VIRGINIA BANKERS ASSOCIATION

GROUP FLEXIBLE BENEFITS PLAN

(January, 2015)

TABLE OF CONTENTS

ARTICLE I
Definition of Terms

ARTICLE II
Eligibility and Participation

ARTICLE III
Benefits and Funding

ARTICLE IV
Elections

ARTICLE V
Health Benefit Plans

ARTICLE VI
Claims Procedure under the Act

ARTICLE VII
Continued Coverage for Qualified Beneficiaries under COBRA Plans

ARTICLE VIII
Plan Administration and Allocation of Authority

ARTICLE IX
Amendment and Termination of the Plan

ARTICLE X
Miscellaneous

ARTICLE XI
Adoption by Additional Employers

ARTICLE XII
Adoption by Additional Employers

APPENDICES

VIRGINIA BANKERS ASSOCIATION

GROUP FLEXIBLE BENEFITS PLAN

(January, 2015)

The Virginia Bankers Association Group Flexible Benefits Plan and Adoption Agreement as completed by the Employer Sponsor are intended to serve the following six purposes:

1. Satisfy the plan document requirements of the Act with respect to the group health plan sponsored and maintained by the Virginia Bankers Association Benefits Corporation (a bona fide association of employers) through the Virginia Bankers Association Medical and Dental Trust. As a group health plan sponsored by a bona fide association of employers, the group health and group dental coverage is subject to the Act and is considered a large group employer. Pursuant to Section 6.2-953 of the Virginia Code, such group health plan is exempt from regulation under Title 38.2 of the Code of Virginia;

2. Documents the terms of the Employer's adoption of the group health and dental plans sponsored and maintained by the Virginia Bankers Association Benefits Corporation (a bona fide association of employers);

3. Satisfy the plan document requirements of the Act with respect to the Employer's fully insured benefits as defined in Department of Labor Regulations Sections 2520.104-21 and 2520.104-43;

4. Documents the terms of the Employer's adoption of the group insurance arrangements sponsored by the Virginia Bankers Association Benefits Corporation providing fully insured benefits as defined in Department of Labor Regulations Sections 2520.104-21 and 2520.104-43;

5. Satisfy the plan document requirements for a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended; and

6. Satisfy the plan document requirements of the Act with respect other employee welfare benefit plans that the Employer elects to include.

Each Employer participates in the Virginia Bankers Association Group Medical and Dental Trust (the "Medical and Dental Trust") which provides certain self-funded group health coverage to Employees of the Employers that are members of the bona fide association of employers and/or the Virginia Bankers Association Group Insurance Trust (the "Group Insurance Trust") which provides certain life, and long-term and short-term disability coverage to Employees of adopting Employers through group insurance arrangements.

An Employer desiring to adopt the Plan should complete the necessary information in the Adoption Agreement. Neither the Virginia Bankers Association nor the Virginia Bankers Association Benefits Corporation can guarantee that any Plan adopted by an Employer will be deemed to satisfy, or will actually satisfy, the requirements of the Internal Revenue Code. Employers considering the use of the Plan must recognize that neither the Virginia Bankers Association, the Virginia Bankers Association Benefits Corporation nor their employees or representatives can give any legal advice as to the acceptability or application of the Plan in any particular situation, and that Employers should consult their own attorney for such advice. The qualification of a welfare plan or cafeteria plan, both upon its establishment and in operation, and the related tax consequences are the responsibilities of the Employer and its own legal counsel.

ARTICLE I
Definition of Terms

The following words and terms as used in this Plan shall have the meaning set forth below, unless a different meaning is clearly required by the context:

1.1 **"Act"**: The Employee Retirement Income Security Act of 1974, as amended from time to time, or the corresponding sections of any subsequent legislation which replaces it, and the regulations issued thereunder.

1.2 **"Administrator"**:

1.2(a) With respect to the Group Health Coverage and the Group Dental Coverage, the Benefits Corporation.

1.2(b) With respect to other Included Benefits other than the Group Health Coverage and the Group Dental Coverage, the Plan Administrator as named in Option 2(c) of the Adoption Agreement.

1.2(c) With respect to the "cafeteria plan" under Section 125 of the Code, the Employer (the "Cafeteria Plan Administrator").

1.3 **"Adoption Agreement"**: The agreement, and any amendment thereto, which sets forth certain elections and representations of the Employer and by execution of which the Employer adopts the Plan.

1.4 **"After-Tax Contribution"**: The contribution made to the Plan by a Participant but not made pursuant to a Pre-Tax Election to have the costs of benefits paid out of his Compensation.

1.5 **"Association"**: The Virginia Bankers Association.

1.6 **"Benefits Corporation"**: The Virginia Bankers Association Benefits Corporation.

1.7 **"Benefit Credits"**: If the Employer elects Option 4(a) of the Adoption Agreement, an amount (expressed in dollars) granted, prior to the Effective Date of the Election, to an Eligible Employee by the Employer for a Plan Year.

(i) The General Benefit Credits granted by the Employer to an Eligible Employee will be accrued ratably by payroll period or month as determined by the Administrator over the Plan Year for which granted and will cease to accrue if and when the Participant ceases to be an Eligible Employee for the Plan Year unless otherwise provided in Option 4(a) of the Adoption Agreement. The Benefit Credits granted by the Employer for each Plan Year shall be determined pursuant to a credit formula determined by the Administrator and set forth in Option 4(a) of the Adoption Agreement. The formula may take into account such factors and criteria as the Employer deems appropriate which may, but need not, include such factors as prior coverages elected or provided, family status, age, pay, length of service, officer status, job and vacation entitlement. The Employer may provide for appropriate changes on a prospective basis in credits granted to an Eligible Employee if the Participant's family status changes during a Plan Year. The Employer shall maintain a record of the formula for each Plan Year.

(ii) The HSA Benefit Credits granted by the Employer to an Eligible Employee who elects a high deductible health plan as defined in Section 223(c)(2) of the Code will be accrued ratably by payroll

period or month as determined by the Employer over the Plan Year for which granted and will cease to accrue if and when the Participant ceases to be an Eligible Employee for the Plan Year unless otherwise provided in Option 4(a) of the Adoption Agreement. The HSA Benefit Credits granted by the Employer for each Plan Year shall be determined pursuant to a credit formula determined by the Employer and set forth in Option 4(a) of the Adoption Agreement. Such HSA Benefit Credits not available in cash must be available comparable basis on behalf of all comparable participating employees in accordance with Treas. Reg. Section 54.4980G-1 through 6. Credits are considered comparable if made either in the same amount or the same percentage of the deductible under the high deductible health plan. Comparability is applied separately to the category of employees who customarily work fewer than 30 hours per week and separately to former employees. HSA Benefit Credits available in cash or other taxable benefits are not subject to the comparability rules, but instead are subject to the nondiscrimination rules under Section 125 of the Code.

1.8 **"Code"**: The Internal Revenue Code of 1986, as the same may be amended from time to time, or the corresponding section of any subsequent Internal Revenue Code, and the regulations issued thereunder.

1.9 **"Compensation"**: For any Employee, the amount earned for services rendered to the Employer prior to any reduction due to an After-Tax Contribution or a Pre-Tax Contribution to the Plan for benefits hereunder or under any other plan in which the Employee is participating. Compensation shall include severance payments made by the Employer if elected by the Employer in Option 4(b) of the Adoption Agreement.

1.10 **"Debit Card"**: A debit card or stored-value card that can be used for the electronic reimbursement of Qualifying Medical Expenses from a Participant's General Health Care Spending Account or HSA Compatible Health Care Spending Account and Qualifying Dependent Care Expenses from a Participant's Dependent Care Spending Account.

1.11 **"Domestic Partner"**: An unmarried person who is eighteen (18) years of age or older, is mentally competent to consent to contract and of the same or opposite gender as an unmarried Participant and who meets the following criteria with respect to the Participant:

(i) Share a singe dedicated relationship of at least 12 months duration and intend to remain the relationship indefinitely;

(ii) Share the same permanent residence and have done so for at least 12 months;

(iii) Are not so closely related by blood that legal marriage would otherwise be prohibited under the laws of the state in which they reside;

(iv) Are financially interdependent and are jointly responsible for each other's common welfare and have provided documentation acceptable to the Administrator evidencing such financial interdependence; and

(v) Have submitted an affidavit of domestic partnership declaring that the above criteria have been met and providing such written evidence acceptable to the Administrator.

1.12 **"Dependent"**: The dependents of an Eligible Employee who are eligible to be covered by an Included Benefit as set forth in the Trust, the policies of the Insurer or, if applicable, Option 4(c) of the Adoption Agreement.

1.13 **"Dependent Care Spending Account"**: The plan of the Employer providing a flexible spending account for the purpose of reimbursing the Participant for Qualifying Dependent Care Expenses in a manner consistent with provisions of Section 129 of the Code and as more specifically described in Appendix A hereto.

1.14 **"Effective Date"**:

1.14(a) The **"Effective Date of the Plan"** with respect to each Employer shall be that date or dates specified in Option 3(a) (or in Option 1(f), in the case of an adopting Employer) of the Adoption Agreement.

1.14(b) The **"Effective Date of the Restatement of the Plan"** with respect to each Employer shall be that date or dates specified in Option 3(b) (or in Option 1(f), in the case of an adopting Employer) of the Adoption Agreement.

1.14(c) The **"Effective Date of the Coverage"** with respect to each Participant shall be the date described in Option 5 of the Adoption Agreement.

1.14(d) The **"Effective Date of the Election"** with respect to each Participant shall be the first day of the first Plan Year beginning after the date on which the election was made except as otherwise provided in Option 3(c) of the Adoption Agreement or in Option 5 of the Adoption Agreement in the case of an Eligible Employee who first becomes eligible to be a Participant during a Plan Year.

1.15 **"Eligible Employee"**: Any Employee as specified in Option 5 of the Adoption Agreement, provided, however, that self-employed individuals shall in no event be eligible to make Pre-tax elections under the cafeteria plan provisions.

1.16 **"Employee"**: Any individual employed in the service of the Employer as a common law employee, and any partner of or sole proprietor constituting one of the controlled or affiliated service entities (determined under Section 414(b), (c), (m) and (o) of the Code) of the Employer. If the Employer selects Option 4(b) of the Adoption Agreement, Employee shall include a former Employee who is receiving severance payments.

1.17 **"Employer"**: The Employer Sponsor and those Employers all of which shall be members of the same controlled or affiliated service group which are treated as a single employer under Section 414(b), (c), (m) or (o) of the Code, named in Option 1(f) of the Adoption Agreement adopting the Plan, collectively, unless the context indicates otherwise.

1.18 **"Employer Sponsor":** The Employer named in Option 1(a) executing the Adoption Agreement for itself and the members of the same controlled or affiliated service group which are treated as a single employer under Section 414(b), (c), (m) or (o) of the Code, named in Option 1(f) of the Adoption Agreement.

1.19 **"General Health Care Spending Account"**: The plan of the Employer providing a flexible spending account for the purpose of reimbursing the Participant for Qualifying Medical Expenses in a manner consistent with provisions of Sections 105 and 106 the Code and as more specifically described in Appendix B hereto.

1.20 **"Health Benefit Plan"**: An Included Benefit that is a group health plan within the meaning of the Act, the Health Insurance Portability and Accountability Act of 1996, the Patient Protection and Affordable Care Act of 2010 or other applicable law and which provides benefits for health care (directly or otherwise) to Employees, former Employees, and their families, as provided under the terms of such Health Benefit Plan.

1.21 **"HSA Compatible Health Care Spending Account":** The plan of the Employer providing a flexible spending account for the purpose of reimbursing the Participant for Qualifying Medical Expenses in a manner consistent with Rev. Rul. 2004-45 (and any subsequent guidance) and the provisions of Sections 105 and 106 of the Code and as more specifically described in Appendix C hereto.

1.22 **"Included Benefit(s)"**: The benefit or benefits specified the Employer in Option 5 of the Adoption Agreement that are provided by the Employer at no cost to the Participant (referred to as Core Benefits), that may be selected on a pre-tax basis by Participants under the Plan (referred to as Pre-tax Benefits) or that may be selected on an after-tax basis by the Participant (referred to as After-tax Benefits). Benefits provided through the Trusts include group life insurance, group-long term and short-term disability insurance, vision insurance and the health and dental coverage. The Dependent Care Spending Account, the General Health Care Spending Account and the HSA Compatible Health Care Spending Account are sometimes referred to as flexible spending accounts.

1.23 **"Insurer"**: The insurance company or companies (or health maintenance organization or organizations) providing an Included Benefit.

1.24 **"Participant"**: An Eligible Employee qualified to participate in the Plan as provided in Article II hereof during the period he is considered a Participant thereunder.

1.25 **"Plan"**: The plan as contained herein or duly amended, as adopted by the Employer pursuant to its elections in the Adoption Agreement.

1.26 **"Plan Sponsor"**:

1.26(a) With respect to the Group Health Coverage and the Group Dental Coverage, the Benefits Corporation through the Virginia Bankers Association Group Medical and Dental Trust.

1.26(b) With respect to other Included Benefits other than the Group Health Coverage and the Group Dental Coverage, the Employer named in Option 1(a) of the Adoption Agreement.

1.27 **"Plan Year"**: The twelve (12) month period commencing on the first day of January of each year, provided, however, in the event this is a Restated Plan which was maintained previously on the basis of a different Plan Year, the Plan Year shall be set forth in Option 4(f) of the Adoption Agreement.

1.28 **"Pre-Tax Contribution"**: The contribution by the Employer to the Plan made on behalf of a Participant pursuant to a Pre-Tax Election made by the Participant.

1.29 **"Pre-Tax Election"**: The Participant's election to select Included Benefit(s) and to pay the cost of Included Benefit(s) out of the Participant's Compensation pursuant to a salary reduction agreement under Section 125 of the Code and Article IV of the Plan.

1.30 **"Restated Plan"**: The Plan, if it is indicated in Option 3(b) of the Adoption Agreement that the Plan is adopted as an amendment or restatement of a previously existing cafeteria plan.

1.31 **"Trust"**: The Virginia Bankers Association Medical and Dental Trust established and maintained by the Virginia Bankers Association Benefits Corporation to provide self-funded health and dental coverage (the "Medical and Dental Trust") and the Virginia Bankers Association Group Insurance Trust established and maintained to provide group term life and accident and health insurance (including disability insurance) or any of such other insurance as its trustees may determine (the "Group Insurance Trust").

ARTICLE II
Eligibility and Participation

2.1 **Eligibility and Time of Participation**. Each Eligible Employee who has satisfied the age and service requirement for participation in an Included Benefit as specified in Option 5 of the Adoption Agreement will be eligible to participate in the Plan. Such Eligible Employee will become a Participant on the Effective Date of the Coverage or if later, the Effective Date of the Election.

2.2 **Cessation of Participation**. Except to the extent specifically provided otherwise under an Included Benefit, participation in the Plan or an Included Benefit shall end on the earliest of the following events:

(a) The date the Participant revokes his coverage elections, consistent with the requirements of paragraph 4.2;

(b) With respect to an Included Benefit, unless otherwise provided in subparagraph (c) hereof, the date the Participant is no longer eligible for coverage under such Included Plan for any reason (including but not limited to change in employment status, retirement, termination of employment, leave of absence or death);

(c) If Option 4(b) of the Adoption Agreement is selected by the Employer and the Participant is receiving severance payments from the Employer, participation in the Plan shall end at the earlier of the times described in this paragraph 2.2 (without regard to (b)), or the end of his severance period or the date on which he is no longer eligible for continued coverage under ARTICLE VII hereof.

(d) The first date the Participant fails to make any required contributions or fails to cooperate with the administrative procedures set forth in the Plan or otherwise established by the Plan Administrator; or

(e) The date the Employer terminates its participation in the Plan, or amends the Plan to terminate coverage under the Included Benefit.

If a Participant ceases to be a Participant for any reason, any election to receive Included Benefits and any related Pre-Tax Election under the Plan shall terminate.

Termination of coverage is permitted to be effective retroactively to the date stated above in the normal course of business where the delay is due to delays in administrative recordkeeping. Such retroactive termination of a Health Benefit Plan shall not be considered to be a rescission of coverage as defined under the Patient Protection and Affordable Care Act, as amended.

2.3 **Reinstatement of Former Participant**. A former Participant who again becomes eligible under paragraph 2.1 to participate in the Plan shall become a Participant on the later of the Effective Date of the Coverage or if applicable, the Effective Date of the Election.

2.4 **Leaves of Absence**. If a Participant takes an approved leave of absence, the rules set forth in this paragraph 2.4 shall apply except to the extent otherwise set forth in policy of insurance issued by the Insurer shall apply to any Included Benefit that is provided by the Insurer. In no event shall any provision of this paragraph 2.4 affect the terms of an Employee's employment or act to terminate or extend an Employee's

employment. The terms of an Employee's employment with the Employer are solely governed by the Employer's employment policies and practices and are not affected by the terms of this Plan.

(a) Family and Medical Leave Act. A Participant who takes an approved leave under the Family and Medical Leave Act of 1993 (an "FMLA Participant") may elect to continue to participate in the Included Benefits under the Plan. To the extent required by the FMLA, the Employer will continue to maintain the FMLA Participant's benefits elected under the Plan on the same terms and conditions as if the FMLA Participant were still an active Employee. An FMLA Participant may make required contributions by either paying the Employer such amounts on an after-tax basis each month during the leave of absence or on a pre-tax basis if the FMLA Participant receives compensation during the FMLA leave. An FMLA Participant will continue to participate in the Included Benefits under the Plan on that basis until the earlier of his or her return to active employment or the expiration of the approved leave of absence. If an FMLA Participant does not elect to continue coverage under an Included Benefit during an approved FMLA leave or if coverage for such FMLA Participant ends during such leave, the FMLA Participant will be allowed to re-enroll in the Included Benefit upon his or her return from such leave on the same basis as the FMLA Participant was participating in such Included Benefit prior to such leave, or as otherwise required by the FMLA.

(b) Military Service Leave. If a Participant is absent from work due to service in the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994, (USERRA) (a "Military Service Participant"), Included Benefits under this Plan will continue on this basis only for the period and on the basis described under the Employer's Military Leave Policy, unless otherwise required by applicable law. If a Military Service Participant foregoes coverage during qualified military service, then such Participant may elect to participate in the Included Benefits Plan immediately upon the Participant's notification to the Employer of reemployment in accordance with USERRA and upon meeting the eligibility requirements for the Plan.

