Proposer Information

Name of Company: T.E.B. Benefits Group Inc

Address: 702 Wyoming Ave

City and State El Paso, Texas 79902

Phone: 888.687.9887

Email Address: marc@teb-inc.com

Signature of Person Authorized to Sign:

Signature

Marc Hernandez

Print Name

President

Title

Indicate status as to “Partnership”, “Corporation”, “Land Owner”, etc.

Corporation

Founded 2005 State of Texas

(Date)

The enclosed offer(s) in response to this RFP is firm for a period of 60 calendar days.

Note:
All submissions relative to these RFP shall become the property of Webb County and are nonreturnable.

If any further information is required, please call the Webb County Contract Administrator, Juan Guerrero, at (956)523-4125.

THIS FORM MUST BE INCLUDED WITH RFP PACKAGE; PLEASE CHECK OFF EACH ITEM INCLUDED WITH RFP PACKAGE AND SIGN BELOW TO COMFIRM SUBMITTAL AND/OR CONFIRMATION OF ACCESS TO ALL DOCUMENTS LISTED FOR EACH REQUIRED ITEM LISTED BELOW.

RFP 2021-004
"Webb County Section 125 Plan Administration and Online Enrollment System"

☒ Proposer Information

☒TPA Questionnaire

☒Conflict of Interest form (Form CIQ)

☒Certification regarding Debarment (Form H2048)

☒Certification regarding Federal lobbying (Form 2049)

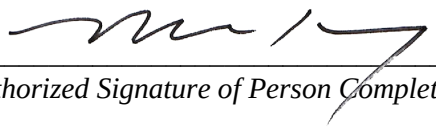
☒Code of Ethics Affidavit

☒Proof of No Delinquent Tax Owed to Webb County

☒Certificate of Liability Insurance

☒Comments Regarding Each Service Requested

☒Use and Disclosure Agreement



Authorized Signature of Person Completing this Package

6-1-2021
Date

T.E.B. BENEFITS GROUP, INC.

401 Congress Avenue, Suite 1540
Austin, Texas 78701
702 Wyoming Avenue
El Paso, Texas 79902

Phone: 855.687.9887
info@teb-inc.com
www.teb-inc.com

June 1, 2021

Webb County, Texas
Purchasing Department
Laredo, Texas 78040

Re: RFP Number 2021-004

TEB Benefits Group Inc. (TEB) is pleased to present our response to your RFP # 2021-004. We are providing Webb County an innovative solution for your benefits management and administration. In addition we will aid the County through the implementation process and will provide exceptional customer service with a wealth of industry knowledge.

Although we have responded to the proposal as requested, we would like to highlight some of the key areas that we feel differentiate us from our competitors.

Benefits Team and Resources

As the County looks for a long-term partner to complement strategic initiatives, we are well suited and ready to facilitate the transition and be an ongoing strategic thinker and resource top achieve short and long-term goals. In order to do this, TEB will provide the County with the following:

Dedicated Account Manager: We understand the efforts involved with making changes to benefit platforms, service providers, and daily maintenance. As a result, TEB will provide the County with a dedicated account manager to support the innovative and new change to T.E.B. Personal attention to the district and its employees strengthens the overall understanding and usage of services available.

Instantaneous Accessibility: In today's benefit administration world, accessing accurate information quickly is a necessity. TEB's technologically advanced systems provide exactly that. Billing reconciliation systems generates customizable reports and records to eliminate redundancy and overwhelming paperwork. Accuracy and timeliness are key elements adhered to by our services to ensure proper accounting and eligibility techniques are maintained. Discrepancies, errors, or missing information are easily identified and corrected by our stanch systems. Electronic data mapping capabilities provide the download of data to specific formats for communication with benefits department, payroll, and vendor systems as needed.

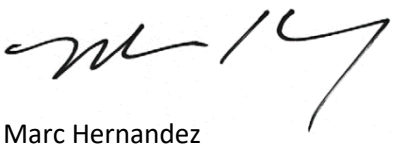
Benefit Enrollment & Administration System & Section 125 Administration

Our proposal puts forward our benefit enrollment & administration system. With this state of the art system employees enroll for all their benefits on-line 24/7 during their open enrollment period. Employees will have ongoing access to view and manage their benefits throughout the year via the employee portal.

Administration staff will be able to manage the benefits portfolio with accuracy and proficiency by eliminating the time-consuming process of billing and reconciliation. Furthermore IT will no longer have to upload files to carriers either weekly or monthly our EDI capability automatically takes care of this task.

In Addition, with out TPA partner NBS your employees and administrators won't be dealing with multiple systems to manage their benefits, ONE SYSTEM ALL ACCESS. No need to upload and download files to different vendors.

As you will see, we are excited about the opportunity we have with Webb County. We are committed to this relationship and trust our proposal reflects the motivation, dedication, expertise, and cost saving results we will provide the County. TEB will ensure the County, their employees, and family members will receive the highest level of service and the best care in the industry. As always, we would appreciate the opportunity to meet to discuss the added value we can bring. If you have any questions or concerns, please do not hesitate to contact me directly at 915-276-6759.



