a Participant.) You may use this Plan to pay for Benefit Options covering only yourself and your tax dependents as defined in Code Section 152 (except as otherwise defined in Code Section 105(b).

The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Options. In other words, if you are eligible to participate in this Plan, it does not necessarily mean you are eligible to participate in all of the Benefit Options. For details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Options, refer to the plan summary for each Benefit Option. If you do not have a summary for a Benefit Option, you should contact the Plan Administrator for information on how to obtain a copy.

Q-3. When does my participation in the Cafeteria Plan end?

Your coverage under the Plan ends on the earliest of the following to occur:

(i) The date that you make an election not to participate in accordance with this Cafeteria Plan Summary;
(ii) The date that you no longer satisfy the Eligibility Requirements of this Plan or all of the Benefit Options;
(iii) The date that you terminate employment with the Employer; or
(iv) The date that the Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will ***automatically*** cease, and you will not be able to make any more Pre-Tax Contributions under the Plan except as otherwise provided pursuant to Employer policy or individual arrangement (e.g., a severance arrangement where the former employee is permitted to continue paying for a Benefit Option out of severance pay on a pre-tax basis). If you are re-hired within the same Plan Year and are eligible for the Plan (or you become eligible again), you may make new elections if you are re-hired or become eligible again more than 30 days after your employment terminated or you otherwise lost eligibility (subject to any limitations imposed by the Benefit Option(s)). If you are re-hired or again become eligible within 30 days, your Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-4. How do I become a Participant?

If you have otherwise satisfied the Eligibility Requirements, you become a Participant by signing an individual Salary Reduction Agreement (sometimes referred to as an "Election Form") on which you agree to pay your share of the cost of the Benefit Options that you choose with Pre-Tax Contributions. You will be provided a Salary Reduction Agreement on or before your Eligibility Date. You must complete the form and submit it to the Plan Administrator or the Plan Service Provider (per the instructions provided with your Salary Reduction Agreement) during one of the election periods described in **Q-6.** below. You may also enroll during the year if you previously elected not to participate and you experience an event described below that allows you to become a Participant during the year. If that occurs, you must complete an election change form during the Election Change Period described in **Q-8.** below. The Plan Service Provider is identified in the Plan Information Summary.

You may be required to complete a Salary Reduction Agreement via telephone or voice response technology, electronic communication, or any other method prescribed by the your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5. What are tax advantages and disadvantages of participating in the Cafeteria Plan?

You save federal income tax, FICA (Social Security) and state income taxes (where applicable) by participating in the Plan. Consider the following example to illustrate the potential tax savings under a cafeteria plan:

Example: You are married and have one child. You pay $2,400 for FSA. You earn $50,000 and your spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Cafeteria Plan		**If you do not participate in the Cafeteria Plan**
1. Gross Income	**$50,000**		**$50,000**
2. Salary Reductions for FSA	**$2,400 (pre-tax)**		**$0**
3. Adjusted Gross Income	**$47,600**		**$50,000**
4. Standard Deduction	**($9,700)**		**($9,700)**
5. Exemptions	**($9,300)**		**($9,300)**
6. Taxable Income	**$28,600**		**$31,000**
7. Federal Income Tax (Line 6 x applicable tax schedule)	**($3,590)**		**($3,950)**
8. FICA Tax (7.65% x Line 3 Amount)	**($3,641)**		**($3,825)**
9. After Tax Contributions	**($0)**		**($2,400)**
10. Pay after taxes and contributions	**$40,369**		**$39,825**
11. Take Home Pay Difference	**$544**		

Plan participation will reduce the amount of your taxable compensation. However, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable compensation.

Q-6. What are the election periods for enrolling in the Cafeteria Plan?

The Cafeteria Plan basically has three election periods: (i) the “Initial Election Period,” (ii) the “Annual Election Period,” and (iii) the “Election Change Period, which is the period following the date you have a Change in Status Event (described below). The following is a summary of the Initial Election Period and the Annual Election Period. The Election Change Period is described in Q-8 below.

6a. What is the Initial Election Period?