(c) Other Approved Medical Leaves of Absence. If a Participant is absent from work due to medical reasons and such absence is an approved leave of absence (as determined by the Employer in accordance with its otherwise applicable approved leave policies), the Participant may elect to continue to participate in the Plan during the period of approved leave of absence. During the period that the Participant is so eligible, the Participant may make Plan contributions by either paying the Employer such amounts on an after-tax basis for applicable coverage during the approved leave of absence or on a pre-tax basis if the Participant receives compensation during the approved leave of absence, in accordance with procedures established by the Plan Administrator. If a Participant does not elect to continue coverage under the Plan during an approved leave of absence or if coverage for such Participant ends during an approved leave, the Participant will be allowed to re-enroll in the Plan upon his or her return to work on the same basis as the Participant was participating in the Plan prior to such leave, provided that the Participant satisfies the requirements of paragraph 2.1. Upon completion of a period of an approved leave of absence, the Participant's participation in this Plan (and that of any dependents) shall terminate, unless the Participant returns to work and satisfies the requirements of paragraph 2.1. In this event, the Participant will be allowed to continue participating in the Plan on the same basis as the Participant was participating in the Plan prior to such approved leave.

2.5 **Former Participants**. Except to the extent otherwise specifically provided in the governing documents applicable to the Included Benefit or policies of the Insurer with respect to an Included Benefit, if a Participant terminates employment and subsequently becomes reemployed by an Employer and thereafter is an eligible Employee (a "Former Participant"), then the Former Participant shall be entitled to commence participation in the Plan, and make a new election, as if the Former Participant were a newly hired Employee. Notwithstanding the previous sentence, if the Employer rehires a Former Participant within 13 consecutive weeks after termination of employment, the Former Participant shall not be permitted to make such a new election and the Administrator shall reinstate such Former Participant's elections as in effect prior to his

termination of employment, subject to an intervening family status changes. The immediately preceding sentence will not apply if the Former Participant is rehired in a different Plan Year than the year in which he terminated employment. In that case, the Participant will be enrolled based on the elections made prior to his termination of employment but scheduled to be effective for the Plan Year in which such Participant is rehired.

2.6 **Termination and Rescission of Coverage**.

2.6(a) Notwithstanding the provisions of the Plan, the Administrator has the right to terminate coverage and eligibility for coverage under the Group Health Coverage if an Employee or his Dependent (including a spouse) makes a false claim under the Plan. A false claim may arise, for example, because an ineligible person is enrolled in the plan (or is not disenrolled when he becomes ineligible), because false information is given about pre-existing or other health conditions, or because a claim is made for services that were not provided in the manner claimed. False claims may occur intentionally or unintentionally. If, for example, the Administrator determines that an ineligible person has been enrolled in the Group Health Coverage, whether because the person did not meet eligibility requirements at the time of enrollment or because the person ceased to meet eligibility requirements and was not properly disenrolled, that person's coverage will be terminated effective the date the person ceased to meet the eligibility requirements. In addition, if the person who was improperly enrolled is a dependent of an Employee, the Administrator may, in its sole discretion, terminate the Employee's coverage and future eligibility for coverage as well.

2.6(b) The Administrator may also decide to terminate coverage retroactively because of a false claim (including ineligible enrollment) and recover any amounts paid by the Group Health Plan. This is called rescission of coverage and there are certain steps the Administrator must follow. First, in most cases, the Administrator must determine that there has been fraud or intentional misrepresentation that leads to the ineligible enrollment or false claim. In addition, the Administrator must provide notice at least 30 days in advance, that coverage will be cancelled retroactively. These rules do not apply where coverage is cancelled because of failure to pay premiums or in certain other circumstances.

ARTICLE III
Benefits and Funding

3.1 **Cost of Benefits**. The cost of benefits under the Plan shall be funded through payments by the Employer and the Participant, in the manner set forth herein. The maximum amount of payments to be made to the Plan on behalf of any Participant shall be the sum of the maximum amount required to pay the premium costs of the Included Benefit(s) selected by the Employer.

3.2 **Included Benefits**. The Included Benefits may include benefits provided by the Employer without additional cost to the Participant or benefits for which Participants are required to pay all or a portion of the costs as follows:

(a) Core Benefit Programs. The Core Benefit Programs are provided by the Employer. The Core Benefit Programs are those paid 100% by the Employer as indicated in Option 5 of the Adoption Agreement.

(b) Pre-tax Benefit Programs. An Employee may elect to have his wages or salary for any Plan Year paid as taxable compensation, or he may elect to have a portion of it applied toward the cost of the Pre-tax Benefit Programs elected by him. An Employee's election shall be irrevocable for the Plan Year, and changes in elections are allowed only prior to the first day of each Plan Year except as provided in paragraph 4.2. The Pre-Tax Benefit Programs are those paid at least in part by Participants on a Pre-Tax basis as indicated in Option 5 of the Adoption Agreement.

(c) After-tax Benefit Programs. An Employee may elect to have a portion of his compensation for a Plan Year applied on an after-tax basis toward the cost of the After-tax Benefit Programs elected by him. Without limitation, the After-tax Benefit Programs shall include the portion of any contribution paid by an Employee for coverage under an Included Benefit for retiree medical or for a Domestic Partner, child of a Domestic Partner, or other eligible dependent who is not recognized as a dependent for purposes of such Included Benefit under the Code. The After-tax Benefit Programs are those paid at least in part by Participants on an After-Tax basis as indicated in Option 5.

3.3 **Description of Cash and Other Benefits**:

3.3(a) The Plan's cash benefit for a Participant is the portion of the Participant's Compensation or Benefit Credit available to the Participant in cash or other taxable benefits that could have been reduced by a Pre-Tax Election if the Participant had elected to receive the Included Benefit(s).

3.3(b) Except as provided in subparagraph 3.3(c), the types and amounts of the Included Benefits selected by the Employer, the requirements for participation, and other terms and conditions of the benefits provided thereunder are set forth in governing documents applicable to the Included Benefit or policies of the Insurer with respect to an Included Benefit. Such documents are incorporated by reference herein.

3.3(c) The types and amounts of the Included Benefits selected by the Employer and available through the Employer's Dependent Care Spending Account, General Health Care Spending Account and HSA Compatible Health Care Spending Account, the requirements for participation, and other terms and conditions of the benefits provided thereunder are set forth in Appendix A, Appendix B and Appendix C hereto, respectively and the related Options of the Adoption Agreement.

ARTICLE IV
Elections

4.1 **Selection and Payment of Cost of Included Benefits**. If a Participant wishes to select benefits hereunder, he may make such selection in his Pre-Tax Election. The cost of such benefit shall be paid in the following manner:

(i) If the Participant elects in his Pre-Tax Election, the cost of the selected Included Benefit(s) to be borne by the Participant shall be paid out of the Participant's Compensation through a salary reduction.

(ii) If the Participant's Compensation is insufficient to cover his Pre-Tax Contribution for the selected Included Benefit(s), the amount otherwise to be charged hereunder as a reduction in Compensation shall be paid by the Participant as an After-Tax Contribution on such basis and at such time as the Administrator and the Participant may agree.

The amount to be paid by the Participant for benefits shall be the sum of the cost of the benefits selected by the Participant less the Benefit Credits granted to the Participant by the Employer.

4.2 **Irrevocability of Pre-Tax Election and Special Election Rights**:

4.2(a) Except as provided below, a Pre-Tax Election shall not be subject to change during the Plan Year to which it applies (notwithstanding any contrary provision of the governing documents applicable to the Included Benefit or policies of the Insurer with respect to an Included Benefit). Notwithstanding the terms of this paragraph, a Participant may make changes in his Pre-Tax Elections during a Plan Year only to the extent permitted by the Included Benefit option.

4.2(b) Notwithstanding the provisions of subparagraph 4.2(a), a Pre-Tax Election made under the Plan (or deemed made pursuant to subparagraphs 4.3(c) or 4.5(a)) shall automatically terminate on the date the Participant ceases to be a Participant in the Plan, although benefits may continue to the extent provided by the governing documents applicable to the Included Benefit or policies of the Insurer with respect to an Included Benefit.

4.2(c) Permissible Changes. A Participant may revoke a Pre-Tax Election for the balance of the Plan Year and file a new Pre-Tax Election with respect to the remainder of the Plan Year only if both the revocation and the new election are on account of and consistent with the changes in coverage or eligibility discussed below. Except as specifically provided below, a Participant must contact the Cafeteria Plan Administrator to revoke a Pre-Tax Election and transmit a new Pre-Tax Election within thirty (30) days of the change in cost or coverage, or change in status. Any new election shall be effective at such time as the Cafeteria Plan Administrator permits, but not earlier than the date of the event giving rise to the new election. A new election shall not be made effective retroactively unless required pursuant to a special enrollment right under HIPAA.

(i) Cost Changes. If during a Plan Year, the Cafeteria Plan Administrator, in its sole discretion, determines there is a significant increase (or decrease) in the cost of an Included Benefit, the Cafeteria Plan Administrator may, in its sole discretion, permit each affected Participant to (a) increase (or decrease) his election under this Plan in an amount sufficient to fund such increased (or decreased) cost, or (b) in the case of a cost increase, revoke his election for such Included Benefit and elect to receive coverage under another similar coverage, or (c) in the case of a cost decrease, revoke his election for a similar coverage and elect to receive the decreased cost.

Notwithstanding the foregoing, if a Participant fails (within thirty (30) days of receipt of notice from the Administrator) to elect to adjust or revoke the election to receive such Included Benefit as provided above, then the Cafeteria Plan Administrator may, on a reasonable and consistent basis, automatically increase (or decrease) the affected Participant's election by the amount necessary to continue coverage under the Included Benefit. If the Cafeteria Plan Administrator determines, in its sole discretion, that a mid-year cost change to an Included Benefit is not significant, the Cafeteria Plan Administrator may direct that the amount of each affected Participant's contributions be automatically increased or decreased to correspond to the change in the required salary reduction amount.

(ii) Changes in Participant's Coverage. If coverage for or on behalf of a Participant under any Included Benefit is significantly curtailed or ceases during a Plan Year, the Cafeteria Plan Administrator, in its sole discretion, may permit each affected Participant to revoke his election under this Plan for such Included Benefit and elect to receive, on a prospective basis, coverage under another Included Benefit or another option under the Included Benefit offering similar coverage. The Cafeteria Plan Administrator may, in its discretion, determine that the following events constitute a significant curtailment of coverage: (A) a substantial decrease in the medical care providers available under the Included Benefit, or a coverage option thereunder; (B) a reduction in benefits for a specific type of treatment a Participant or eligible dependent is currently receiving; (C) a reduction in benefits for a specific medical condition for which a Participant or eligible dependent is currently receiving treatment; or (D) any other similar fundamental loss of coverage.

If a new Included Benefit or a coverage option under an Included Benefit is added or significantly improved under the Plan during any Plan Year, the Cafeteria Plan Administrator, in its sole discretion, may permit Participants to modify their elections under this Plan to elect the new or improved coverage option or Included Benefit and, correspondingly, to revoke their elections for similar coverage under another Included Benefit. If an Included Benefit or a coverage option under an Included Benefit is eliminated during any Plan Year, the Cafeteria Plan Administrator, in its sole discretion, may permit an affected Participant to modify his elections under this Plan to elect another Included Benefit providing similar coverage.

(iii) Changes in Spouse or Dependent's Coverage. A Participant may modify his election under this Plan during a Plan Year on account of and corresponding with a change made under the plan of his spouse or dependent's (or former spouse or dependent's) employer (the "other plan") if: (A) the other plan permits participants to make an election change that would be permitted under this Plan and/or (B) the other plan has a different period of coverage than this Plan and the spouse or dependent (or former spouse or dependent) makes an election change during the other plan's open enrollment period.

(iv) Certain Changes in Status. If a Participant experiences a change in status, as described below, that results in a change in eligibility under an Included Benefit for him or his dependents, he may modify or revoke his election for the remainder of the Plan Year, provided the revocation or modification is consistent with the change in status:

(A) A change in the legal marital status of the Participant, including marriage, death of spouse, divorce, legal separation or annulment;

(B) A change in the number of dependents (as determined with respect to a particular benefit), including birth, adoption, placement for adoption, or the death of the Participant's dependent;

(C) An employment status change of the Participant, spouse or dependent, including termination or commencement of employment, switch between part-time and full-time employment, a strike or lockout, commencement of or return from an unpaid leave of absence, change in the worksite, or change in job classification impacting eligibility under this Plan or a benefit under this Plan;

(D) The Participant's dependent satisfies or ceases to satisfy the requirements for dependent status because of age, marriage, student status or similar circumstance; or

(E) A change in the residence of the Participant or dependent.

(v) Changes Permitted under Health Benefit Plans. The following events may permit a Participant to modify his elections with respect to an Included Benefit that is a Health Benefit Plan:

(A) A special enrollment event as required by HIPAA. The Participant may change his election to the extent necessary to permit him to exercise his special enrollment rights under HIPAA.

(B) Entitlement to (or loss of) Medicare or Medicaid. A Participant may change his election to add or drop coverage for himself or his dependents consistent with the change in eligibility for Medicare or Medicaid.

(C) Receipt of a qualified medical child support order or other court order which affects a dependent child's health coverage. The Participant (or the Administrator) may change his election to provide coverage for the dependent child in accordance with the order, and a Participant may change his election to drop coverage for the dependent child if the order requires another individual to provide coverage for the child and that coverage is provided.

(D) A Participant's leave under the Family and Medical Leave Act of 1993, as amended (FMLA). The Participant may revoke his existing election and make such other election for the remainder of the Plan Year as may be provided under the FMLA and applicable regulations.

(vi) Consistency. Changes in elections which are permitted above must be consistent with the change in status or other event giving rise to the election change. Election changes are generally deemed consistent with the change in status or other event only if made on account of and corresponding with the change in status or other event.

(vii) Loss of Medicaid or SCHIP Coverage. An employee may change his election under the Plan to enroll himself and/or an affected dependent in an eligible Health Benefit Plan offered under the Plan upon losing coverage under a State Medicaid or child health insurance program provided:

(A) The employee and/or his dependent is otherwise eligible for coverage under the Health Benefit Plan;

(B) The employee or his dependent loses coverage under the State Medicaid or child health insurance program as a result of loss of eligibility for such coverage; and

(C) The employee requests to change his election within sixty (60) days after termination of such coverage.

Any election change under this provision shall be effective as of the first day of the month following the employee's request for an election change is received by the Cafeteria Plan Administrator unless an earlier date is required by law.

(viii) Eligibility for State Assistance with Cost of Plan Coverage. An employee may change his election under the Plan and enroll himself and/or an affected dependent in a Health Benefit Plan offered under the Plan upon becoming eligible for State assistance (through a State Medicaid or child health insurance program) toward payment of the cost of coverage under such benefit option, provided:

(A) The employee and/or his dependent is otherwise eligible for coverage under the Plan and such benefit option; and

(B) The employee requests to change his election within sixty (60) days after termination of such coverage.

Any election change under this provision shall be effective as of the first day of the month following the employee's request for an election change is received by the Cafeteria Plan Administrator unless an earlier date is required by law.

4.3 **Annual Elections**:

4.3(a) A Pre-Tax Election shall be made on a Plan Year by Plan Year basis by each Participant prior to the period such benefit is first available to the Participant (or within a reasonable time thereafter if the

Administrator determines that extenuating circumstances have prevented the Employee from having adequate time to make an election and if such extension of time does not cause the salary reduction feature of the Plan to cease to be a cafeteria plan under Section 125 of the Code).

4.3(b) Pre-Tax Elections may be made by Participants during the periods set forth below and such elections shall be effective as follows:

(i) The initial election upon establishment of the Plan shall be made during the period specified in Option 3(c) of the Adoption Agreement and shall be effective on the Effective Date of the Election for the remainder of the Plan Year. If no initial election is made the Participant will be deemed to have elected benefits for the remainder of the Plan Year as specified in Option 6(a) of the Adoption Agreement.

(ii) The election period for an Eligible Employee who becomes a Participant during a Plan Year shall be the thirty (30) day period ending with the Effective Date of the Election to be effective on the Effective Date of the Election for the remainder of the Plan Year. If no election is made by an Eligible Employee upon becoming a Participant, such Participant will be deemed to have elected benefits for the remainder of the Plan Year as specified in Option 6(a) of the Adoption Agreement. If the Employer selected the standard benefit election as described in Option 6(a)(2) and a benefit option is no longer available at the time of an Employee's initial election, the Benefits Corporation shall designate a replacement benefit option for the one no longer available. Such replacement option shall be communicated in the enrollment material.

(iii) Unless otherwise provided above, Pre-Tax Elections shall be made during the three (3) month period ending on the last day of the Plan Year to be effective on the first day of the next following Plan Year.

(iv) Participants who do not have a Pre-Tax Election in effect for any Plan Year shall be eligible to make a Pre-Tax Election for any subsequent Plan Year during the period described in clause (iii) of this subparagraph and such Pre-Tax Election shall be effective on the first day of the next following Plan Year.

4.3(c) Participants who participated in the Plan through a Pre-Tax Election during any Plan Year shall be required to re-elect benefits or shall be deemed to have elected benefits for the following Plan Year as specified in Option 6(b) of the Adoption Agreement. If any Participant shall be deemed to have elected benefits identical to those elected for the Plan Year immediately preceding the Plan Year for which no election was made, as specified in Options 6(b)(1) and (2) of the Adoption Agreement or shall be deemed to have elected the standard benefits as specified in Option 6(b)(4), and a benefit option is no longer available in a subsequent Plan Year, the Benefits Corporation shall designate a replacement benefit option for the one no longer available. Such replacement option shall be communicated in the open enrollment material.

4.4 **Procedures Established by Cafeteria Plan Administrator**.

4.4(a) The Cafeteria Plan Administrator shall establish and may from time to time change the election procedures for benefits and contributions under the Plan, provided that any such election procedures relating to the Pre-Tax Election under the Plan shall be consistent with the applicable requirements of Section 125 of the Code. Each Participant must contact the Cafeteria Plan Administrator within thirty (30) days from the date of the event if such Participant desires to change any existing benefit elections on account of such change.

4.4(b) The Cafeteria Plan Administrator may request and receive any documents the Cafeteria Plan Administrator deems necessary to substantiate a change in status or other event giving rise to the election change. Such documents shall include without limitation a marriage certificate, divorce decree, birth

certificate, confirming letter from spouse's former employer, or any other relevant document. All such documents shall be provided at the Participant's expense, if any.

4.4(c) Participants entitled to elect benefits under the Plan shall be provided written information regarding available benefits under the Plan, the required contribution amounts with respect to such benefits and the election procedures therefor on a prospective basis prior to each annual Pre-Tax Election and prior to each other permissible election as the Cafeteria Plan Administrator may determine.

4.4(d) The Cafeteria Plan Administrator has sole discretion and authority to determine if a change in election is permissible, and must approve any such change.

4.5 **Changes in Selected Benefits by Cafeteria Plan Administrator:**

4.5(a) Notwithstanding the foregoing, if the Cafeteria Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any non-discrimination requirement imposed by the Code or exceed any limitation on benefits provided to Highly Compensated Employees or Key Employees, the Cafeteria Plan Administrator shall take any action it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, but is not limited to, a modification of elections by Highly Compensated Employees or Key Employees with or without the consent of such Employee.

4.5(b) For purposes hereof:

(i) The term "Highly Compensated Employee" shall mean a Participant who is (A) an officer of the Employer, (B) a shareholder owning more than five percent (5%) of the voting power or value of all classes of stock of the Employer, or (C) otherwise treated under Section 125 of the Code as highly compensated. In addition, a spouse or dependent (as defined in Section 152 of the Code) of a Highly Compensated Employee shall also be treated as a Highly Compensated Employee.

(ii) The term "Key Employee" shall mean any person who is a Key Employee within the meaning of Section 416(i) of the Code.

4.6 **Procedure For Payment of Premium Cost of Benefits and Rebates to Participants**. Any premium cost under the Plan for Included Benefits paid by the Participant for benefits provided through the Trust shall be forwarded to the Trust by the Employer on the earliest date on which such amounts can reasonably be segregated from the general assets of the Employer and in no event later than fifteen (15) days after the calendar month of contribution, in the case of payroll deduction contributions. The Participant's contribution toward the cost of benefits under the flexible spending accounts made by Pre-Tax Election shall remain general assets of the Employer until such time as the Department of Labor determines that it will enforce its position that such contributions are plan assets required by the Act to be held in trust. At that time the Employer shall be required to place Participant contributions made to the Health Care Account and the HSA Compatible Health Care Account in trust as required by the Act.

4.7 **Participant Contributions and Election Procedures for After-tax Benefits**. In the case of contributions required to be made by a Participant for After-tax benefits (whether for a Participant, if elected by the Plan Sponsor in Option 4(c) of the Adoption Agreement, for his Domestic Partner, or his Domestic Partner's dependents or for other individuals who are not Employees or Participants), such contributions shall be made by such Participant out of his compensation pursuant to an "after-tax" payroll deduction agreement or made by "after-tax" lump sum or periodic contributions (where pay is insufficient to cover such contributions and any other contributions, taxes and other amount withheld from his pay or otherwise due from him) and payable at such times as the Cafeteria Plan Administrator may from time to time determine. Elections

regarding such coverages and contributions shall be made or changed at such time or times and on such basis as the Cafeteria Plan Administrator may determine or permit.

ARTICLE V
Health Benefit Plans

5.1 **HIPAA Privacy and Security Standards.** If a Health Benefit Plan is not exempted from the requirements of the Privacy Standards and the Security Standards, then this paragraph shall apply.

5.1(a) The Health Benefit Plan shall not disclose Protected Health Information to any member of an Employer's workforce or to any member of the Plan Sponsor's workforce unless each of the conditions set out in this paragraph are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment. "Protected Health Information" shall include "genetic information," as defined in the Privacy Standards. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

5.1(b) Protected Health Information disclosed to members of Employer's workforce or to members of the Plan Sponsor's workforce shall be used or disclosed by them only for purposes of Health Benefit Plan administrative functions. The Health Benefit Plan's administrative functions shall include all Health Benefit Plan treatment, payment functions and health care operations. The terms "treatment," "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" shall include activities taken to determine or fulfill Health Benefit Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information shall not be used or disclosed for "underwriting" purposes, as defined in the Privacy Standards.

5.1(c) The Health Benefit Plan shall disclose Protected Health Information only to members of the Employer's workforce or to members of the Plan Sponsor's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" or to "Members of the Plan Sponsor's workforce" shall refer to all employees and other persons under the control of the Employer or Plan Sponsor. The Plan Sponsor and Employer shall keep updated lists of those authorized to receive Protected Health Information.

(i) An authorized member of the Employer's or Plan Sponsor's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Health Benefit Plan.

(ii) In the event that any member of the Employer's or Plan Sponsor's workforce uses or discloses Protected Health Information other than as permitted by this paragraph and the Privacy Standards, the incident shall be reported to the Health Benefit Plan's privacy officer. The privacy officer shall take appropriate action, including:

(A) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(B) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(C) mitigation of any harm caused by the breach, to the extent practicable; and

(D) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

5.1(d) The Plan Sponsor agrees and by executing the Adoption Agreement, all Employers agree to:

(i) Not use or further disclose the information other than as permitted or required by the Health Benefit Plan documents or as required by law;

(ii) Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Plan Sponsor or Employer creates, maintains or transmits on behalf of the Health Benefit Plan.

(iii) Ensure that any agent or subcontractor, (i) to whom it provides Protected Health Information received from the Health Benefit Plan, agrees to the same restrictions and conditions that apply to the Plan Sponsor or Employer with respect to such information, and/or (ii) to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(iv) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor or Employer;

(v) Report to the Health Benefit Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this paragraph, or required by law;

(vi) Make available Protected Health Information to individual Health Benefit Plan members as required by Section 164.524 of the Privacy Standards;

(vii) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information as required by Section 164.526 of the Privacy Standards;

(viii) Make available the Protected Health Information required to provide an accounting of disclosures to individual Health Benefit Plan members as required by Section 164.528 of the Privacy Standards;

(ix) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Health Benefit Plan with the Privacy Standards;

(x) If feasible, return or destroy all Protected Health Information received from the Health Benefit Plan that the Plan Sponsor or Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such

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

(xi) Ensure the adequate separation between the Health Benefit Plan and members of the Plan Sponsor's or Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above, and to use reasonable and appropriate security measures to comply with this provision

5.2 **USERRA**.

5.2(a) Each Health Benefit Plan shall be operated in accordance with the requirements of the Uniformed Services Employment and Re-employment Rights Act (USERRA) and the regulations thereunder. USERRA provisions may vary slightly among the various Health Benefit Plans. To the extent consistent with applicable law, the specific USERRA provisions in any Health Benefit Plan shall govern over the terms of this paragraph 5.3.

5.2(b) Unless otherwise specifically provided in the applicable Governing Documents:

(i) a Participant must notify the Employer of his intention to elect USERRA prior to the expiration of the COBRA election period provided under the Health Benefit Plan; and

(ii) any period of USERRA continuation of coverage shall run concurrently with COBRA continuation coverage.

5.3 **Qualified Medical Child Support Order Procedures.** Each Health Benefit Plan shall provide benefits in accordance with the terms of a qualified medical child support order that meets the requirements of Section 609(a) of the Act. Each Health Benefit Plan shall establish reasonable written procedures to determine whether a medical child support order is a qualified medical child support order. Such procedures shall be made available upon request of a Participant at no charge.

5.4 **Medicaid**. To the extent required by Section 609(b) of the Act:

5.4(a) Payment for benefits with respect to a Participant under a Health Benefit Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant or a beneficiary of the Participant as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

5.4(b) The fact that a Participant is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account in enrolling such Participant or in determining or making benefit payments for such Participant.

5.4(c) To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act in any case in which a Health Benefit Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under such program will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

5.5 **Coverage of Dependent Children in Case of Adoption**. To the extent required by Section 609(c) of the Act:

5.5(a) With respect to any Health Benefit Plan that provides coverage for the dependent children of Employees, such Health Benefit Plan shall provide benefits to dependent children placed with an Employee for adoption (as defined by Section 609(c) of the Act) under the same terms and conditions as apply to the natural children of the Employee, irrespective of whether the adoption has become final.

5.5(b) Such Health Benefit Plan shall not restrict coverage of a child adopted or placed for adoption by an Employee, solely on the basis of a preexisting condition of such child at the time such child would otherwise become eligible for coverage under the Health Benefit Plan, if the adoption or placement for adoption occurs while the Employee is eligible for coverage under the Health Benefit Plan.

5.6 **HIPAA Portability and Nondiscrimination Requirements**.

5.6(a) If a Health Benefit Plan is not exempted under Section 732 of the Act from the HIPAA portability and nondiscrimination requirements as set out in Sections 701 through 706 of the Act and the regulations thereunder, the Health Benefit Plan shall be operated in accordance with such requirements.

5.6(b) If a Health Benefit Plan is not an exempted program under Section 732(b), (c) or (d) of the Act, it shall be operated in accordance with the provisions of Section 702 of the Act which restrict the use and collection of genetic information and the requirement or request for genetic testing.

5.7 **Newborn and Mothers Health Protection Act**. To the extent required by Section 711 of the Act:

5.7(a) If a Health Benefit Plan provides benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child, such Health Benefit Plan shall not, except as provided in subparagraph 5.7(b):

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal birth, to less than 48 hours; or

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or

(iii) require that a provider obtain authorization from the Health Benefit Plan or the health insurance issuer for prescribing any length of stay required under clauses (i) and (ii).

5.7(b) Subparagraph 5.7(a) shall not apply in connection with any Health Benefit Plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under subparagraph 5.7(a) is made by an attending provider in consultation with the mother.

5.7(c) Such Health Benefit Plan shall not:

(i) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the Health Benefit Plan, solely for the purpose of avoiding the requirements of subparagraph 5.7(a) above.

(ii) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under subparagraph 5.7(a) above.

(iii) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual Participant or beneficiary in accordance with subparagraph 5.7(a) above.

(iv) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual Participant or beneficiary in a manner inconsistent with subparagraph 5.7(a) above; or

(v) restrict benefits for any portion of a period within a hospital length of stay required under subparagraph 5.7(a) above in a manner which is less favorable than the benefits provided for any preceding portion of such stay; provided, nothing herein shall be construed to limit the terms of the Health Benefit Plan with respect to deductibles, copayments or other cost-sharing provisions and limitations, except that such terms may not impose greater limits or cost sharing on any length of stay required under subparagraph 5.8(a) above than for any preceding portion of such stay.

5.8 **Mental Health Parity**. If a Health Benefit Plan is not exempted under Section 732 of the Act from the parity in mental health and substance abuse disorder benefit requirements as set out in Section 712 of the Act and the regulations thereunder, a Health Benefit Plan that provides both medical and surgical benefits and mental health benefits shall not impose any lifetime or annual limits on mental health benefits that violate the requirements of Section 712 of the Act. A Health Benefit Plan that provides both medical and surgical benefits (MS benefits) and mental health or substance abuse disorder benefits (MHSA benefits) shall provide, to the extent required by Section 712 of the Act, that: (i) the financial requirements applicable to MHSA benefits shall be no more restrictive than the predominant financial requirements applicable to all MS benefits; (iii) there are no separate cost sharing requirements applicable only to MHSA benefits; (iv) treatment limitations applicable to MHSA benefits are no more restrictive than the predominant treatment limitations applicable to substantially all MS benefits; and (v) there are no separate treatment limitations applicable only to MHSA benefits.

5.9 **Women's Health and Cancer Rights Act**. If a Health Benefit Plan is not exempted under Section 732 of the Act from the parity in mandated coverage for Post-mastectomy reconstructive surgery requirements as set out in Section 713 of the Act and the regulations thereunder, if a Health Benefit Plan which provides medical and surgical benefits with respect to a mastectomy, then this paragraph shall apply. Such Health Benefit Plan shall, with respect to a Participant who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, provide coverage for the following (subject to applicable deductibles, copayments and other Health Benefit Plan limitations):

(i) reconstruction of the breast on which the mastectomy has been performed;

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(iii) prostheses and physical complications for all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient.

5.10 **Children's Health Insurance Program Reauthorization Act (CHIPRA)**. If an Employee's Dependent receives State child health assistance under a Health Benefit Plan which provides qualified employer-sponsored coverage, the State shall be treated as a secondary payor under such Health Benefit Plan to the extent required by CHIPRA.

5.11 **Patient Protection and Affordable Care Act.** If a Health Benefit Plan is not exempted under Section 732 of the Act from the requirements of Title I of the Patient Protection and Affordable Care Act of 2010, the Health Benefit Plan shall be operated in accordance with such requirements.

5.12 **Michelle's Law**. If a Health Benefit Plan is not exempted under Section 732 of the Act from the coverage of dependent students on medically necessary leave of absence requirements of Section 714 of the Act, the Health Benefit Plan shall not terminate a Dependent child's eligibility on the basis of failure to meet the plan's full-time student requirements, if applicable, to the extent that such failure results from a medically necessary disability leave of absence of not more than one year, all as required by Michelle's Law.

5.13 **GINA (Genetic Information Nondiscrimination Act)**. If a Health Benefit Plan is not exempted under Section 732 of the Act from the requirements of Section 702 of the Act, the Health Benefit Plan shall not increase contribution amounts based on genetic information; request or require an individual or family member to undergo a genetic test; or collect genetic information prior to or in connection with enrollment, or at any time for underwriting purposes, as required by GINA.

5.14 **Subrogation and Recovery**. If a Participant incurs covered expenses or receives benefits under the Group Health Coverage and/or the Group Dental Coverage that is exempt from regulation under Title 38.2 of the Code of Virginia (collectively referred to in this paragraph as the "Plan") with respect to an injury or illness for which a third party (or its insurer) may be liable, the Plan and Medical and Dental Trust retain all rights of subrogation, recovery and reimbursement as set out herein.

5.14(a) If any Employee, Participant or Dependent incurs charges or expenses for any illness, injury or other condition, whether or not such charges are incurred before or after such person became an Employee, Participant or Dependent, and such Employee, Participant or Dependent, his successors and assigns, including but not limited to, dependents or beneficiaries, has or may have a legal right to seek restitution or otherwise recover from another party or parties, then any payment of benefits made under the Plan based on such illness, injury or other condition automatically shall be subject to the provisions of this paragraph 5.14. The legal right to seek restitution or otherwise recover from another party or parties includes, but is not limited to, rights against Workers Compensation or similar on-the-job injury or illness statute and any third party, his insurance company or any other responsible or obligated party for such act, for example, medical malpractice, homeowners or other umbrella liability insurance, uninsurance or underinsurance motorist coverage, or any such other coverage, including coverage resulting from a "no fault" motor vehicle insurance statute or other similar legislation (collectively referred to as "Third Parties"). The provisions do not apply to individual health insurance plans or policies purchased by or for the Employee, Participant or Dependent.

5.14(b) The Employee, Participant or Dependent shall advise the Plan of any claim or potential claim he might have against Third Parties as of the date the person becomes an Employee, Participant or Dependent under the Plan or, if later, within sixty (60) days of the act which gives rise to such claim if such act also results in payment of benefits being made under the Plan.

5.14(c) By virtue of becoming a Participant or Dependent under the Plan, the Participant or Dependent, his successors and assigns, including but not limited to, dependents or beneficiaries, agrees to assign to the Plan and Medical and Dental Trust any payments made to such Participant or Dependents by Third Party or Parties relating to such illness, injury or other condition. In the event the Participant or Dependent challenges such assignment, the Plan and Medical and Dental Trust shall have no obligation whatsoever to make any payments to or on behalf of such Participant or Dependent for benefits relating to the injury, illness or other condition.

5.14(d) By virtue of becoming a Participant or Dependent under the Plan, the Participant or Dependent, his successors and assigns, including but not limited to, dependents or beneficiaries, shall, subject to applicable law, assign, transfer and subrogate to the Plan and Medical and Dental Trust all rights, claims, interests and rights of action against a Third Party or Parties, limited to the extent of the payments made under the Plan and Medical and Dental Trust to or on behalf of such Participant for which a Third Party or Parties might be liable or otherwise obligated.

5.14(e) By virtue of becoming a Participant or Dependent under Plan, the Participant or Dependent, his successors and assigns, including but not limited to, dependents or beneficiaries, shall, subject to applicable law, authorize the Plan and Medical and Dental Trust to sue, compromise or settle in his name or, at the Plan's or Health Benefit Plan's election, enter and prosecute in his name, a legal action for recovery of the payments made under the Plan and Medical and Dental Trust against a Third Party or Parties with all due diligence and at the expense and under the exclusive control of the Plan and Medical and Dental Trust.

5.14(f) The Participant or Dependent, his successors and assigns, including but not limited to, dependents or beneficiaries, shall provide the Plan and Medical and Dental Trust with any information necessary to enforce its rights resulting from payments made under the Plan and Medical and Dental Trust, and shall assist the Plan and Medical and Dental Trust in securing and exercising these rights and shall not prejudice the Plan and Medical and Dental Trust in any way in enforcing its rights to recover under this paragraph 5.15.

5.14(g) By virtue of becoming a Participant or Dependent under the Plan, the Plan and Medical and Dental Trust are entitled to recover the amount of benefits paid on behalf of the Participant or Dependent as well as any costs of enforcement of its rights. The Plan's and Medical and Dental Trust's right of recovery will not be reduced by the Participant's or Dependent's attorney fees and costs or in accordance with any "common fund" or "attorney fund" doctrine.

5.14(h) By virtue of becoming a Participant or Dependent under the Plan, the Participant or Dependent agrees to cooperate with the Plan and Medical and Dental Trust, and its agents and shall sign and deliver such documents as the Plan and Medical and Dental Trust reasonably requests to protect their right of subrogation/reimbursement. The Participant or Dependent shall not take any action that prejudices the Plan's or Medical and Dental Trust's right of recovery and consents to the right of the Plan and Medical and Dental Trust, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's and Medical and Dental Trust's rights under this paragraph. Without limitation, the Participant or Dependent agrees, and agrees to instruct his attorneys and agents, to hold the proceeds of such settlement or recovery in a dedicated account until such time as the Plan and Medical and Dental Trust has received all amounts it is entitled to recover hereunder.