If you want to participate in the Plan when you are first hired, you must enroll during the "Initial Election Period" described in the enrollment materials you will receive. If you make an election during the Initial Election Period, your participation in this Plan will begin on the later of your Eligibility Date or the first pay period coinciding with or next following the date that your election is received. The effective date of coverage under the Benefit Options will be effective on the date established in the governing documents of the Benefit Options. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status Event described in **Q-8.** below**. If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year.** Failure to make an election under this Plan generally results in no coverage under the Benefit Options; however, the Employer may provide coverage under certain Benefit Options automatically. These automatic benefits are called “Default Benefits”. Any Default Benefits provided by your Employer will be identified in the enrollment material. In addition, your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a pre-tax basis. You will be notified in the enrollment material whether there will be a corresponding Pre-Tax Contribution for such default benefits.

6b. What is the Annual Election Period?

The Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you have a Change in Status Event described below. You must make an election each Annual Election Period in order to participate in the Flexible Spending Accounts and/or to contribute to a Health Savings Account during the next Plan Year.

The Plan Year is generally a 12-month period (a short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. How is my Benefit Option coverage paid for under this Plan?

You may be *required* to pay for any Benefit Option coverage that you elect with Pre-Tax Contributions. Alternatively, your Employer may allow you to pay your share of the contributions with After-Tax Contributions. The enrollment material you receive will indicate whether you

have to pay with Pre-Tax Contributions or whether you have the option to pay with After-Tax Contributions.

When you elect to participate both in a Benefit Option and this Plan, an amount equal to your share of the annual cost of those Benefit Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use Pre-tax Contributions (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

An Employer may choose to pay for a share of the cost of the Benefit Options you choose with Employer Contributions. The amount of Employer Contributions that is applied by the Employer towards the cost of the Benefit Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward at the Employer's sole discretion at any time. The Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Employer Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material or in the Plan Information Summary.

Q-8. Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your election under this Plan during the Plan Year. There are, however, a few exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Plan or under all of the Benefit Options that you have chosen.

Second, you may voluntarily change your election during the Plan Year if you satisfy the following conditions (prescribed by federal law):

(a) You experience a “Change in Status Event” that affects your eligibility under this Plan and/or a Benefit Option; or

(b) You complete and submit a written Election Change Form to the Plan Service Provider within 30 days of the event.

The following is a summary of the applicable Change in Status Events and cost or coverage changes. Note: These rules do not apply to a Code Section 223 Health Savings Account offered under the Cafeteria Plan. See Part 7 below for more information regarding election changes related to the Health Savings Account.

1. Changes in Status. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of, and correspond with, the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- Change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse),
- Change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),

- Event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student), or

  If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for Pre-Tax Contributions within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of, and corresponds with, the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of, and corresponds with, a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for the Dependent Care FSA, the event may also affect eligibility for the dependent care exclusion). A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan.

In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- Loss of Dependent Eligibility. For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage, and Health FSA benefits), a special rule governs which type of election change is consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse; the death of your Spouse or your Dependent; or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The Employer offers a calendar year cafeteria plan that allows Employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the Plan Year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the Plan Year; Sharon loses eligibility for coverage under the Plan, while the child is still eligible for coverage under the Plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- However, you may increase your election to pay for COBRA coverage under the Employer's plan for yourself (if you still have pay) or any other individual

who lost coverage but is still a tax dependent (e.g. a child who lives with you and to whom you provide over half of their support but who has lost eligibility under the Plan).

- Dependent Care FSA Benefits. With respect to the Dependent Care FSA benefit, you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; or (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

2. Certain Judgments, Decrees, and Orders. If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospectively effective from the date of the election or such later time as determined by the Plan Administrator. Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-9. What happens to my participation under the Cafeteria Plan if I take a leave of absence?

If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Option offered under this Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Option, the election change rules described herein will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-10. How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

Q-11. What happens if my request for a benefit under this Cafeteria Plan (e.g., an election change or other issue germane to Pre-tax Contributions) is denied?

You will have the right to a full and fair review process. You should refer to the Claims Review Procedures Appendix for a detailed summary of the Claims Procedures under this Plan.

PART 3. CASH BENEFITS

During any one Plan Year, the maximum salary reduction amount a Participant can elect under this Plan cannot exceed the sum of the cost of the Benefit Options offered under this Plan (as identified in Part 4 below). Any part of this maximum salary reduction amount that you do not elect will be paid to you as regular, taxable compensation.