5.14(i) If a Participant or Dependent, his successors and assigns, including but not limited to, dependents or beneficiaries, receives any judgment, settlement or other payment from a Third Party or Parties, the Participant or Dependent shall reimburse the Plan and Medical and Dental Trust from the first of such payments received to the extent of the expenses paid under the Plan and Medical and Dental Trust regardless of whether the judgment, settlement or other payment allocates any specified amount to medical expenses paid under the Plan and Medical and Dental Trust. This means that the rights of subrogation and reimbursement set forth in this paragraph 5.14 may be exercised against the first dollars received or claimed regardless of whether the Participant, Dependent and/or such Participant's or Dependent's beneficiaries or dependents have been completely compensated or made whole for their loss. If the Participant or Dependent, his successors and assigns, including but not limited to, dependents or beneficiaries, fails to timely and fully reimburse the Plan and Medical and Dental Trust for such expenses, any future claims the Participant or Dependent makes under the Plan and Medical and Dental Trust shall be offset by any amounts owed by the Participant or Dependent to the Plan and Medical and Dental Trust.

5.14(j) The conditions set forth in this paragraph 5.14 shall not diminish, waive, or foreclose any common law, statutory or equitable rights that the Plan and Medical and Dental Trust may have under applicable law, and all such rights in the interest of the Plan and Medical and Dental Trust and each Participant or Dependent under the Plan and Medical and Dental Trust hereby are expressly reserved to such persons.

5.14(k) The Participant or Dependent, his successors and assigns, including but not limited to, dependents or beneficiaries, shall have absolutely no authority to sign a release to any Third Party or Parties for monies for which the Plan and Medical and Dental Trust may be entitled to reimbursement under this paragraph 5.14, and no benefits shall be payable under this Plan and Medical and Dental Trust for any charges or expenses, for any injury, illness, or other condition for which a Participant or Dependent has already received a recovery from such Third Parties.

5.14(l) In addition to the subrogation and reimbursement rights described above, if the Participant or Dependent is paid benefits that should not have been paid, or which exceeded the amount that should have been paid under the Plan and Medical and Dental Trust, the Administrator has the right to recover this amount by withholding it from subsequent benefits which are due to such Participant or Dependent, or by other means which the Administrator chooses.

ARTICLE VI
Claims and Appeals Procedures

6.1 **General Claims Procedures**. The specific guidelines for filing a claim or a request for a review of a denied claim shall be set out in the Governing Documents for each Included Benefit. Such procedures shall comply with the general provisions of this Article VI and shall be designed to ensure the independence and impartiality of the persons involved in making decisions on such Claims. A Claimant must follow all internal claims and appeal procedures and, where applicable, all external review procedures, before he can file a lawsuit to contest the decision. Any such lawsuit must be filed no later than two years (or such shorter period set out in the Governing Documents of an Included Benefit) following the date of a Final Adverse Benefit Determination (as defined below). Unless otherwise provided in paragraph 6.2 and 6.3, the claim and appeal process shall be as follows.

6.1(a) Definitions. For purposes of this paragraph 6.1, the following capitalized terms shall have the meanings set forth below:

"Adverse Benefit Determination" means a total or partial denial of a Claim. For a Non-Grandfathered Plan (as defined in subparagraph 6.2(a)), a retroactive rescission of coverage due to fraud or misrepresentation shall be treated as an Adverse Benefit Determination.

"Appeal" means a Claimant's written request for review of an Adverse Benefit Determination in accordance with this Article.

"Claim" means any request for a benefit under an Included Benefit, made by a Claimant or by a representative of a Claimant, which complies with the reasonable procedure for making benefit Claims under such program.

"Claimant" means any Participant, former Participant or other person claiming any benefit under an Included Benefit, or a person who has been authorized to act on his behalf in accordance with the procedures of the Included Benefit.

"Claims Administrator" means the person or entity designated by the Administrator in accordance with paragraph 8.2 to manage the payment of claims under an Included Benefit. If authority and responsibility to determine adverse claims determinations (within the meaning of Section 503 of the Act) is delegated by the Administrator to the Claims Administrator, the Claims Administrator shall act as claims fiduciary with respect to the Included Benefit. If no such third party has been designated as

the Claims Administrator, the Administrator will serve as the Claims Administrator for purposes of this Article.

"Final Adverse Benefit Determination" means an Adverse Benefit Determination issued in connection with the last stage of Appeal as set forth in this Article.

6.1(b) Initial Claims.

(i) A Claimant must file a written claim for a benefit with the Claims Administrator in accordance with the procedures for that Benefit Program. Within ninety (90) days following receipt of such Claim by the Claims Administrator, notice of any denial thereof, in whole or in part, shall be delivered to the Claimant. The aforesaid ninety (90) day response period may be extended to one hundred eighty (180) days after receipt of the Claim if special circumstances exist and if written notice of the extension to one hundred eighty (180) days indicating the special circumstances involved and the date by which a decision is expected to be made is furnished to the Claimant within ninety (90) days after receipt of the Claim. If a Claimant has not received notification within ninety (90) days (or such extended periods as may be applicable) that his Claim has been allowed, the Claimant shall be considered to have exhausted the Plan's internal claims procedure and shall be entitled to pursue any remedies available to Claimant under the Act.

(ii) The written or electronic notice of denial shall be set forth in a manner designed to be understood by the Claimant, and shall include specific reasons for the denial, reference to specific Plan provisions, a description of any additional material or information necessary for the Claimant to perfect his Claim and an explanation of why such material or information is necessary, and a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of the Act following a Final Adverse Benefit Determination.

6.1(c) Appeals.

(i) Within one hundred eighty (180) days after the date on which the Claimant receives a written Adverse Benefit Determination, the Claimant may (a) file an Appeal with the Claims Administrator for a review of the denied claim and (b) submit written comments, documents, records and other information relating to the Claim to the Claims Administrator. The Claims Administrator shall have sixty (60) days to process the Appeal, unless the Claims Administrator determines that special circumstances require an extension of processing time, in which case the Claims Administrator may have up to an additional sixty (60) days to process the application. If the Claims Administrator determines that an extension of time for processing is required, the Claims Administrator will furnish written or electronic notice of the extension to the Claimant before the end of the initial (sixty) 60-day period. Any notice of extension will describe the special circumstances necessitating the additional time and the date by which the Claims Administrator expects to render its decision on the Appeal.

(ii) The Claimant's Appeal shall be in writing and shall be directed to the Claims Administrator. The Claimant shall have the right to be represented at such review, to review all documents relevant to the Claim, and to submit written comments, documents, records and other information relating to the Claim. The Claimant shall be provided upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the Claim. The Claim Administrator's review of the Appeal shall take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Claims Administrator shall respond electronically or in writing within sixty (60) days (or such extended period as may be applicable) after the receipt of the request for the Appeal. The decision on review shall be

written in a manner calculated to be understood by the Claimant and shall include specific reasons for the decision, reference to the specific Plan provisions upon which the determination is based, and a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to his Claim.

6.2 **Claims Procedures for Health Benefit Plans**. The specific guidelines for filing a Claim or Appeal of a denied Claim shall be set out in the Governing Documents for each Health Benefit Plan. Such procedures shall comply with the general provisions of this paragraph 6.2.

6.2(a) Definitions. For purposes of this paragraph 6.2, the following capitalized terms shall have the meanings set forth below:

"Concurrent Care Claim" means a Claim for an ongoing course of treatment to be provided over a period of time or number of treatments. Any reduction or termination by the Health Benefit Plan of the course of treatment (other than by plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is considered an Adverse Benefit Determination.

"Non-Grandfathered Plan" means a Health Benefit Plan that is (1) subject to Title I of the Patient Protection and Affordable Care Act of 2010, as amended, and (2) does not meet the requirements for "grandfathered status" within the meaning of that Act.

"Pre-Service Claim" means any Claim for a benefit under a Health Benefit Plan which conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

"Urgent Care Claim" means a Pre-Service Claim for medical care or treatment with respect to which the time frame for a non-urgent care determination could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of the Health Benefit Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

"Post-Service Claim" means any Claim that is not a Pre-Service Claim.

6.2(b) Notice to Claimant of Adverse Benefit Determinations.

(i) Claims. Except with respect to Urgent Care Claims (the notification for which may be oral followed by written or electronic notification within three days of the oral notification), upon its initial determination of a Claim, the Claims Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the Claimant:

(A) The specific reason or reasons for the adverse determination including, for Non-Grandfathered Plans, the denial code and its corresponding meaning, and a description of the Non-Grandfathered Plan's standard, if any, that was used in denying the Claim.

(B) Reference to the specific Health Benefit Plan provisions on which the determination was based.

(C) A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.

(D) A description of the Health Benefit Plan's Appeal procedures, including any voluntary appeal procedures offered by the Health Benefit Plan and, for Non-Grandfathered Plans any external review procedures, and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under Section 502 of the Act following a Final Adverse Benefit Determination.

(E) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge, or a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the Claimant upon request.

(F) If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Benefit Plan to the Claimant's medical circumstances, will be provided, or a statement will be included that such explanation will be provided free of charge, upon request.

(G) For Non-Grandfathered Plans, information sufficient to allow the Claimant to identify the Claim involved (including date of service, the healthcare provider, the Claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(H) For Non-Grandfathered Plans, information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and Appeals procedures and external review process.

(ii) Appeals. The Claims Administrator shall also provide written or electronic notice of an Adverse Benefit Determination on Appeal. This notice shall contain the information listed in subparagraphs (b)(i)(A) through (H), as well as:

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

(B) In the case of a Final Adverse Benefit Determination for a Non-Grandfathered Plan, a discussion of the decision.

6.2(c) Appeals. A Claimant who receives an Adverse Benefit Determination has one hundred eighty (180) days following receipt of the notification in which to Appeal the decision to the Claims Administrator. A Claimant may submit written comments, documents, records, and other information relating to the Claim. If the Claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(i) A document, record, or other information shall be considered relevant to a Claim if it:

(A) was relied upon in making the benefit determination;

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

(C) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Health Benefit Plan documents and Health Benefit Plan provisions have been applied consistently with respect to all Claimants; or

(D) constituted a statement of policy or guidance with respect to the Health Benefit Plan concerning the denied treatment option or benefit.

(ii) For Non-Grandfathered Plans, the Claims Administrator shall provide the Claimant any new or additional evidence that is relied upon, considered or generated by or at the direction of the Non-Grandfathered Plan. This new evidence shall be provided free of charge and must be provided to Claimant as soon as possible and sufficiently in advance of the time within which a Final Adverse Benefit Determination is required, to allow the Claimant time to respond.

(iii) If a Final Adverse Benefit Determination will be based on a new or additional rationale, the Claimant must be provided with this rationale as soon as possible and sufficiently in advance of the date on which the Final Adverse Benefit Determination must be provided, in order to give the Claimant a reasonable opportunity to respond prior to that date.

(iv) The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Health Benefit Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

(v) If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination, nor a subordinate of any individual involved in the original determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Health Benefit Plan in connection with the initial determination will be identified.

(vi) If specifically provided under the Health Benefit Plan, a Claimant may file a second Appeal with the Claims Adminstrator. This second Appeal shall also be subject to the terms of this paragraph 6.4.

6.2(d) Time for Responses. Upon receipt of a Claim or an Appeal of an Adverse Benefit Determination, the Claims Administrator (or its delegate) shall make its determination and provide any required notice within the following time periods.

(i) Urgent Care Claims. The Claims Administrator shall decide the Claim as soon as feasible, but no later than seventy-two (72) hours following receipt of the Claim. (For Non-Grandfathered Plans, this time shall be twenty-four (24) hours.) If additional information is needed in order to decide the Claim, the Claims Administrator will notify the Claimant within twenty-four (24) hours and Claimant shall have at least forty-eight (48) hours to provide the required information. The Claims Administrator will notify Claimant of its benefit determination within forty-eight (48) hours after

the earlier of: (i) receipt of the required information, or (ii) the expiration of the period afforded to Claimant to provide the information. In the case of an Adverse Benefit Determination, Claimant will be provided a description of the expedited claim review process for Urgent Care Claims.

Appeal of an Adverse Benefit Determination shall be decided as soon as feasible, but no later than seventy-two (72) hours after the Claims Administrator receives the request for Appeal.

(ii) Pre Service Claims. A Pre-Service Claim shall be decided within fifteen (15) days after the Claims Administrator receives the Claim, although the review period may be extended an additional fifteen (15) days if necessary due to circumstances beyond the Claims Administrator's control. Claimant will be notified within the timeframe of the reason for the extension and the date the Claims Administrator expects to render its decision.

If Claimant does not follow a Health Benefit Plan's procedures for filing a Pre-Service Claim, the Claims Administrator must notify Claimant within five (5) days of the proper procedures for Claimant to complete the claim.

If the Claims Administrator cannot render a decision within fifteen (15) days because Claimant has not provided sufficient information to review the Claim, the notice of extension must describe the specific information needed to complete the Claim. Claimant will be given at least forty-five (45) days from receipt of this notice to provide the required information. The Claims Administrator has fifteen (15) days after it receives the information to render its decision.

The Claims Administrator will decide an Appeal of a denied Pre-Service Claim within thirty (30) days after receiving the request for review; provided, if a Health Benefit Plan provides for two levels of Appeal, each level of Appeal shall be decided within fifteen (15) days.

(iii) Concurrent Care Claims. An Adverse Benefit Determination involving Concurrent Care will be made sufficiently in advance of any reduction in or termination of treatment to allow Claimant to Appeal the Adverse Benefit Determination. If a course of treatment involves urgent care, Claimant's request to extend the course of treatment will be decided as soon as possible, but not later than twenty-four (24) hours after the Claims Administrator receives the request, provided that the request is made at least twenty-four (24) hours prior to the expiration of treatment.

(iv) Post Service Claims. A Post-Service Claim shall be decided within thirty (30) days after the Claims Administrator receives the Claim. The Claims Administrator may extend the review period for an additional fifteen (15) days if necessary due to circumstances beyond the control of the Claims Administrator. The Claims Administrator will notify Claimant within the original thirty (30)-day period of the reason for the extension and the date by which the Claims Administrator expects to render its decision.

If the Claims Administrator cannot render a decision within thirty (30) days because Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Health Benefit Plan, the notice of extension will describe the specific information needed to complete the Claim. Claimant will be given at least forty-five (45) days from receipt of the notice to provide the required information. The Claims Administrator has fifteen (15) days from the date of receiving such information to render its decision.

An Appeal involving a Post-Service Claim shall be decided by the Claims Administrator within sixty (60) days after receiving the request for review; provided, if a Health Benefit Plan provides for two levels of Appeal, each level of Appeal shall be decided within thirty (30) days.

6.2(e) External Review Process. For Non-Grandfathered Plans, upon exhaustion of the internal claims and appeal procedures, a Claimant may request that the Claim be reviewed under the Non-Grandfathered Plan's external review process. The Non-Grandfathered Plan shall comply with the applicable State external review process, if any, and if none, the federal external review process. If the federal external review process applies, the following guidelines shall apply.

(i) The Claimant must file his request for external review within four (4) months after receipt of the Final Adverse Benefit Determination.

(ii) The Administrator will determine whether the Claim is eligible for review under the external review process. This determination is based on whether:

(A) The Claimant is or was covered under the Non-Grandfathered Plan at the time the Claim was made or incurred;

(B) The denial relates to the Claimant's failure to meet the Non-Grandfathered Plan's eligibility requirements;

(C) The Claimant has exhausted the Non-Grandfathered Plan's internal claims and appeal procedures; and

(D) The Claimant has provided all the information required to process an external review.

(iii) Within one business day after completion of this preliminary review, the Administrator will provide written notification to the Claimant of whether the claim is eligible for external review.

(iv) If the request for review is complete but not eligible for external review, the Administrator will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number.

(v) If the request is not complete, the notice will describe the information needed to complete it. The Claimant will have forty-eight (48) hours or until the last day of the four (4) month filing period, whichever is later, to submit the additional information.

(vi) If the request is eligible for the external review process, the Administrator will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for external review has been accepted. The notice should include a statement that the Claimant may submit in writing, within ten (10) business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Non-Grandfathered Plan. The Non-Grandfathered Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the external review process will end.

(vii) If the Non-Grandfathered Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(A) The Claimant's medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;

(D) The terms of the Non-Grandfathered Plan;

(E) Appropriate practice guidelines;

(F) Any applicable clinical review criteria developed and used by the plan; and

(G) The opinion of the IRO's clinical reviewer.

(viii) The IRO must provide written notice to the Non-Grandfathered Plan and the Claimant of its final decision within forty-five (45) days after the IRO receives the request for the external review. The IRO's decision notice must contain:

(A) A general description of the reason for the external review, including information sufficient to identify the claim;

(B) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(C) References to the evidence or documentation the IRO considered in reaching its decision;

(D) A discussion of the principal reason(s) for the IRO's decision;

(E) A statement that the determination is binding and that judicial review may be available to the Claimant; and

(F) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under federal guidelines.

(ix) Generally, a Claimant must exhaust the Non-Grandfathered Plan's claims and appeal procedures in order to be eligible for the external review process. However, an expedited external review is available if:

(A) The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Non-Grandfathered Plan's internal claims and appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

(B) The Claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(x) Immediately upon receipt of a request for expedited external review, the Non-Grandfathered Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within forty-eight (48) hours to both the Claimant and the Non-Grandfathered Plan.

6.3 **Claims Procedures For Disability Claims**. To the extent a claim involves a claim for disability benefits, the Claims and Appeal procedures shall comply with the general provisions of this paragraph 6.3.

6.3(a) Definitions. For purposes of this paragraph 6.3, the term "Claim" shall mean any request for a benefit under an Included Benefit other than a Health Benefit Plan, which complies with the reasonable procedure for making benefit Claims under such program, and the resolution of which requires a determination of disability by the Claims Administrator.

6.3(b) Notice to Claimant of Adverse Benefit Determinations. Upon its initial determination of a Claim, or upon its determination of an Appeal of a Claim, the Claims Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the Claimant:

(i) The specific reason or reasons for the Adverse Benefit Determination.

(ii) Reference to the specific Benefit Program provisions on which the determination was based.

(iii) A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.

(iv) A description of the Benefit Program's Appeal procedures, including any voluntary appeal procedures offered by the Benefit Program, and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under Section 502 of the Act following a Final Adverse Benefit Determination.

(v) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge, or a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the Claimant upon request.

(vi) If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided, or a statement will be included that such explanation will be provided free of charge, upon request.

(vii) For notification of an Adverse Benefit Determination on Appeal, a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

6.3(c) Appeals. A Claimant who receives an Adverse Benefit Determination of an initial Claim has one hundred eighty (180) days following receipt of the notification in which to Appeal the decision. A Claimant may submit written comments, documents, records, and other information relating to the Claim. If the Claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(i) A document, record, or other information shall be considered relevant to a Claim if it:

(A) was relied upon in making the benefit determination;

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

(C) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Benefit Program documents and Benefit Program provisions have been applied consistently with respect to all Claimants; or

(D) constituted a statement of policy or guidance with respect to the Benefit Program concerning the denied treatment option or benefit.

(ii) The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary who is neither the individual who made the adverse determination nor a subordinate of that individual.

(iii) If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination, nor a subordinate of any individual involved in the original determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Benefit Program in connection with the initial determination will be identified.

6.3(d) Time for Responses. Upon receipt of a Claim or an Appeal of an Adverse Benefit Determination, the Claims Administrator shall provide any required notice within the following time periods forty-five (45) days after the Administrator receives the Claim. The Claims Administrator may extend the review period for an additional thirty (30) days if necessary due to circumstances beyond the control of the Insurer. The Claims Administrator will notify Claimant within the timeframe of the reason for the extension and the date by which the Claims Administrator expects to render its decision. If, prior to the end of the first thirty (30)-day extension period, the Claims Administrator determines that, due to matters beyond its control, a decision cannot be made within that extension period, the Claims Administrator may extend the review period for an additional thirty (30) days. Any notice of extension under this subparagraph shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent decision in the Claim, and the additional information needed to resolve those issues.

Claimant will be given at least forty-five (45) days from receipt of the notice to provide the required information. The Administrator has fifteen (15) days from the date of receiving such information to render its decision.

6.4 **Voluntary Appeals, Including Voluntary Arbitration**.

6.4(a) If an Included Benefit specifically provides for a voluntary appeal or arbitration, a Claimant may file an appeal or request for arbitration in accordance with procedures set out in the Governing Documents. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

6.4(b) The Included Benefit waives any right to assert that a Claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Included Benefit. A Claimant may elect a voluntary appeal only after exhaustion of Appeals of an Adverse Benefit Determination as explained in the paragraph above, entitled "Appeals."

6.4(c) The Included Benefit will provide to the Claimant, at no cost and upon request, sufficient information about the voluntary appeal process to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the Claimant's rights to any other benefits under the Included Benefit; will list the rules of the appeal; state the Claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

6.4(d) No fees or costs will be imposed on the Claimant as part of the voluntary level of appeal.

ARTICLE VII
Continued Coverage for Qualified Beneficiaries under COBRA Plans

7.1 **Right to Elect Continued Coverage**. Upon the occurrence of a Qualifying Event, any Qualified Beneficiary thereby entitled to Continued Coverage under a Health Benefit Plan including the General Health Care Spending Account and the HSA Compatible Health Care Spending Account (the "COBRA Plans") shall, to the extent required by law, have the right to elect Continued Coverage under such Plan subject to payment of any required premium therefor and the procedures and limitations herein provided.

7.2 **Definitions and Special Rules**. For the purposes of this ARTICLE VII:

7.2(a) The term "Qualified Beneficiary" means:

(i) Any individual who on the date immediately preceding a Qualifying Event is covered by a COBRA Plan as a Participant's Dependent Spouse or child (sometimes referred to as a "Spouse Beneficiary" or a "Child Beneficiary", respectively). In addition, a Child Beneficiary includes a child born to, or placed for adoption with, the Participant during the Continued Coverage period described in this ARTICLE.

(ii) In the case of a Qualifying Event described in clause (ii) of subparagraph 7.2(b) (termination of employment or reduction in hours), any Participant who on the date immediately preceding such Qualifying Event is covered by a COBRA Plan (sometimes referred to as a "Participant Beneficiary").

(iii) In the case of a Qualifying Event described in clause (vi) of subparagraph 7.2(b) (bankruptcy of the Employer), any Participant who is retired from active employment of the Employer and who on the date immediately preceding such Qualifying Event is covered by the COBRA Plan and any Dependent of such retired Participant or surviving spouse of a deceased retired Participant who on the date immediately preceding such Qualifying Event is covered by the COBRA Plan (sometimes referred to as "Bankruptcy Beneficiary"). For purposes hereof, (A) classification as retired (as opposed to terminated) shall be determined under the Employer's standard personnel practices; and (B) references to a Participant is intended to include a retired Participant unless the context otherwise indicates.

(iv) Any Participant, Spouse or Child Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of Continued Coverage under this ARTICLE shall be referred to as a "Disabled Beneficiary". A Disabled Beneficiary will be considered to have been disabled during the first 60 days of Continued Coverage if such Disabled Beneficiary was determined to be disabled before the 60-day period and such Disabled Beneficiary has not received a subsequent Social Security Act determination that he is no longer disabled.

7.2(b) The term "Qualifying Event" with respect to a Participant or his Dependents or surviving spouse of a deceased retired Participant means any of the following events which, except for the application of this

ARTICLE VII, would result in loss of coverage (other than Continued Coverage) for any such individual under a COBRA Plan at any time during the otherwise applicable eighteen (18) or thirty-six (36) months or lifetime duration of Continued Coverage (as described in clauses (i), (ii) and (iii) of subparagraph 7.2(d)):

(i) The death of the Participant.

(ii) The termination of employment as an Eligible Employee or reduction of hours of the Participant's employment (except where the termination is the result of the Participant's gross misconduct). For this purpose, an Eligible Employee's termination of employment may be deemed to occur at the end of any severance period provided under any severance plan or agreement adopted or executed by the Employer (but only if the severance plan or the termination agreement entered into with the employee specifically provides that the Participant shall have a right to the maximum COBRA period following the end of the severance period).

(iii) The divorce or legal separation of the Participant from his Spouse.

(iv) The Participant's becoming entitled to benefits under Title XVIII of the Social Security Act.

(v) A Dependent child of the Participant ceasing to be a Dependent child under the general requirements of the COBRA Plan.

(vi) The institution by the Employer of bankruptcy proceedings under Title 11 of the United States Code if a substantial elimination of coverage under the COBRA Plan occurs within one (1) year before or after the date such proceedings were commenced.

7.2(c) The term "Continued Coverage" means health coverage which is identical to that provided or available, from time to time, under a COBRA Plan to similarly situated Participants with respect to whom a Qualifying Event has not occurred. Continued Coverage under this ARTICLE shall not be conditioned directly or indirectly on the insurability of the Qualified Beneficiary.

7.2(d) Continued Coverage shall be effective during the period beginning on the date on which the earliest Qualifying Event occurs and ending on the earliest of the following dates:

(i) In the case of a Qualifying Event described in clause (ii) of subparagraph 7.2(b) (termination of employment or reduction in hours), the date which is eighteen (18) months following the date of the Qualifying Event, provided, however that:

(A) In the case of a Disabled Beneficiary, such eighteen (18) month period described in this clause shall be extended to twenty-nine (29) months for the Disabled Beneficiary and all Qualified Beneficiaries in his family unit if the Qualified Beneficiary provides notice to the Administrator of such disability determination within sixty (60) days after the date of the determination and in no event after the end of the eighteen (18) month period.

(B) In the case of a Participant who becomes entitled to benefits under Title XVIII of the Social Security Act less than eighteen (18) months before the Qualifying Event, the aforesaid eighteen (18) month period (or twenty-nine (29) month period, if applicable) shall be extended to a thirty-six (36) month period beginning on the date the Participant becomes entitled to benefits under Title XVIII of the Social Security Act for each Spouse Beneficiary and Child Beneficiary.

(C) If a second Qualifying Event which is an event that gives rise to a thirty-six (36) month period of Continued Coverage as described in clause (iii) of subparagraph 7.2(b) occurs

with respect to a covered Spouse Beneficiary or Child Beneficiary during the aforesaid eighteen (18) month period (or the twenty-nine (29) month period if clause (i)(A) of this subparagraph 7.2(d) applies), such eighteen (18) month period (or twenty-nine (29) month period, if applicable) described in this clause shall be extended to thirty-six (36) months following the date of the original Qualifying Event for each such Spouse Beneficiary and Child Beneficiary.

(ii) In the case of a Qualifying Event described in clause (vi) of subparagraph 7.2(b) (bankruptcy of the Employer), the date of death of the Bankruptcy Beneficiary who is the retired Participant or the surviving spouse or surviving Domestic Partner of a deceased retired Participant who died before the occurrence of such Qualifying Event, provided, however, that upon the death of a Bankruptcy Beneficiary who is a retired Participant, the continued coverage for Bankruptcy Beneficiaries who are the surviving spouse and dependent children of such retired Participant shall be extended for thirty-six (36) months following the date of death.

(iii) In the case of a Qualifying Event other than the Qualifying Events described in clause (i) of subparagraph 7.2(b) (death of the Participant), clause (ii) of subparagraph 7.2(b) (termination of employment or reduction in hours) or clause (vi) of subparagraph 7.2(b) (bankruptcy of the Employer), the date which is thirty-six (36) months following the date of the Qualifying Event.

(iv) The date on which the Employer and all Affiliates cease to provide any health coverage to all employees.

(v) The date on which coverage ceases with respect to a Qualified Beneficiary as a result of the failure to make timely payment of any premium required for Continued Coverage by or on behalf of the Qualified Beneficiary.

(vi) The date occurring after the election to receive Continued Coverage on which the Qualified Beneficiary becomes covered under any other group health plan (whether as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary (other than such exclusion or limitation which does not apply to (or is satisfied by) a Qualified Beneficiary by reason of Sections 9801 et. seq. of the Code or parallel sections of the Act) or becomes entitled to benefits under Title XVIII of the Social Security Act, provided, however that Continued Coverage shall not end by reason of eligibility for benefits under Title XVIII of the Social Security Act if such benefits are available by reason of a Qualifying Event described in clause (vi) of subparagraph 7.2(b) (bankruptcy of the Employer).

(vii) In the case of a Disabled Beneficiary, coverage shall end for the Disabled Beneficiary and all Qualified Beneficiaries in his family unit as of the later of the first day of the month that begins more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that such Qualified Beneficiary is no longer disabled or the end of the coverage period that applies without regard to the disability extension (i.e., the eleven (11) month period described in clause (i)(B) of subparagraph 7.2(d) if such final determination is made during such disability extension period.

7.2(e) The premium which the Administrator may require as a condition of Continued Coverage:

(i) Shall be paid entirely on an after-tax basis to the Administrator or its designee (unless otherwise provided),

(ii) Shall be paid in monthly installments (provided that in no event shall any premium for Continued Coverage be required to be paid before forty-five (45) days after the date of the election of Continued Coverage),

(iii) Except as provided in (ii) of this subparagraph, shall be due on the first day of each month, subject to a grace period equal to the longest of (A) thirty (30) days, (B) the grace period, if any, provided under the COBRA Plan, or in the case of a COBRA Plan that is an Insured Benefit, under the Policy for Participants, or the grace period, if any, the Insurer allows the Employer under the Policy for the COBRA Plan.

(iv) Shall not exceed an amount which is one hundred two percent (102%) of the cost to the COBRA Plan (without regard to whether such cost is paid by the Employer or the Participant) for such period of coverage for similarly situated Participants and additional insureds with respect to whom no Qualifying Event has occurred. In the case of a COBRA Plan that is a not provided by an Insurer, such cost shall be based on the past cost of providing similar benefits to similarly situated Employees or shall be actuarially determined taking into account such factors as shall be prescribed by regulations under Section 4980B (formerly Section 162(k)) of the Code and as may be deemed relevant by the Administrator.

The determination of the premium required to be paid by or on behalf of a Qualified Beneficiary shall be made for a twelve (12) month period and determined before the beginning of such period (or if based on the policy year; as soon after premium rates for such policy year are set by the Insurer in the case of a COBRA Plan that is provided under a policy issued by an Insurer).

7.3 **Notice and Election Procedures**. The rules relating to the notice and election procedures for Continued Coverage are as follows:

7.3(a) The Administrator shall provide a general notice in writing of the benefits described in this ARTICLE VII to each Eligible Employee who becomes a Participant in a COBRA Plan and to such Eligible Employee's covered Spouse, if any, within ninety (90) days of a Participant's or a Spouse's coverage under the COBRA Plan commences. Such general notice shall contain at least the information required by the regulations under Section 606(a) of the Act and may be provided as part of a summary plan description. If the Participant and the covered Spouse reside at the same address, a single notice addressed to both individuals may be sent to the common address provided the Spouse's coverage under the COBRA Plan commences on or after the Participant's coverage commences but not after the ninety (90) day general notice period. Notwithstanding the above, if an election notice is required under subparagraph 7.3(c) prior to the expiration of the ninety (90) day period, then the election notice under subparagraph 7.3(c) shall be provided to the Participant or the covered Spouse instead of the general notice under this subparagraph 7.3(a).

7.3(b) The Administrator shall be notified of Qualifying Events as follows:

(i) In the case of a Qualifying Event described in clauses (i), (ii), (iv) or (vi) of subparagraph 7.3(b) (death, termination of employment or reduction in hours, entitlement to benefits under Title XVIII of the Social Security Act, or bankruptcy of the Employer), the Employer employing the Participant or from whose employment a retired Participant has retired shall provide written notice to the Administrator of such Qualifying Event with respect to the Participant or retired Participant no later than thirty (30) days after the date of such Qualifying Event, or, if later, after the date of loss of coverage due to such Qualifying Event. Such notice shall contain at the information required by the regulations under Section 606(a) of the Act.

(ii) In the case of a Qualifying Event described in clause (iii) or (v) of subparagraph 7.2(b) (divorce or legal separation or change in status of a dependent) or a second Qualifying Event under clause (i)(A) of subparagraph 7.2(d), the Participant or Qualified Beneficiary shall notify the Administrator of such Qualifying Event no later than sixty (60) days after the latest of (1) the date of such Qualifying Event, (2) the date of loss of coverage due to such Qualifying Event, or (3) the date on which the Participant or Qualified Beneficiary is informed of his responsibility to provide the notice and the COBRA Plan's procedures for providing the notice. Such notice by the Qualified Beneficiary shall be made in accordance

with the procedures set forth in the applicable summary plan description and the regulations under Section 606(a) of the Act.

(iii) The notices required in clause (ii), above may be provided by a Participant, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of a Participant or Qualified Beneficiary. The provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

7.3(c) The Administrator shall provide an election notice to each Qualified Beneficiary with respect to whom a Qualifying Event has occurred notifying him of rights under this ARTICLE VII as follows:

(i) Such notice shall be provided within fourteen (14) days of the Administrator's timely receipt of the notice required in subparagraph 7.3(b).

(ii) Notwithstanding clause (i) above, with regard to the Administrator's timely receipt of a notice required under clause (i) of subparagraph 7.3(b) from the Employer of the Participant and provided the Employer of the Participant is also the administrator of the Plan, such notice shall be provided within forty-four (44) days after the date of such Qualifying Event, or, if later, after the date of loss of coverage due to such Qualifying Event.

(iii) The notice required under this paragraph shall be written in a manner calculated to be understood by the average Participant and shall contain at least the information required by the regulations under Section 606(a) of the Act.

(iv) Such notice shall be provided to each Qualified Beneficiary except that: (1) if the Participant and the covered Spouse reside at the same address, a single notice addressed to both individuals may be sent to the common address; (2) if the Qualified Beneficiary is a dependent child and the Participant or Spouse reside at the same address, a single notice may be sent to the individual residing with the dependent child.

7.3(d) In the event the Administrator receives a notice under clauses (ii), (iii), or (iv) of subparagraph 7.3(b) relating to an individual (such as an Eligible Employee, Qualified Beneficiary or other individual) and the Administrator determines that such individual is not entitled to Continued Coverage under this Article VII, the Administrator shall provide to such individual an explanation as to why the individual is not entitled to Continued Coverage. Such notice shall be provided in the time frame set forth in clause (i) of subparagraph 7.3(c), shall be written in a manner calculated to be understood by the average Participant and shall contain at least the information required by the regulations under Section 606(a) of the Act.

7.3(e) The Administrator shall provide notice to each Qualified Beneficiary with respect to a Qualifying Event of any termination of continuation coverage that takes effect earlier than the end of the maximum period of Continued Coverage applicable to such Qualifying Event. Such notice shall be provided as soon as practicable following the Administrator's determination that Continued Coverage shall terminate. Such notice shall be written in a manner calculated to be understood by the average Participant and shall contain at least the information required by the regulations under Section 606(a) of the Act.

7.3(f) Notices under required under subparagraphs 7.3(a) - (e) shall be given by either electronic media (as allowed under regulations under Section 104 of the Act), hand delivery or by first class mail to the last known address of the Participant, Spouse, Qualified Beneficiary and/or Administrator as required above and in accordance with procedures adopted by the Administrator. Notice delivered to the Participant will not be considered to be notice to the Spouse unless delivered in accordance with specific rules set forth in subparagraph 7.3.

7.3(g) The Qualified Beneficiary may elect to receive Continued Coverage by filing an election therefor with the Administrator during the following applicable election period:

(i) The election period shall begin on the earlier of (A) the date specified by the Administrator or (B) the date on which coverage otherwise terminates as a result of the earliest Qualifying Event.

(ii) The election period shall end on the later of (A) the date specified by the Administrator or (B) sixty (60) days after the later of (I) the date on which coverage otherwise terminates as a result of the earliest Qualifying Event or (II) the date of the Administrator's notification described in subparagraph 7.3(c).

7.3(h) For purposes hereof:

(i) An election of Continued Coverage by a Participant, Spouse or Bankruptcy Beneficiary who is a retired Participant, spouse or surviving spouse of a retired Participant shall be deemed to be an election to receive Continued Coverage on behalf of all Qualified Beneficiaries with respect to the Qualifying Event unless the election otherwise provides.

(ii) A Participant, Spouse, Child and Bankruptcy Beneficiary each may make separate elections or elections of different or no coverage.

(iii) An election may be made and/or revoked at any time and any number of times during an election period.