PART 4. FSA SUMMARY

Q-1. Who can participate in the FSA?

Each Employee who satisfies the Eligibility Requirements is eligible to participate on the Plan Entry Date. The Eligibility Requirements and Plan Entry Date are described in Part 5, the Plan Information Summary.

Q-2. How do I become a Participant?

If you have otherwise satisfied the Eligibility requirements, you become a Participant in the Plan by electing Health Care Reimbursement benefits and/or Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in Part 2, the Cafeteria Plan Summary. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election.

You may also become a participant if you experience a change in status event that permits you to enroll mid-year (see **Q-8.** of Part 2, Cafeteria Plan Summary, for more details regarding mid-year election changes and the effective date of those changes).

Once you become a Participant, your "Eligible Dependents" also become covered. For purposes of the Health FSA, Eligible Dependents are the following:

(i) Your legal Spouse (as determined by state law to the extent consistent with the federal Defense of Marriage Act) and

(ii) any other individuals who would qualify as a tax Dependent under Code Section 105(b).

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree, or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

NOTE Employee and child(ren) only Election: Your participation in this Health FSA could disqualify your spouse from establishing and making/receiving tax favored contributions to a health savings account as defined in Code Section 223 unless you have elected the limited reimbursement option set forth below. If a spouse maintains a Code Section 223 health savings account or wishes to establish a Code Section 223 health savings account, you may make an election during the initial enrollment period and/or the annual enrollment period to exclude your spouse from coverage under the Health FSA and cover only the participant and the participant's eligible dependents (but only to the extent identified as an option in Part 5, the Plan Information Summary).

Q-3. What is my "Health Care Account"?

If you elect to participate in the Health FSA, the Employer will establish a "Health Care Account" to keep a record of the reimbursements to which you are entitled, as well as the Pre-tax Contributions you elected to pay for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Health FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4. What is my "Dependent Care Account"?

If you elect to participate in the Dependent Care FSA, the Employer will establish a "Dependent Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-5. When does coverage under the FSA end?

Your coverage under the FSA ends on the earlier of the following to occur:

(i) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;
(ii) The last day of the Plan Year unless you make an election during the Annual Election Period;
(iii) The date that you no longer satisfy the FSA Eligibility Requirements;
(iv) The date that you terminate employment; or
(v) The date that the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

You may be entitled to elect Continuation Coverage (as described in **Q-19.** below) under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on the earliest of the following to occur:

(i) The date your coverage ends;

(ii) The date that your dependents cease to be eligible dependents (e.g. you and your spouse divorce);

(iii) The date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Health FSA.

If you terminate employment or you cease to be eligible during the Plan Year, you may submit for reimbursement of Eligible Day Care Expenses incurred after the date of separation up to the amount of your Dependent Care Account to the extent set forth in the Plan Information Summary.

You and/or your covered dependents may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail below.

Q-6. Can I ever change my FSA election?

You can change your election under the Health FSA in the following situations:

(i) *For any reason during the Annual Election Period*. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(ii) *Following a Change In Status Event*. You may change your FSA election during the Plan Year only if you experience an applicable Change in Status Event. See **Q-8.** of Part 2, the Cafeteria Plan Summary, for more information on election changes. **NOTE: You may not make Health FSA election changes as a result of any cost or coverage changes**.

Q-7. What happens to my Health Care Account if I take an approved leave of absence?

Refer to **Q-9**, Part 2 of the Cafeteria Plan Summary to determine what, if any, specific changes you can make during a leave of absence. If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at either (a) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or (b) at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

Q-8. What is the maximum annual Health Care Reimbursement that I may elect under the Health FSA, and how much will it cost?

You may elect any annual reimbursement amount subject to the maximum annual Health Care Reimbursement Amount and Minimum Reimbursement Amount described in the Plan Information Summary. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-9. What is the maximum annual Dependent Care Reimbursement that I may elect under the Dependent Care FSA?

The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently $5,000 per Plan Year if you:

- are married and file a joint return;
- are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or
- are single.

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax free basis during the Plan Year cannot exceed the lesser of your earned income (as defined in Code Section 32) or your spouse's earned income.

Your Spouse will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your Spouse is

(i) physically or mentally incapable of caring for himself or herself, or
(ii) a full-time student (as defined by Code Section 21).

Q-10. How are Reimbursement benefits paid for under this Plan?

When you complete the Salary Reduction Agreement, you specify the amount of Health Care and/or Dependent Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Benefit Credits, to the extent available. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Benefit allocated to your FSA Account.

If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you (this check may be written off a Plan Service Provider account; however, all benefits are paid as needed from the Employer's general assets); (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the participant); (iii) if an electronic payment card is used, payment may be made directly to the care provider at the point of purchase (subject to the Plan's right of reimbursement)

Q-11. What amounts will be available for Health Care Reimbursement at any particular time during the Plan Year?

So long as coverage is effective, the full, annual amount of Health Care Reimbursement you have elected, reduced by the amount of previous Health Care Reimbursements received during the Year, will be available at any time during the Plan Year, without regard to how much you have contributed.

Q-12. How do I receive reimbursement under the FSA?

Under these FSA's, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Traditional Paper Claims" below for more information). Alternatively, if applicable you can use an electronic payment card to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

Traditional Paper Claims: When you incur an Eligible Expense, you file a claim with the Plan's Plan Administrator by completing and submitting a Request for Reimbursement Form (Claim Form). You may obtain a Request for Reimbursement Form from the Plan Administrator.. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

1. Name of person receiving service
2. Name and address of service provider
3. Nature of service or supplies (drug name if a prescription or over-the-counter medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service

The Plan Service Provider will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Expenses during the Plan Year in which they were incurred or during the Run-Out Period following the end of the Plan Year (or if applicable, the Claims Submission Grace Period following the date that you cease to be a participant). The Run-Out Period (and the Claims Submission Grace Period) is described in Part 5, the Plan Information Summary.

Electronic Payment Card. If applicable, alternatively, you may be able to use, if enabled as a Plan option in Part 5, the Debit Card to pay the expense. In order to be eligible for the debit card you must agree to abide by the terms and conditions of the card program as set forth in "Cardholder Agreement" which accompanies initial card mailing, including any potential fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.

Q-13. What is an "Eligible Medical Expense"?

An “Eligible Medical Expense” is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d);
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes prescriptions, and some over-the-counter products such as bandages, saline solution, and medical devices (over-the-counter medicines require a prescription). Not every health related expense you or your eligible Dependents incur constitutes an expense for “medical care.” For example, an expense is not for “medical care”, as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible Dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Service Provider/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for over-the-counter “medicines” are not an eligible expense unless submitted with a prescription. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. “Stockpiling” of over-the-counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

In addition, certain expenses that might otherwise constitute “medical care” as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums;
- Over-the counter medicines without a prescription
- Expenses incurred for qualified long-term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

Q-14. What is an "Eligible Day Care Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses ("Eligible Day Care Expenses"). Generally, an expense must meet <u>all</u> of the following conditions for it to be an Eligible Employment Related Expense:

1. The expense is incurred (expenses are considered incurred only if the service has already occurred) for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual". A Qualifying Individual is:

(i) An individual age 12 or under who is a “qualifying child” of the Employee as defined in Code Section 152(a)(1). Generally speaking, a “qualifying child” is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support; or

(ii) A Spouse or other tax Dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

NOTE: There is a special rule for children of divorced parents. The child is a Qualifying Individual of the “custodial parent”, as defined in Code Section 152(e).

3. The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expense is not paid or payable to a “child” (as defined in Code Section 152(f)(1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Employment Related Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address, and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-15. When must the expenses be incurred in order to receive reimbursement?

Eligible Expenses must be incurred ***during*** the Plan Year and while you are a Participant in the Plan. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses arising before the FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year, or, after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

If the Employer has adopted a Grace Period, you may also be able to use amounts allocated to the FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period," if adopted, will be described in Part 5, the Plan Information Summary.

Q-16. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Healthcare Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to an Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year that are submitted for reimbursement within the Run-Out Period described in the Plan Information Summary. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's sole discretion).

If the Employer has adopted a Grace Pperiod following the end of the Plan Year, amounts allocated to the FSA that are unused at the end of the Plan Year may also be used to reimburse expenses incurred during the Grace Period following the end of the Plan Year. Any amounts not used for expenses incurred during the Plan Year and during the grace period will be forfeited.