7.4 **Specific Continued Coverage Rules**.

7.4(a) Subparagraph 7.2(d) shall not apply if (i) the COBRA Plan is not subject to the HIPAA portability provisions in Code sections 9831 and 9832 because the benefits under COBRA Plan are “excepted benefits” (i.e., the maximum benefit payable to or on behalf of the Participant or Dependent as benefits under the COBRA Plan for a Plan Year does not exceed two times the Participant’s salary reduction election amount under the COBRA Plan for the Plan Year (or, if greater, the amount of the Participant's salary reduction election amount under the COBRA Plan for the Plan Year, plus $500); the Participant or Dependent has other coverage available under a group health plan of the Employer for the Plan Year; and the other coverage is not limited to benefits that are excepted benefits), and (ii) in the Plan Year in which the Qualifying Event occurs, the maximum amount that the Plan could be required to pay as benefits under the COBRA Plan paid for a full Plan Year of Continued Coverage equals or exceeds the maximum benefit available under the COBRA Plan for the Plan Year. If these conditions are met Continued Coverage shall be effective during the period beginning on the date on which the earliest Qualifying Event occurs and ending on the last day of the Plan Year in which the Qualifying Event occurred.

7.4(b) The Plan need not offer Continued Coverage for the COBRA Plan at all if the plan is described in subparagraph 7.4(a) and if, as of the date of the Qualifying Event, the Participant or Dependent could not become entitled to receive during the remainder of the Plan Year benefits under the COBRA Plan that exceed the maximum amount that the Plan is permitted to require to be paid for Continued Coverage for COBRA Plan for the remainder of the Plan Year. In determining the amount of benefits under the COBRA Plan that a Participant or Dependent can become entitled to receive during the remainder of the Plan Year, there may be deducted from the maximum benefit available to or with respect to that Participant or Dependent for the Plan Year (based on the election made for the Participant’s COBRA Plan for the Plan Year before the date of the Qualifying Event) any reimbursable claims submitted for benefits under the COBRA Plan for that Plan Year before the date of the Qualifying Event.

7.5 **USERRA Continuation Coverage**. The Plan will provide continuation coverage to the extent required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If the

Participant does not elect Continued Coverage as provided in paragraph 7.1 with respect to his military leave, in order to be eligible for USERRA continuation coverage the Participant must elect such continuation coverage within sixty (60) days (unless precluded by military necessity) of the first day of the Participant's absence from work in order to perform his military service or, if sooner, the period ending on the day after the deadline the Participant must apply to return to work with the Employer. Premiums for continuation coverage must be paid within thirty (30) days after the initial election and thereafter are due the first day of each month. If the Participant does elect Continued Coverage as provided in paragraph 7.1 with respect to his military leave and wishes to extend such coverage to the twenty-four (24) month maximum as allowed under USERRA, he must notify the Plan Administrator within thirty (30) days of the exhaustion of his Continued Coverage of such election.

7.6 **Special Rules for Assistance Eligible Individuals.**

7.6(a) The Plan's provisions concerning COBRA are amended as provided below to allow for (1) payment of reduced premiums and the provision of a second election period by certain COBRA qualified beneficiaries, (2) the provision for additional COBRA notices, and (3) an exception to the rules for crediting certain prior coverage. This amendment does not apply to a health flexible spending account.

7.6(b) The COBRA continuation coverage provisions of the Plan shall be administered in accordance with the requirements of ARRA Section 3001 with respect to "assistance eligible individuals", as defined in ARRA Section 3001(a)(3). Notwithstanding any other Plan provision to the contrary, the Plan shall determine whether an individual has had a 63-day break in coverage for purposes of determining creditable coverage under the Health Insurance Portability and Accountability Act (HIPAA), in accordance with the terms of ARRA Section 3001.

ARTICLE VIII
Plan Administration and Allocation of Authority

8.1 **Plan Administrator**.

8.1(a) The Administrator is a "named fiduciary" of the Plan, as defined in Section 402(a)(2) of the Act.

8.1(b) With respect to Included Benefits other than the Group Health Coverage and Group Dental Coverage, the Administrator has delegated to the Benefits Corporation certain administrative duties responsibilities as described in the Group Insurance Program Participation Agreement executed by and between the Employer Sponsor and the Benefits Corporation.

8.2 **Administrator's Powers and Duties**.

8.2(a) The Administrator shall have sole authority to control and manage the operation and administration of the respective Included Benefits. The Employer Sponsor and each Participating Employer shall provide all information about their respective Included Benefits as the Administrator deems necessary to carry out its responsibilities.

8.2(b) The Administrator shall have complete discretion to interpret the provisions of the respective Included Benefits and to make findings of fact. Decisions by the Administrator may not be overturned unless found by a court to be arbitrary and capricious and having no foundation. All determinations of the Administrator with respect to any matter relating to the administration of the respective Included Benefits shall be conclusive and binding on all persons.

8.2(c) The Administrator shall have the following powers and duties:

(i) to require any person to furnish such reasonable information as the Administrator may request for the proper administration of the respective Included Benefits as a condition to receiving any benefits under the respective Included Benefits;

(ii) to make and enforce such rules and regulations and prescribe the use of such forms as the Administrator shall deem necessary for the efficient administration of the respective Included Benefits;

(iii) to decide on questions concerning the respective Included Benefits and the eligibility of any Employee to participate in the respective Included Benefits, in accordance with the provisions of the respective Included Benefits; provided ,however that, in the case of the group health and dental coverages, the Employer Sponsor shall determine eligibility of any Employee to participate;

(iv) to determine the amount of benefits that shall be payable to any person in accordance with the provisions of the respective Included Benefits; and

(v) to designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Administrator under the terms of the respective Included Benefits, and to retain such actuaries, accountants (including Employees who are actuaries or accountants), consultants, third-party administration service providers, legal counsel, or other specialists, as the Administrator may deem appropriate and necessary for the effective administration of the respective Included Benefits.

8.2(d) The Administrator and any delegate shall be fully indemnified by the Employer Sponsor and by each Participating Employer against all liabilities, costs, and expenses (including defense costs but excluding any amount representing a settlement unless such settlement is approved by the Employer Sponsor) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Administrator or having been assigned or delegated any of the powers or duties of the Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the respective Included Benefits, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

8.2(e) To the extent permitted by law, neither the Administrator nor any other entity or person shall incur any liability for any acts or for failure to act except for his or her own willful misconduct or willful breach of the respective Included Benefits.

8.3 **Fiduciary Duties and Responsibilities**. The Administrator and its delegates with discretionary authority under the respective Included Benefit, shall discharge his duties with respect to the respective Included Benefit solely in the interest of the Participants and their beneficiaries; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the respective Included Benefit; and in accordance with the terms of the respective Included Benefit. Each Plan fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in exercising such authority.

ARTICLE IX
Amendment and Termination of the Plan

9.1 **Plan Sponsor's Right to Amend or Terminate the Plan**.

9.1(a) The Plan Sponsor reserves the right to itself through action by its Board of Directors, and each participating Employer hereby agrees that the Plan Sponsor shall have the right on behalf of all participating Employers, to modify, alter, amend or terminate the Plan at any time, including but not limited to the termination of the Plan as a whole or the termination of participation in the Plan by any Employer, except no such modification, alteration, amendment or termination shall in any manner be deemed to affect the provisions of the Trust, governing documents applicable to the Included Benefit or policies of the Insurer with respect to an Included Benefit without the express written consent of the trustees of the Trust, the Benefits Corporation or the Insurer, respectively. Notice of any such modification, alteration, amendment or termination shall be given in writing to the affected Employer(s). Any such termination of participation shall be reflected in Option 1(f) of the Adoption Agreement.

9.1(b) Notwithstanding the foregoing, the Plan Sponsor hereby delegates to the Benefits Corporation the right to modify, alter, or amend the Plan in whole or in part to make any technical modification, alteration or amendment which in the opinion of counsel for the Benefits Corporation is required by law and is deemed advisable and to make any other modification, alteration or amendment which does not, in Benefit Corporation's view, substantially or materially Included Benefits and elections made by the Employer Sponsors.

9.2 **Termination of Participation in the Plan by an Employer**. A participating Employer may in its sole and absolute discretion terminate its participation in the Plan by action of its Board of Directors specifying the date of such termination. Notice of termination of such Employer's participation shall be delivered to the Plan Sponsor and Administrator and reflected in Option 1(f) of the Adoption Agreement.

9.3 **Automatic Amendment or Termination of the Plan**. The Plan shall automatically terminate or the provisions of the Plan shall be automatically amended upon the termination or cancellation of all Included Benefit(s) under the Trust or upon the amendment (including termination or cancellation) of any of the Included Benefit(s) under the Trust.

9.4 **Effective Date of Termination**. Unless otherwise specifically provided in the Trust, the governing documents applicable to the Included Benefit or policies of the Insurer with respect to an Included Benefit, any termination of an Included Benefit shall be effective as to expenses not then incurred for the performance of services or provision of care and supplies in the case of medical insurance benefits and as to deaths or other benefit entitlement events not then occurred in the case of other benefits.

9.5 **Amendment or Termination of Form of the Plan by the Benefits Corporation**. The Benefits Corporation in its sole and absolute discretion may amend the form of the Plan or terminate its maintenance and offering through the Benefits Corporation at any time and as to any one or more Employer. Notice of any such modification, alteration, amendment or termination shall be given in writing to the affected Employer(s). Any such termination of participation shall be reflected in Option 1(f) of the Adoption Agreement.

ARTICLE X
Miscellaneous

10.1 **Headings**. The headings in the Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

10.2 **Gender and Number**. In the construction of the Plan, the masculine shall include the feminine or neuter, and the singular shall include the plural and vice versa in all cases where such meanings would be appropriate.

10.3 **Governing Law**. The Plan shall be construed, enforced and administered according to the laws of the Commonwealth of Virginia and federal laws preempting the same.

10.4 **Employment Rights**. Participation in the Plan shall not give any Employees the right to be retained in the employ of the Employer nor, upon dismissal or upon his voluntary termination of employment, to have any right or interest in the Plan other than as herein provided.

10.5 **Right to Require Information and Reliance Thereon**. The Association, Benefits Corporation, Plan Sponsor, Employer, Administrator and Insurer shall have the right to require any person entitled to benefits to provide it with such information, in writing, and in such form as may be necessary to the administration or maintenance of the Plan and may rely thereon in all matters arising hereunder. Any payments in accordance with the provisions of the Plan in good faith reliance upon any such written information provided by a Participant shall be in full satisfaction of all claims by such Participant; and any payment to any other person entitled to benefits in accordance with the provisions of the Plan in good faith reliance upon any such written information provided by such person shall be in full satisfaction of all claims by such person.

10.6 **Effect of Plan on Trust and Insurer**. Except as expressly provided herein, nothing contained in the Plan shall be construed to alter the terms of the Trust or policies of the Insurer or to provide any benefits other than those provided by the Trust and the policies of the Insurer.

10.7 **Persons Permitted to Act on Behalf of the Employer with Respect to the Plan**. Whenever the Employer is permitted or required to perform any act in connection with the Plan, such act may be performed by its President, its Chief Executive Officer, the Chairman of its Board of Directors or any other person duly authorized by its President, its Chief Executive Officer, its Board of Directors or its Chairman thereof.

10.8 **Indemnification of Persons Acting on Behalf of the Employer**. The Employer agrees to indemnify and reimburse, to the fullest extent permitted by law, members of its Board of Directors, the Administrator, and other employees acting for the Employer, and all such former Board of Directors members, Administrators and employees, for any and all expenses, liabilities or losses arising out of any act or omission relating to the rendition of services for or the management and administration of the Plan.

ARTICLE XI
Adoption by Additional Employers

11.1 **Adoption by Additional Employers**. Any Employer which is a member of the same controlled or affiliated service group as the Employer Sponsor (as determined under Sections 414(b), (c), (m) or (o) of the Code) and which, with the consent of the Plan Sponsor, desires to adopt the Plan may do so by executing an "Adoption of Plan by Additional Employer" to be attached to the Adoption Agreement. Such Employer's participation shall be reflected and acknowledged by the Administrator in Option 1(f) of the Adoption Agreement.

ARTICLE XII
Adoption by Additional Employers

12.1 **Agreement**.

The undersigned Chief Operating Officer of the Benefits Corporation has signed this agreement, thereby evidencing the adoption of the group health and dental plans on the date noted below and the acceptance of this agreement as the plan document for the group insurance arrangements it administers.

Virginia Bankers Association Benefits Corporation

By Laurie H Milligan

Its Chief Operating Officer

Date 2/10/15

VIRGINIA BANKERS ASSOCIATION
GROUP FLEXIBLE BENEFITS PLAN

(January, 2015)

Schedule I

List of Authorized Members of the Plan Sponsor's Workforce

(Effective as of January 1, 2015)

The following persons are authorized to receive Protected Health Information in accordance with the provisions of paragraph 5.1 of the Plan:

Job Position	**Administrative Function**
Privacy Officer - Vice President Retirement Plans and Compliance	
Chief Operating Officer	Assist with members questions and claims resolution
Director/Vice President of Sales and Marketing	Assist with members questions and claims resolution
Manager of Health and Welfare Plans	Assist with members questions and claims resolution, maintenance of data base
Benefits Coordinator/ Administrative Assistant	Assist with members questions and claims resolution, maintenance of data base
Special Projects Coordinator	Assist with members questions and claims resolution
General Counsel	Oversee and advise on compliance

It is intended that the Employer will only receive health information that has been "de-identified" such that it does not meet the definition of "Protected Health Information.

VIRGINIA BANKERS ASSOCIATION

GROUP FLEXIBLE BENEFITS PLAN

DEPENDENT CARE SPENDING ACCOUNT

Appendix A

A-1.1 **Introduction**. The Dependent Care Spending Account is an unfunded welfare plan and flexible spending account. Any amounts contributed to the accounts hereunder shall be maintained as a book account by the Administrator and shall constitute a liability of the Employer. Benefits paid or reimbursed shall be paid out of the general assets of the Employer upon presentation of the approved claim therefor. The amounts paid or reimbursed for Qualifying Dependent Care Expenses incurred by a Participant shall be charged to and withdrawn from his account in the Plan and are intended to be excluded from the Participant's federal gross income as contributions to and benefits under dependent care assistance plan under Section 129 of the Code.

A-1.2 **Eligibility for and Termination of Participation**. Each Eligible Employee who elects pursuant to the Plan to participate in the Dependent Care Spending Account shall become a Participant in the Dependent Care Spending Account as of the first day of the payroll period for which the election is effective. Participation shall cease on the earlier of:

(i) The effective date of the Participant's revocation of his election to participate in the Dependent Care Spending Account as permitted under the Plan;

(ii) The last day of the Plan Year unless a new election to participate is filed during the applicable enrollment period for the following Plan Year; or

(iii) The effective date of the termination of the Dependent Care Spending Account.

A-1.3 **Definitions**. For purposes hereof, the following terms have the meanings set forth below:

A-1.3(a) "Benefit Claim Period": The Plan Year plus the period through March 31, following the end of the Plan Year. Notwithstanding the foregoing, prior to the beginning of a Plan Year, the Employer may further limit the Benefit Claim Period applicable to a Participant who terminated employment during the Plan Year. Such limited Benefit Claims Period shall be communicated to Participants and to the ASO prior to the beginning of the Plan Year.

A-1.3(b) "Dependent": The spouse of a Participant and any individual who meets the definition of a dependent under Section 152 of the Code with respect to the Participant.

A-1.3(c) "Earned Income": Compensation as defined in Section 32(c)(2) of the Code excluding any benefits paid or incurred by an employer for Qualifying Dependent Care Expenses. In the case of a Participant's spouse who is a student or incapable of self-care, such spouse shall be deemed for each month during which such spouse is a full-time student at an educational institution, or is incapable of self-care, to be gainfully employed and to have Earned Income of not less than:

(i) $250 (or such other amount as may be provided under Section 21(d)(2)(A) of the Code) if there is one Qualifying Individual with respect to the Participant during the calendar year; or

(ii) $500 (or such other amount as may be provided under Section 21(d)(2)(A) of the Code) if there are two or more Qualifying Individuals with respect to the Participant during the calendar year.

In the case of a married couple, the provisions relating to deemed Earned Income shall apply with respect to only one spouse for any month.

A-1.3(d) "Employment-Related Expenses": Expenses that are:

(i) Incurred to enable the Participant and, where applicable, his spouse to be gainfully employed for any period for which the Participant has one or more Qualifying Individuals; and

(ii) Paid for household services or for the care of one or more Qualifying Individuals with respect to the Participant. Expenses are considered to be paid for household services if they are paid for the performance in and about the Participant's house of ordinary and usual services for maintenance of the household. However, expenses are not considered as paid for household services unless the expenses are attributable in part to the care of a Qualifying Individual.

An expense is considered an Employment-Related Expense incurred for services performed outside the household of the Participant only if the expense is incurred for the care of (A) one or more Qualifying Individuals of the Participant who is described in clause (i) of subparagraph A-1.3(f); or (B) a Qualifying Individual of the Participant not described in clause (i) of subparagraph A-1.3(f) who regularly spends at least eight (8) hours each day in the Participant's household. Additionally, if such services are performed in a dependent care center (which is a facility which provides care for more than six (6) individuals who are not residents of the facility and which receives a fee, payment or grant for providing such care), the dependent care center must comply with all applicable laws.

A-1.3(e) "Qualifying Dependent Care Expenses": Employment-Related Expenses incurred by a Participant during the Plan Year on behalf of a Qualifying Individual. An expense is not considered a Qualifying Dependent Care Expense if the expense is paid or incurred to an individual:

(i) With respect to whom a personal exemption deduction as a dependent is allowable under Section 151(e) of the Code to the Participant or his spouse for the calendar year; or

(ii) Who is a child (including a step-child) of the Participant under the age of nineteen (19) at the end of the calendar year.

The primary purpose of expenses for the care of a Qualifying Individual must be to assure that individual's well-being and protection. Not all benefits bestowed upon a Qualifying Individual are considered as provided for his care. Accordingly, amounts paid to provide food, clothing or education are not expenses paid for the care of a Qualifying Individual. However, where the manner of providing care is such that the expense which is incurred includes expenses for other benefits which are incident to and inseparably a part of the care, the full amount of the expense is considered to be incurred for care. For example, the full amount paid to a nursery school in which a qualifying child is enrolled is considered as being for the care of the child, even though the school also furnished lunch and educational services. Educational expenses incurred for a child in the kindergarten, first grade or higher grade level are not expenses incurred for the care of a Qualifying Individual. Expenses paid for the care of a Qualifying Individual do not include expenses paid for care provided at an overnight camp.