Q-17. What happens if a Claim for Benefits under the Health FSA is denied?

You will have the right to a full and fair review process. You should refer to the Claims Review Procedure Appendix, Appendix I, for a detailed summary of the Claims Procedures under this Plan.

Q-18. What happens to unclaimed FSA Reimbursements?

Any FSA funds that are unclaimed by participants after any Grace Period, if in effect, and after the Run Out period (90 days from Plan Year End) shall be forfeited. Reimbursement benefit payments including uncashed benefit checks within 90 days after reimbursement is made shall be forfeited.

After the Plan Year and Run Out Period is completed the accounts will be reconciled. Any funds remaining will be returned to the Employer to be used as part of their general assets and may be used to offset Plan administrative costs.

Q-19. What is COBRA continuation coverage?

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to this Health FSA unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the employer is a "small employer" or the Health FSA is a church Plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). These rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued

Only “Qualified Beneficiaries” are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A “Qualified Beneficiary” is the Participant, covered Spouse, and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain Qualifying Events. The table below describes the Qualifying Events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Covered Dependent
1. Covered Employee’s Termination of employment or reduction in hours of employment	√	√	√
2. Divorce or Legal Separation		√	
3. Child ceasing to be an eligible dependent			√
4. Death of the covered employee		√	√

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health FSA upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the COBRA Administrator (if a COBRA Administrator is not identified in the Plan Information Summary, then contact the Plan Administrator) in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) the date of the event (ii) the date on which coverage is lost because of the event. Your written notice must identify the Qualifying Event, the date of the Qualifying Event and the Qualified Beneficiaries impacted by the Qualifying Event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g. divorce decree).

An employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) and return it to the COBRA Administrator identified in the Plan Information Summary within 60 days from the date you would lose coverage for one of the reasons described above, or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the Qualifying Event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the Qualifying Event (depending on the type of Qualifying Event and the level of Non-Elective contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a Qualifying Event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);
- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- if you become entitled to Medicare; or
- if the employer no longer provides group health coverage to any of its employees.

Q-20. Will I be taxed on the Dependent Care Reimbursement benefits I receive?

You will not normally be taxed on your Dependent Care Reimbursement so long as your family's aggregate Dependent Care Reimbursement (under this Dependent Care FSA and/or another employer's Dependent Care FSA) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-21. If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit.

Q-22. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived

at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

Q-23. What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under the FSA that exceed the amount of Eligible Expenses that have been properly substantiated during the Plan Year as set forth in this SPD, or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways: (i) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of such notification; (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (i) – (iii), the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

Q-24. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies.

Q-25. How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

ERISA Rights (not applicable to non-ERISA Plans)

The Health FSA Plan may be an ERISA welfare benefit plan if your employer is a private employer. If this is an ERISA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report including a copy of this Summary Plan Description.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse, or Dependent children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your eligible Dependents will have to pay for such coverage. You should review **Q-19.** of this Health FSA Summary for more information concerning your COBRA continuation coverage rights.

(To the extent the Health FSA is subject to HIPAA's portability rules) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and Beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and have the claim reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The

court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART 5. PLAN INFORMATION SUMMARY

1. Employer Organization

Name of Organization:	TOWN OF CONCORD
Federal Employer ID Number:	04-6001121
Street Address:	22 MONUMENT SQUARE
City, State, Zip:	CONCORD, MA 01742
Nature of Business:	MUNICIPALITY
2. Plan Information	
Plan Number:	502
Plan Name:	TOWN OF CONCORD CAFETERIA PLAN
Plan Year Runs*:	JANUARY 1 – DECEMBER 31

*This Plan is designed to run on a 12-month plan year period as stated above. A Short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan.

Plan Administrator:	CAFETERIA PLAN ADVISORS, INC
Street Address:	420 WASHINGTON STREET, SUITE 100
City, State, Zip:	BRAINTREE, MA 02184
Phone:	781-848-9848

Benefits Coordinator

Employer Name:	TOWN OF CONCORD
Street Address:	22 MONUMENT SQUARE
City, State, Zip:	CONCORD, MA 01742

The appointed Plan Service Provider in conjunction with the Plan Administrator will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

3. Eligibility Requirements

(a) Except as provided in (b) below, the Classification of eligible Employees consists of All Employees.

(b) Employees excluded from this classification group are those individual Employees who fall into one or more of the following categories below:

Employees who are not eligible for coverage under group medical plan.

Employees who work less than 20 hours per week

4. Service Period Requirement

An Employee meeting the eligibility requirements shall be allowed to participate in the Flexible Spending plan on the first day of employment and has up to 30 days from date of hire to enroll.

5. Plan Entry Date

The Plan Entry Date is the date when an Employee who has satisfied the Eligibility Requirements may commence participation in the Plan. Each year each participant may elect in writing on a form filed with the plan administrator on or before the date he first becomes eligible to participate in the plan, and on or before the first day of any plan year thereafter, to be reimbursed from the plan for Unreimbursed Medical Expenses incurred during that year by him to the extent described and defined in the Plan Documents.

6. Benefit Package Options

The following Benefit Package Options are offered under this Plan:

FSA HEALTH CARE ACCOUNT (with Debit Card)

FSA DEPENDENT CARE ACCOUNT

7. Flexible Spending Account Elections

Amounts contributed for reimbursement benefits are segregated for record keeping and accounting purposes only, and this process does not constitute a separate fund or entity as the reimbursements are made from the general assets of the plan sponsor.

A. Health FSA

(a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is **$2,600**

(b) The maximum annual reimbursement amount that a Participant may receive during the year is the annual reimbursement amount elected by the Employee on the Salary Reduction Agreement for Health FSA coverage, not to exceed the amount set forth in (a) above.

(c) Minimum Contribution for this Benefit per Plan Year per Employee is NONE.

(d) In order to receive reimbursement under the Health FSA, the claim or claims must equal or exceed the Minimum Payment Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Payment Amount, except those claims submitted for reimbursement during the last month of the Plan Year or during the Run-Out, whichever is applicable, will not be subject to the Minimum Payment Amount. The Minimum Payment Amount under this Plan is hereby set as $1.00.

For the Health FSA account a, debit card will be issued to Participants. Using the debit card for eligible expenses will debit the Participants account accordingly.

B. Dependent Care Assistance Plan

(a) The maximum annual reimbursement amount a Participant may elect under the Dependent Care Assistance Plan for any Plan Year is the lesser of the maximum established by the Plan described in (b) below or the statutory maximum specified in Code Section 129 (as described in your Summary Plan Description).

(b) The maximum annual reimbursement amount established by the Dependent Care Assistance Plan is as follows: **$5,000** for married filing jointly or single and $2500 for married filing separately.

(c) The maximum annual reimbursement that a Participant may receive during the year is the annual reimbursement amount elected by the Participant on the Salary Reduction Agreement, not to exceed the amount in (a) above.

(d) Minimum Contribution for the Benefit per Plan Year per Employee is NONE.

(e) In order to receive reimbursement under the Dependent Care Assistance Plan, the claim or claims must equal or exceed the Minimum Payment Amount. If a

claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Payment Amount, except that claims submitted for reimbursement during the last month of the Plan Year or during the Run-Out, whichever is applicable, will not be subject to the Minimum Payment Amount. The Minimum Payment Amount under this Plan is hereby set as $1.00.

8. Run-Out Period, Grace Period, Roll-Over Option

Run-Out Period

A. The Active Employee Run-Out is the period of time that begins the day after the Plan Year ends during which the Employee can submit claims for payment of Qualified Expenses incurred during the Plan Year. See Part 5, Sec. 9 for Run-Out information.

B. The Terminated Employee/Coverage Run-Out is the period of time after an Employee terminates employment (or loses eligibility to participate in the Plan) during which the Employee can submit claims for expenses incurred while the Employee remained a Participant. See Part 5, Sec. 9 for Run-Out information.

Grace Period

As indicated in Part 5, Sec. 9 below the Employer has the option to adopt a Grace Period for your benefits. View this section to determine if the Grace Period is included.

If a Grace Period has been adopted, it will begin on the first day of the next Plan Year and (depending on the benefit) will end up to two (2) months and fifteen (15) days later. To view a list of benefits and associated grace information, see Part 5, Sec. 9.

In order to take advantage of the Grace Period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the Grace Period relates, or
- (for Health FSA) A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the Grace Period relates.