A-1.3(f) "Qualifying Individual": An individual who is:

(i) The Participant's non-spouse Dependent who is under the age of thirteen (13) with respect to whom the Participant is entitled to a personal exemption deduction under Section 151(e) of the Code; or

(ii) The Participant's Dependent who is physically or mentally incapable of self-care.

A-1.4 **Description of Benefits**. The amount elected by the Participant to be contributed to the Dependent Care Spending Account for a Plan Year shall be used to pay or reimburse Participants for Qualifying Dependent Care Expenses incurred by the Participant during such Plan Year.

A-1.5 **Participant Contributions**. Each Eligible Employee may elect to contribute any amount from a the minimum chosen by the Employer in Option 5(j)(1) of the Adoption Agreement and up to the maximum chosen by the Employer in Option 5(j)(1) of the Adoption Agreement (provided, however, if the Participant is married filing a separate return, the maximum amount that he may elect to contribute is two thousand five hundred dollars ($2,500) in any Plan Year) to his account under the Dependent Care Spending Account. Changes in the contribution elections by Participants may be made only in accordance with the terms of the Plan.

A-1.6 **Limitations on Participant Contributions and Benefits**.

A-1.6(a) The aggregate amount of benefits paid or reimbursed to or on behalf of a Participant at any time during a Plan Year shall not exceed the balance in the Participant's Dependent Care Spending Account as of the date of such payment.

A-1.6(b) The amount of Qualifying Dependent Care Expenses of a Participant which may be paid or reimbursed under the Dependent Care Spending Account for any given calendar year shall not exceed:

(i) If the Participant is not married on the last day of the calendar year, the Earned Income of the Participant for the calendar year.

(ii) If the Participant is married on the last day of the calendar year, the lesser of:

(A) The Earned Income of the Participant for the calendar year; or

(B) The Earned Income of the Participant's spouse for the calendar year.

A-1.6(c) Notwithstanding the foregoing, in no event shall a Participant be permitted to excluded under this Plan an amount in excess of five thousand dollars ($5,000) (or two thousand five hundred dollars ($2,500) in the case of a married individual filing a separate return) for any calendar year.

A-1.6(d) The Administrator shall limit the benefits of Participants who are in the "limitation class" with respect to a Plan Year so that benefits paid at any date during the Plan Year with respect to individuals in the limitation class do not exceed twenty-five percent (25%) of all benefits paid thereunder to such date during the Plan Year. An individual is considered in the "limitation class" with respect to a payment in a Plan Year if the individual, or his spouse or dependents (determined on the same basis as "dependent" for purposes of Section 152 of the Code, but with respect to the individual in question), owns on any day on or before the date of the payment during Plan Year more than five percent (5%) of the total number of shares of outstanding stock of the Employer (determined pursuant to the attribution rules under Section 1563(d) and (e) of the Code, but without regard to Section 1563(e)(3)(C) of the Code).

A-1.6(e) The Administrator shall further limit the benefits of Participants who are "highly compensated employees" with in the meaning of Section 414(q) of the Code so that the average of the benefits provided under the Dependent Care Spending Account and all other plans providing dependent care assistance to Employees who are not highly compensated employees are at least fifty-five percent (55%) of the average of the benefits under such plans provided to Employees who are highly compensated employees. In applying this limitation, the Administrator may, but need not, exclude Employees whose compensation (determined under Section 414(q)(7) of the Code or in any other manner permitted under the Code that does not discriminate in favor of highly compensated employees) is less than $25,000 for any Plan Year.

A-1.7 **Procedure for Filing Claims**.

A-1.7(a) Participants may, during the Benefit Claim Period, request reimbursement of Qualifying Dependent Care Expenses. Such request shall contain the information required by the ASO (as defined in subparagraph A-1.7(b)) to substantiate the claim including, but not limited to:

(i) A third party, written statement setting forth the amount and purpose of the expenditure;

(ii) The name of the Qualifying Individual to whom the expenditure relates; and

(iii) The name, address, and taxpayer identification number of the person performing the services, or in the case of an organization exempt from tax under Section 501(c)(3) of the Code, the name and address of such organization.

Except in the case of any claim filed during the last month of the Plan Year and during the Benefit Claim Period that extends beyond the end of the Plan Year, such claim, together with any claims filed under the other flexible spending accounts, must be for a minimum of five dollars ($5.00).

A-1.7(b) The ASO for benefits provided hereunder is the Benefits Corporation or such other entity as may be designated by the Benefits Corporation to perform the functions of the administrative services organization for the Dependent Care Spending Account.

A-1.8 **Forfeiture of Unused Benefits**. Any amounts remaining in a Participant's account for a Plan Year at the end of the Benefit Claim Period with respect to such Plan Year shall be forfeited in whole or in part and used to offset future contributions and payments due from the Employer under the Dependent Care Spending Account and, in the event of termination of the Dependent Care Account, any such forfeitures shall revert to the Employer unless otherwise provided by the Employer.

A-1.9 **Debit Card**. A Debit Card shall be issued upon the request of a Participant who elects to participate in the Dependent Care Spending Account and who agrees to comply with all of the terms and conditions of use of the Debit Card. Without limitation, the Participant must certify at the time of enrollment and with each use of the Debit Card that he will use the card only for Qualifying Dependent Care Expenses, that the expense paid with the card has not been reimbursed, and that he will not seek reimbursement from any other plan covering dependent care benefits. Use of the card for Qualifying Dependent Care expenses will only be accepted where the merchant category code matches that of a day care provider. Use of the card in contravention of these terms may constitute fraud upon the Plan and be treated accordingly by the Employer. Payment of an expense with the Debit Card in accordance with the terms of this Paragraph A-1.9 shall be deemed to be, and shall be treated as, a reimbursement to Participant from his Dependent Care Account. Payment of an expense with the Debit Card shall be treated as conditional pending receipt of such documentation as the Claims Administrator may require pursuant to paragraph A-1.10; provided, these documentation requirements shall not apply in the following circumstances unless the ASO subsequently determines under paragraph A-1.10 that payment was improper:

A-1.9(a) If the claim is for reimbursement of a recurring Qualifying Dependent Care Expense that matches expenses previously approved as to amount, provider and time period (for example, a claim by a Participant for a day care provider that he incurs on a regular basis for the same amount), no additional documentation shall be required as a condition of approval of the Debit Card transaction.

A-1.9(b) If a dependent care provider or other independent third party (such as a claims administrator) provides information to verify that the claim is for a Qualifying Dependent Care Expense at the time, no additional documentation shall be required as a condition of approval of the Debit Card transaction.

A-1.10 **Substantiation and Recoupment of Unauthorized Expenses**.

A-1.10(a) If additional information is needed by the ASO to properly verify that the expense is a Qualifying Dependent Care Expense, the ASO will notify that Participant within fifteen (15) days of the initial use of the card for the questioned expense. If the proper verification is not received within fifteen (15) days of the initial notice a second notice will be sent. If verification is not received within eight (8) days of the second notice, reimbursements under Participant's Dependent Care Spending Account shall be suspended from the date of such notice until the date Participant establishes that the payment was proper.

A-1.10(b) In the event an expense paid with a Debit Card is determined not to be a Qualifying Dependent Care Expense or the substantiation is not received as required by subparagraph A-1.10(a), the ASO shall notify Participant that he shall be required to repay the amount of such improper payment. Such notice shall comply with the procedures for denial of a claim under paragraph 9.2. If the Participant fails to repay the amount due within fifteen (15) days of the claim denial, ASO shall offset, up to the amount of the improper payment, against any suspended claims reimbursement requests made by Participant since the date of the Administrator's notice of improper payment. If any amounts remain unpaid, ASO shall, in its discretion, (1) offset any amounts remaining unpaid against future claim reimbursement requests by Participant, and/or (2) direct Participant's Employer to withhold from Participant's Compensation, in accordance with applicable law and the Employer's payroll practices, and remit to the Plan, an amount sufficient to recover any remaining amounts due. If the full amount of the improper payment is not recovered using these methods, then the Employer shall treat the amount due as any other business indebtedness. Any amounts which are recovered by the ASO with respect to a Plan Year no later than 90 days after the end of each Plan Year (or such other deadline as the Employer shall establish for the filing of claims) shall be credited to Participant's Dependent Care Account for such Plan Year.

VIRGINIA BANKERS ASSOCIATION
GROUP FLEXIBLE BENEFITS PLAN

GENERAL HEALTH CARE SPENDING ACCOUNT

Appendix B

B-1.1 **Introduction**. The General Health Care Spending Account is an unfunded welfare plan and flexible spending account. Any amounts deposited into the accounts hereunder shall be maintained as a book account by the Administrator and shall constitute a liability of the Employer. Benefits paid or reimbursed shall be paid out of the general assets of the Employer upon presentation of the approved claim therefor. The amounts paid or reimbursed for Qualifying Medical Expenses incurred by a Participant shall be charged to and withdrawn from his account in the Plan and are intended to be excluded from the Participant's federal gross income as contributions to and benefits under an accident and health plan within the meaning of Sections 105 and 106 of the Code.

B-1.2 **Eligibility for and Termination of Participation**. Each Eligible Employee who elects pursuant to the Plan to participate in the General Health Care Spending Account shall become a Participant in the Health Care Spending Account as of the first day of the payroll period for which the election is effective. Participation in the General Health Care Spending Account shall cease on the earlier of:

(i) The last day of the payroll period in which the Participant ceases to be an Eligible Employee;

(ii) The effective date of the Participant's revocation of his election to participate in the General Health Care Spending Account as permitted under the Plan;

(iii) The last day of the Plan Year unless a new election to participate is filed during the applicable enrollment period for the following Plan Year or, if later and

(A) The Employer elects in Option 5(i)(7) of the Adoption Agreement to apply the grace period, the last day of the Grace Period, or

(B) The Employer elects in Option 5(i)(7) of the Adoption Agreement to permit a Carryover, the date as of which the balance in the Participant's General Health Care Spending Account reaches zero ($0) or

(iv) The effective date of the termination of the General Health Care Spending Account.

B-1.3 **Definitions**. For purposes hereof, the following terms shall have the meanings set forth below:

B-1.3(a) "ASO": The Benefits Corporation or such other entity as may be designated by the Benefits Corporation to perform the functions of the administrative services organization for the General Health Care Spending Account.

B-1.3(b) "Benefit Claim Period": The Plan Year plus the period through March 31, following the end of the Plan Year. Notwithstanding the foregoing, the Benefit Claim Period applicable to a Participant who terminated employment during the Plan Year is ninety (90) days following the date of such termination.

B-1.3(c) "Benefit Credit": The credit amount, if any, selected by the Employer in Option 4(a) of the Adoption Agreement. Such amount shall not exceed one hundred percent (100%) of the amount elected to be

contributed to the General Health Care Spending Account by such Participant for the Plan Year or, if greater, $500.

B-1.3(d) "Carryover" If the Employer elects in Option 5(i)(7) of the Adoption Agreement to permit a Participant's unused balance to be carried over to the subsequent Plan Year, the amount up to $500, remaining in a Participants account at the end of the immediately preceding Plan Year. The ASO shall establish and communicate rules for determining the amount of the Carryover after taking into account reimbursements made for the prior Plan Year during the run-out portion of the Benefit Claim Period occurring through March 31 following the end of the prior Plan Year.

B-1.3(e) "Dependent": The spouse of a Participant and any individual who meets the definition of a dependent under Section 105(b) of the Code with respect to a Participant. Notwithstanding, Dependent shall exclude for this purpose, a Participant's spouse or other dependents who are covered by a high deductible health plan as defined in Section 223(c)(2) of the Code.

B-1.3(f) "Grace Period": If the Employer elects in Option 5(i)(7) of the Adoption Agreement to apply the grace period rules, the 2-1/2 month period following the end of a Plan Year.

B-1.3(g) "General Health Care Spending Account": The book account established by the Administrator on behalf of a Participant consisting of the amount elected to be contributed to the General Health Care Spending Account by such Participant for the Plan Year, plus any Benefit Credit made by the Employer and, if the Employer elects in Option 5(i)(7) of the Adoption Agreement to permit a Carryover, plus the Carryover and then reduced by any benefits previously paid to the Participant with respect to the Plan Year.

B-1.3(h) "Qualifying Medical Expenses": All expenses (to the extent not covered by insurance or for which a Participant is not otherwise compensated) incurred by the Participant for "medical care" (as defined in Section 213 of the Code) of the Participant or any Dependent of the Participant, including, but not limited to all amounts paid for hospital, medical, vision, hearing, mental, drug dependence, dental care and pharmaceutical bills. Expenses for medical care also include deductible and co-insurance amounts paid by the Participant for such medical care. Notwithstanding the foregoing, Qualifying Medical Expenses do not include premiums for other accident or health insurance or long term care services or insurance. Notwithstanding any other provision of the Plan to the contrary, Qualifying Medical Expenses eligible for reimbursement under the Health Care Account shall include expenses for medicines or drugs incurred only if the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin. The Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug subject to this rule and whether the requirement of a prescription has been satisfied.

B-1.4 **Description of Benefits**. The General Health Care Spending Account for a Plan Year shall be used to pay or reimburse the Participant for Qualifying Medical Expenses incurred by the Participant while a Participant during such Plan Year or by a Participant's Dependent, while a Dependent during such Plan Year and, if elected by the Employer in Option 5(i)(7) of the Adoption Agreement, during the Grace Period.

B-1.5 **Participant Contributions**. Each Eligible Employee may elect to contribute any amount from a minimum chosen by the Employer in Option 5(i)(A) of the Adoption Agreement and up to the maximum chosen by the Employer in Option 5(i)(A) of the Adoption Agreement to his account under the General Health Care Spending Account. Changes in the contribution elections by Participants may be made only in accordance with the terms of the Plan.

B-1.6 **Limitations on Participant Contributions**.

B-1.6(a) Notwithstanding the foregoing, the permissible contribution by a Participant for any Plan Year shall not exceed the lesser of the amount described in the Adoption Agreement or the established for such purpose under Section 125 of the Code, as adjusted for inflation. Any Carryover will not count toward the permissible contribution limit.

B-1.6(b) Notwithstanding the foregoing, the Administrator may limit the amount of contributions permitted by highly compensated Participants at any time and from time to time in order to prevent the Plan from being considered discriminatory within the meaning of Section 105(h) of the Code. For purposes hereof, the term "highly compensated Participants" shall mean those persons who are "highly compensated participants" within the meaning of Section 105(h) of the Code.

B-1.7 **Special Carryover Rules**.

B-1.7(a) An Employer must amend its Adoption Agreement to adopt the Carryover provisions and any previous election of the Grace Period must be terminated, prior to the beginning of the Plan Year from which amounts will be carried over. Any Grace Period previously elected will not apply to unused amounts that may be part of the Carryover.

B-1.7(b) Carryover amounts shall not be cashed out or converted to any other taxable or non-taxable benefit.

B.1-7(c) If a Participant elects coverage under a high deductible health plan (within the meaning of Section 223(c)(2) of the Code) for the following Plan Year, any Carryover shall be applied to the account balance in the HSA Compatible Health Care Spending Account, unless the Participant, prior to the beginning of the following Plan Year elects to decline or waive the Carryover.

B-1.8 **Forfeiture of Unused Benefits**.

B-1.8(a) Forfeitures shall be used to offset future contributions and payments due from the Employer under the General Health Care Spending Account and, in the event of termination of the General Health Care Spending Account, any such forfeitures shall revert to the Employer unless otherwise provided by the Employer.

B-1.8(b) If the Employer elects in Option 5(i)(7) of the Adoption Agreement to apply the grace period rules, any amounts remaining in a Participant's account for a Plan Year at the end of the Grace Period with respect to such Plan Year shall be forfeited.

B-1.8(c) If the Employer elects in Option 5(i)(7) of the Adoption Agreement, any amounts remaining in a Participant's account for a Plan Year at the end of the Benefit Claim Period with respect to such Plan Year in excess of $500 shall be forfeited.

B-1.9 **Procedure for Filing Claims**. Participants may, during the Benefit Claim Period, request reimbursement of Qualifying Medical Expenses. Such request shall contain the information required by the ASO to substantiate the claim including, but not limited to a third party, written statement setting forth the amount and purpose of the expenditure and the Participant and, if applicable, the Dependent to whom the expenditure relates. The request must also state the date the expense was incurred and if incurred during the Grace Period, the request must designate the General Health Care Spending Account for which Plan Year the Participant wishes the reimbursement to be made from, in the event that there is an unused balance from the immediately preceding Plan Year. Except in the case of any claim filed during the last month of the Plan Year and during the Benefit Claim Period that extends beyond the end of the Plan Year, such claim, together with any claims filed under the other flexible spending accounts, must be for a minimum of five dollars ($5.00).

B-1.10 **Debit Card**.

B-1.10(a) A Debit Card shall be issued upon the request of a Participant who elects to participate in the General Health Care Spending Account and who agrees to comply with all of the terms and conditions of use of the Debit Card. Without limitation, the Participant must certify at the time of enrollment and with each use of the Debit Card that he will use the card only for Qualifying Medical Expenses, that the expense paid with the card has not been reimbursed, and that he will not seek reimbursement from any other plan covering health benefits.

B-1.10(b) Use of the Debit Card for Qualifying Medical Expenses will be accepted when the merchant category code matches that of a health care related merchant code, except that the merchant category code of Drug Stores and Pharmacies will not be accepted unless (A) the store vendor or merchant has implemented an inventory information approval system as described in IRS Notice 2006-69 or (B) on a store location by location basis, 90% of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care under Section 213(d) of the Code (including non-prescription medication described in Rev. Rul. 2003-102).