The following additional rules will apply to the Grace Period:

- Eligible expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the Grace Period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Because Run-Out claims may be submitted after Grace Period claims, claims may be reordered to maximize reimbursement; as a result, grace claims and/or payments may be reassigned to the current Plan Year.

  For example, assume that $200 remains in your Health FSA account at the end of the 2013 Plan Year, and further assume that you have elected to allocate $2400 to the Health FSA for the 2014 Plan Year. If you submit for reimbursement an Eligible Medical Expense of $500 that was incurred on January 15, 2014, $200 of your claim will be paid out of the unused amounts remaining in your Health FSA from the 2013

Plan Year and the remaining $300 will be paid out of amounts allocated to your Health FSA for 2014.

- Expenses incurred during a Grace Period must be submitted before the end of the Run-Out Period described in this SPD. The Run-Out Period applies to claims, incurred both during the previous Plan Year and the Grace Period, that are reimbursable from the previous Plan Year. Any unused amounts from the end of a Plan Year to which the Grace Period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the Grace Period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the Run-out Period. To see a list of benefits and associated Run-Out information, see Part 5, Sec. 9.

You may not use Health FSA amounts to reimburse Eligible Day Care Expenses (and if the Grace Period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse Eligible Medical Expenses).

Roll-Over Option

As indicated in Part 5, Sec. 9 below, the Employer has the option to adopt a roll-over, allowing participants to roll up to $500 of unused/unclaimed funds for the FSA Healthcare accounts to the succeeding Plan Year.

The Employer has the option to set the roll-over amount, up to $500 maximum. View this section to determine if the FSA Medical account includes this option and the amount.

In order to take advantage of the Roll-Over option, you must be:

- A Participant in the applicable Flex Spending account(s) on the last day of the Plan Year to which the Roll-Over applies, or
- (for Health FSA) A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the Roll-Over applies.

The following additional rules will apply to the Roll-Over:

- If a Roll-Over option has been adopted, the rolled funds become available after the run out period has expired for the current Plan Year.

  For example, assume that $200 remains in your Health FSA account at the end of the 2013 Plan Year and after the Run-Out Period. Further assume that you have elected to allocate $2500 to the Health FSA for the 2014 Plan Year. The $200 will roll to the 2014 plan year making the total amount available for plan year 2014 of $2700 ($2500 election plus the $200 amount rolled).

- The Roll-Over amount does not affect the maximum amount of salary reduction contributions that a participant is permitted to make.

The Roll-Over Option cannot be adopted to a Plan Year for which the Grace Period Option is in effect. The Employer would need to cancel the Grace Period and opt for the Roll-Over.

9. Roll-over Option, Grace Period and Run-Out Summary Information

Benefit	Roll Over Option	Roll Over Amount	Grace Period Adopted	Grace Period Days	Grace End Date	Active Employee Run-Out	Terminated Employee / Coverage Run-Out
FSA Health Care	**YES**	**$500**	**NO**			**90 days after plan yr ends**	**90 days after termination**
FSA Dependent Care	N/A	N/A	NO			90 days after plan yr ends	90 days after termination

10. Administration Fee:

Administration of the Flexible Spending Accounts:

Administrative fees paid by employee: $5.00 pppm
$1.00 pppm for debit card

11. Benefit Plan Option Documents

The actual terms and the conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Cafeteria Plan adopted through this Agreement as to substantive content.

APPENDIX I

CLAIMS REVIEW PROCEDURE APPENDIX

The Plan has established the following claims review procedures in the event you are denied a benefit under this Plan. The procedure set forth below does not apply to benefit claims filed under the Benefit Options other than the Health FSA and Dependent Care FSA.

Step 1: *Notice is received from Plan Administrator.* If your claim is denied, you will receive written notice from the Plan Administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Plan Administrator, the Plan Administrator may take up to an additional 15 days to review your claim. You will be provided notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Plan Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: Once you have received your notice from the Plan Administrator, review it carefully. The notice will contain:

a. the reason(s) for the denial and the Plan provisions on which the denial is based;
b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d. a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Plan Administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from* Administrator*.* If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Plan Service Provider.

Step 5: You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Important Information

Other important information regarding your appeals:

- (Health FSA Only) Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.