B-1.10(c) Use of the card in contravention of these terms may constitute fraud upon the Plan and be treated accordingly by the Employer. Notwithstanding the provisions of paragraph B-1.9, payment of an expense with the Debit Card in accordance with the terms of this paragraph B-1.10 shall be deemed to be, and shall be treated as, a reimbursement to Participant from his General Health Care Spending Account. Payment of an expense with the Debit Card shall be treated as conditional pending receipt of such documentation as the Claims Administrator may require pursuant to paragraph B-1.11; provided, these documentation requirements shall not apply in the following circumstances unless the Claims Administrator subsequently determines under paragraph B-1.11 that payment was improper:

(i) If the dollar amount of a transaction at a medical care provider or qualifying pharmacy equals the dollar amount of the copayment for that service or product under the Health Benefit Plan benefit option elected by the Participant, no additional documentation shall be required as a condition of approval of the Debit Card transaction.

(ii) If the Claim is for reimbursement of a recurring Qualified Medical Expense that matches expenses previously approved as to amount, medical care provider or qualifying pharmacy and time period (for example, a Claim by a Participant for a prescription drug that he has refilled on a regular basis at the same provider for the same amount), no additional documentation shall be required as a condition of approval of the Debit Card transaction.

(iii) If medical care provider, qualifying pharmacy or merchant using an inventory information approval system provides information to verify that the Claim is for a Qualified Medical Expense at the time and point of sale, no additional documentation shall be required as a condition of approval of the Debit Card transaction.

B-1.11 **Substantiation and Recoupment of Unauthorized Expenses**.

B-1.11(a) If additional information is needed by the ASO to properly verify that the expense is a Qualifying Medical Expense, the ASO will notify that Participant within fifteen (15) days of the initial use of the card for the questioned expense. If the proper verification is not received within fifteen (15) days of the initial notice a second notice will be sent. If verification is not received within eight (8) days of the second notice, reimbursements under Participant's Health Care Spending Account shall be suspended from the date of such notice until the date Participant establishes that the payment was proper.

B-1.11(b) In the event an expense whether or not paid with a Debit Card is determined not to be a Qualifying Medical Expense or the substantiation is not received as required by subparagraph B-1.11(a), the ASO shall notify Participant that he shall be required to repay the amount of such improper payment. Such notice shall comply with the procedures for denial of a claim under paragraph 6.2. If the Participant fails to repay the amount due within fifteen (15) days of the claim denial, ASO shall offset, up to the amount of the improper payment, against any suspended claims reimbursement requests made by Participant since the date of the Administrator's notice of improper payment. If any amounts remain unpaid, ASO shall, in its discretion, (1) offset any amounts remaining unpaid against future claim reimbursement requests by Participant, and/or (2) direct Participant's Employer to withhold from Participant's compensation, in accordance with applicable law and the Employer's payroll practices, and remit to the Plan, an amount sufficient to recover any remaining amounts due. If the full amount of the improper payment is not recovered using these methods, then the Employer shall treat the amount due as any other business indebtedness. Any amounts which are recovered by the ASO with respect to a Plan Year no later than 90 days after the end of each Plan Year (or such other deadline as the Employer shall establish for the filing of claims) shall be credited to Participant's General Health Care Spending Account for such Plan Year.

B-1.12 **Termination of Participation; COBRA**. A Participant's participation in the General Health Care Spending Account shall end as of the earliest date described in paragraph B-1.2 and medical expenses incurred after such date shall not be eligible for reimbursement; provided, the General Health Care Spending Account shall be administered in accordance with the requirements of the Consolidated Omnibus Reconciliation Act of 1985, as amended, and the regulations thereunder (COBRA). If a Participant or his covered Dependent loses eligibility to participate in the General Health Care Spending Account during a Plan Year and he is eligible for COBRA continuation coverage, he shall be eligible to elect continuation coverage under COBRA and continue making contributions to his General Health Care Spending Account on an after-tax basis in the same amount as his then-current salary reduction agreement, plus a two percent administrative fee. In this case, his Qualified Medical Expenses shall be eligible for reimbursement (subject to the terms of the General Health Care Spending Account) if incurred on or before the earlier of (i) the last day of the Plan Year plus, if elected by the Employer in Option 7(a) of the Amendment to the Adoption Agreement, the Grace Period, or (ii) the last day for which the Participant makes his COBRA contributions.

VIRGINIA BANKERS ASSOCIATION
GROUP FLEXIBLE BENEFITS PLAN

HSA COMPATIBLE HEALTH CARE SPENDING ACCOUNT

Appendix C

C-1.1 **Introduction**. The HSA Compatible Health Care Spending Account is an unfunded welfare plan and flexible spending account. Any amounts deposited into the accounts hereunder shall be maintained as a book account by the Administrator and shall constitute a liability of the Employer. Benefits paid or reimbursed shall be paid out of the general assets of the Employer upon presentation of the approved claim therefor. The amounts paid or reimbursed for Qualifying Medical Expenses incurred by a Participant shall be charged to and withdrawn from his account in the Plan and are intended to be excluded from the Participant's federal gross income as contributions to and benefits under an accident and health plan within the meaning of Sections 105 and 106 of the Code.

C-1.2 **Eligibility for and Termination of Participation**. Each Eligible Employee who elects pursuant to the Plan to participate in the HSA Compatible Health Care Spending Account shall become a Participant in the HSA Compatible Health Care Spending Account as of the first day of the payroll period for which the election is effective. Participation in the HSA Compatible Health Care Spending Account shall cease on the earlier of:

(i) The last day of the payroll period in which the Participant ceases to be an Eligible Employee;

(ii) The effective date of the Participant's revocation of his election to participate in the HSA Compatible Health Care Spending Account as permitted under the Plan;

(iii) The last day of the Plan Year unless a new election to participate is filed during the applicable enrollment period for the following Plan Year or, if later and

(A) The Employer elects in Option 5(i)(7) of the Adoption Agreement to apply the grace period, the last day of the Grace Period, or

(B) The Employer elects in Option 5(i)(7) of the Adoption Agreement to permit a Carryover, the date as of which the balance in the Participant’s Health Care Spending Account reaches zero ($0) or

(iv) The effective date of the termination of the HSA Compatible Health Care Spending Account.

C-1.3 **Definitions**. For purposes hereof, the following terms shall have the meanings set forth below:

C-1.3(a) “ASO”: The Benefits Corporation or such other entity as may be designated by the Benefits Corporation to perform the functions of the administrative services organization for the HSA Compatible Health Care Spending Account.

C-1.3(b) "Benefit Claim Period": The Plan Year plus the period through March 31, following the end of the Plan Year. Notwithstanding the foregoing, the Benefit Claim Period applicable to a Participant who terminated employment during the Plan Year is ninety (90) days following the date of such termination.

C-1.3(c) “Benefit Credit”: The credit amount, if any, selected by the Employer in Option 4(a) of the Adoption Agreement. Such amount shall not exceed one hundred percent (100%) of the amount elected to be contributed to the HSA Compatible Health Care Spending Account by such Participant for the Plan Year or, if greater, $500.

C-1.3(d) “Carryover” If the Employer elects in Option 5(i)(7) of the Adoption Agreement to permit a Participant’s unused balance to be carried over to the subsequent Plan Year, the amount up to $500, remaining in a Participants account at the end of the immediately preceding Plan Year. The ASO shall establish and communicate rules for determining the amount of the Carryover after taking into account reimbursements made for the prior Plan Year during the run-out portion of the Benefit Claim Period occurring through March 31 following the end of the prior Plan Year.

C-1.3(e) “Dependent”: The spouse of a Participant and any individual who meets the definition of a dependent under Section 105(b) of the Code with respect to a Participant.

C-1.3(f) “Grace Period”: If the Employer elects in Option 5(i)(7) of the Adoption Agreement to apply the grace period rules, the 2-1/2 month period following the end of a Plan Year.

C-1.3(g) “HSA Compatible Health Care Spending Account”: The book account established by the Administrator on behalf of a Participant consisting of the amount elected to be contributed to the HSA Compatible Health Care Spending Account by such Participant for the Plan Year, plus any Benefit Credit made by the Employer and, if the Employer elects in Option 5(i)(7) of the Adoption Agreement to permit a Carryover, plus the Carryover and then reduced by any benefits previously paid to the Participant with respect to the Plan Year.

C-1.3(h) "Qualifying Medical Expenses": All expenses (to the extent not covered by insurance or for which a Participant is not otherwise compensated) incurred by the Participant during the Plan Year and, if elected by the Employer in Option 5(i)(7) of the Adoption Agreement, during the Grace Period, and in the case of a Dependent, while a Dependent, for the following expenses:

(i) "preventive care" (as described in Section 223(c)(2)(C) of the Code and the regulations thereto) of the Participant or any

(ii) "permitted coverage" but not through insurance or for long-term care services) (as described in Section 223(c)(1)(B) of the Code and the regulations thereto) of the Participant; or

(iii) "medical care" (as described in Section 213 of the Code) of the Participant or any Dependent, but only to the extent such medical care is incurred after the annual deductible of the high deductible group health plan has been satisfied, including but not limited to the amounts paid for hospital, medical, vision, hearing, mental, drug dependence, dental care, pharmaceutical bills, and co-insurance amounts paid by the Participant for such medical care under the high deductible group health plan.

Notwithstanding the foregoing, Qualifying Medical Expenses do not include premiums for other accident or health insurance. Notwithstanding any other provision of the Plan to the contrary, Qualifying Medical Expenses otherwise eligible for reimbursement under the HSA Compatible Health Care Spending Account shall include expenses for medicines or drugs only if the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin. The Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug subject to this rule and whether the requirement of a prescription has been satisfied.

C-1.4 **Description of Benefits**. The HSA Compatible Health Care Spending Account for a Plan Year shall be used to pay or reimburse the Participant for Qualifying Medical Expenses incurred by the Participant while a Participant during such Plan Year or by a Participant's Dependent, while a Dependent during such Plan Year and, if elected by the Employer in Option 5(i)(7) of the Adoption Agreement, during the Grace Period.

C-1.5 **Participant Contributions**. . Each Eligible Employee may elect to contribute any amount from a minimum chosen by the Employer in Option 5(i)(B) of the Adoption Agreement and up to the maximum chosen by the Employer in Option 5(i)(B) of the Adoption Agreement to his account under the HSA Compatible Health Care Spending Account. Changes in the contribution elections by Participants may be made only in accordance with the terms of the Plan.

C-1.6 **Limitations on Participant Contributions**.

C-1.6(a) Notwithstanding the foregoing, the permissible contribution by a Participant for any Plan Year shall not exceed the lesser of the amount described in the Adoption Agreement or the established for such purpose under Section 125 of the Code, as adjusted for inflation. Any Carryover will not count toward the permissible contribution limit.

C-1.6(b) Notwithstanding the foregoing, the Administrator may limit the amount of contributions permitted by highly compensated Participants at any time and from time to time in order to prevent the Plan from being considered discriminatory within the meaning of Section 105(h) of the Code. For purposes hereof, the term "highly compensated Participants" shall mean those persons who are "highly compensated participants" within the meaning of Section 105(h) of the Code.

C-1.7 **Special Carryover Rules**.

C-1.7(a) An Employer must amend its Adoption Agreement to adopt the Carryover provisions and any previous election of the Grace Period must be terminated, prior to the beginning of the Plan Year from which amounts will be carried over. Any Grace Period previously elected will not apply to unused amounts that may be part of the Carryover.

C-1.7(b) Carryover amounts shall not be cashed out or converted to any other taxable or non-taxable benefit.

C.1-7(c) If a Participant elects coverage under a high deductible health plan (within the meaning of Section 223(c)(2) of the Code) for the following Plan Year, any Carryover from the General Health Care Spending Account shall be applied to the account balance in the HSA Compatible Health Care Spending Account, unless the Participant, prior to the beginning of the following Plan Year elects to decline or waive the Carryover.

C-1.8 **Forfeiture of Unused Benefits**.

C-1.8(a) Forfeitures shall be used to offset future contributions and payments due from the Employer under the HSA Compatible Health Care Spending Account and, in the event of termination of the HSA Compatible Health Care Spending Account, any such forfeitures shall revert to the Employer unless otherwise provided by the Employer.

C-1.8(b) If the Employer elects in Option 5(i)(7) of the Adoption Agreement to apply the grace period rules, any amounts remaining in a Participant's account for a Plan Year at the end of the Grace Period with respect to such Plan Year shall be forfeited.

C-1.8(c) If the Employer elects in Option 5(i)(7) of the Adoption Agreement, any amounts remaining in a Participant's account for a Plan Year at the end of the Benefit Claim Period with respect to such Plan Year in excess of $500 shall be forfeited.

C-1.9 **Procedure for Filing Claims**. Participants may, during the Benefit Claim Period, request reimbursement of Qualifying Medical Expenses. Such request shall contain the information required by the ASO to substantiate the claim including, but not limited to a third party, written statement setting forth the amount and purpose of the expenditure and the Participant and, if applicable, the Dependent to whom the expenditure relates. The request must also state the date the expense was incurred and if incurred during the Grace Period, the request must designate the HSA Compatible Health Care Spending Account for which Plan Year the Participant wishes the reimbursement to be made from, in the event that there is an unused balance from the immediately preceding Plan Year. Except in the case of any claim filed during the last month of the Plan Year and during the Benefit Claim Period that extends beyond the end of the Plan Year, such claim, together with any claims filed under the other flexible spending accounts, must be for a minimum of five dollars ($5.00).

C-1.10 **Debit Card**.

C-1.10(a) A Debit Card shall be issued upon the request of a Participant who elects to participate in the HSA Compatible Health Care Spending Account and who agrees to comply with all of the terms and conditions of use of the Debit Card. Without limitation, the Participant must certify at the time of enrollment and with each use of the Debit Card that he will use the card only for Qualifying Medical Expenses, that the expense paid with the card has not been reimbursed, and that he will not seek reimbursement from any other plan covering health benefits.

C-1.10(b) Use of the Debit Card for Qualifying Medical Expenses will be accepted when the merchant category code matches that of a health care related merchant code, except that the merchant category code of Drug Stores and Pharmacies will not be accepted unless (A) the store vendor or merchant has implemented an inventory information approval system as described in IRS Notice 2006-69 or (B) on a store location by location basis, 90% of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care under Section 213(d) of the Code (including non-prescription medication described in Rev. Rul. 2003-102).

C-1.10(c) Use of the card in contravention of these terms may constitute fraud upon the Plan and be treated accordingly by the Employer. Notwithstanding the provisions of paragraph C-1.9, payment of an expense with the Debit Card in accordance with the terms of this paragraph C-1.10 shall be deemed to be, and shall be treated as, a reimbursement to Participant from his HSA Compatible Health Care Spending Account. Payment of an expense with the Debit Card shall be treated as conditional pending receipt of such documentation as the Claims Administrator may require pursuant to paragraph C-1.11; provided, these documentation requirements shall not apply in the following circumstances unless the Claims Administrator subsequently determines under paragraph C-1.11 that payment was improper:

(i) If the dollar amount of a transaction at a medical care provider or qualifying pharmacy equals the dollar amount of the copayment for that service or product under the Health Benefit Plan benefit option elected by the Participant, no additional documentation shall be required as a condition of approval of the Debit Card transaction.

(ii) If the Claim is for reimbursement of a recurring Qualified Medical Expense that matches expenses previously approved as to amount, medical care provider or qualifying pharmacy and time period (for example, a Claim by a Participant for a prescription drug that he has refilled on a regular basis at the same provider for the same amount), no additional documentation shall be required as a condition of approval of the Debit Card transaction.

(iii) If medical care provider, qualifying pharmacy or merchant using an inventory information approval system provides information to verify that the Claim is for a Qualified Medical Expense at the time and point of sale, no additional documentation shall be required as a condition of approval of the Debit Card transaction.

C-1.11 **Substantiation and Recoupment of Unauthorized Expenses**.

C-1.11(a) If additional information is needed by the ASO to properly verify that the expense is a Qualifying Medical Expense, the ASO will notify that Participant within fifteen (15) days of the initial use of the card for the questioned expense. If the proper verification is not received within fifteen (15) days of the initial notice a second notice will be sent. If verification is not received within eight (8) days of the second notice, reimbursements under Participant's HSA Compatible Health Care Spending Account shall be suspended from the date of such notice until the date Participant establishes that the payment was proper.

C-1.11(b) In the event an expense paid with a Debit Card is determined not to be a Qualifying Medical Expense or the substantiation is not received as required by subparagraph C-1.11(a), the ASO shall notify Participant that he shall be required to repay the amount of such improper payment. Such notice shall comply with the procedures for denial of a claim under paragraph 6.2. If the Participant fails to repay the amount due within fifteen (15) days of the claim denial, ASO shall offset, up to the amount of the improper payment, against any suspended claims reimbursement requests made by Participant since the date of the Administrator's notice of improper payment. If any amounts remain unpaid, ASO shall, in its discretion, (1) offset any amounts remaining unpaid against future claim reimbursement requests by Participant, and/or (2) direct Participant's Employer to withhold from Participant's Compensation, in accordance with applicable law and the Employer's payroll practices, and remit to the Plan, an amount sufficient to recover any remaining amounts due. If the full amount of the improper payment is not recovered using these methods, then the Employer shall treat the amount due as any other business indebtedness. Any amounts which are recovered by the ASO with respect to a Plan Year no later than 90 days after the end of each Plan Year (or such other deadline as the Employer shall establish for the filing of claims) shall be credited to Participant's HSA Compatible Health Care Account for such Plan Year.

C-1.12 **Termination of Participation; COBRA**. A Participant's participation in the HSA Compatible Health Care Spending Account shall end as of the earliest date described in paragraph C-1.2 and medical expenses incurred after such date shall not be eligible for reimbursement; provided, the Health Care Account shall be administered in accordance with the requirements of the Consolidated Omnibus Reconciliation Act of 1985, as amended, and the regulations thereunder (COBRA). If a Participant or his covered Dependent loses eligibility to participate in the HSA Compatible Health Care Spending Account during a Plan Year and he is eligible for COBRA continuation coverage, he shall be eligible to elect continuation coverage under COBRA and continue making contributions to his HSA Compatible Health Care Spending Account on an after-tax basis in the same amount as his then-current salary reduction agreement, plus a two percent administrative fee. In this case, his Qualified Medical Expenses shall be eligible for reimbursement (subject to the terms of the HSA Compatible Health Care Spending Account) if incurred on or before the earlier of (i) the last day of the Plan Year plus, if elected by the Employer in Option 5(i)(7) of the Amendment to the Adoption Agreement, the Grace Period, or (ii) the last day for which the Participant makes his COBRA contributions.