Marc Hernandez
President, T.EB. Benefits Group Inc.

T.E.B. Benefits Group Inc

Solving the benefits and HR puzzle

Benefits Enrollment & Administration

PROPOSAL

Webb County

June 1, 2021

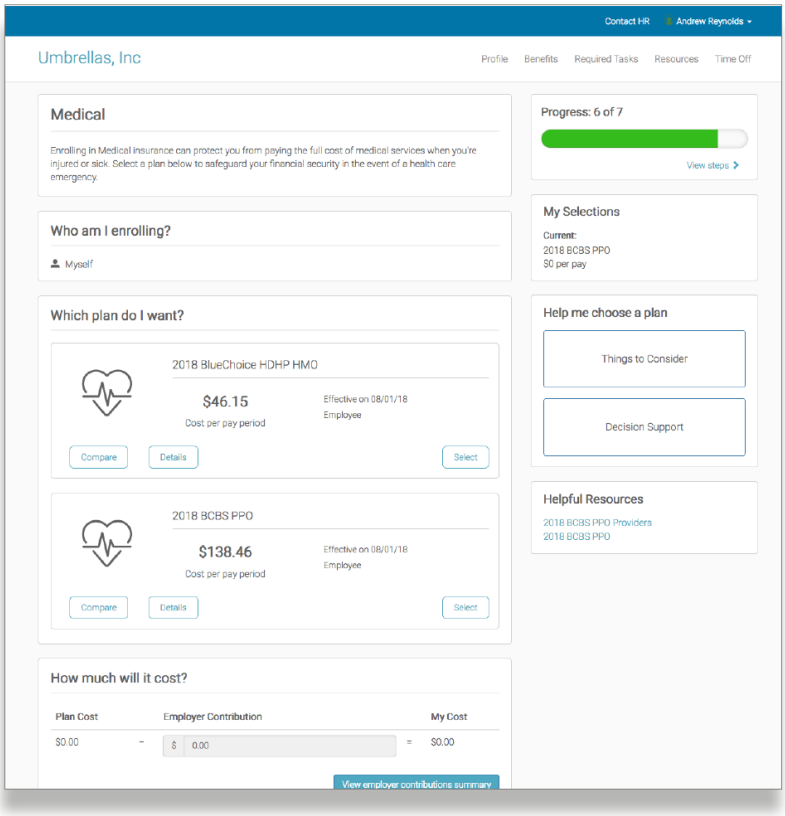
State-of-The-Art Technology with a Personal Touch

OUR PRODUCTS

Benefits Enrollment & Administration System

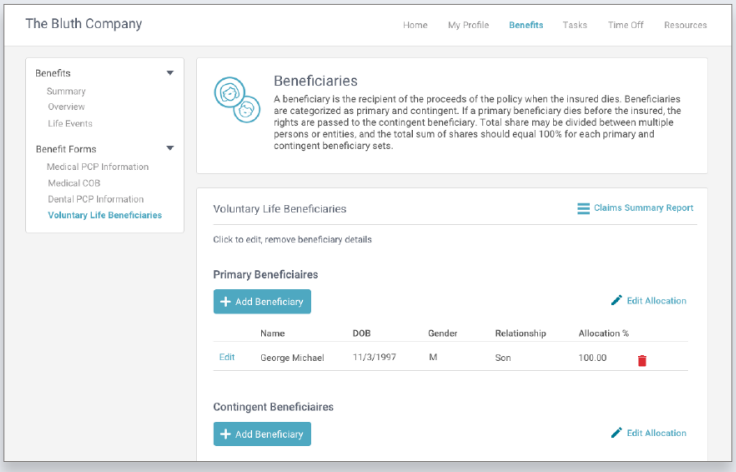
All-in-One Benefits Solution

- Get new hires quickly enrolled
- Compare & select plans
- Review eligibility for all employees
- Monitor employee enrollment status & deadlines
- Manage contribution levels
- Store, review, and acknowledge important plan documents
- Customizable reporting capabilities



The T.E.B. Difference……
Our system FULLY integrates with most major insurance providers.

FULL INTEGRATION means real-time data exchange between our system and the carrier. No need for file transfers.



Simplify Benefits Administration

Easy to manage
Enroll, renew, & manage your employee benefits online

No tricks up our sleeve
Simple HR & employee self-service portals

Always open
Review benefits and plan details 24 hours a day, 7 days a week, 365 days a year

Reports, Reports, Reports

Everyone hates reports but without them we can't efficiently run a benefits program

- Hundreds of report options available at your fingertips both Ad-Hoc and pre-set options.
- Self-customizable to fit every individual administrator or carriers needs
- Automatic run option where the system runs it at your specified time and sends it to your tasks page
- Various formats: excel, txt, pdf, doc, csv, or our team will create one based on your needs.

Home Employees Reports Wall ACA PTO Tasks Benefits Payroll Documents Settings

Reports

Ad Hoc Reports

Row-Based Report
Column-Based Report
Payroll Deductions Report
Voluntary and Group Life Report
HSA Report
Cafeteria Report
Retirement Report

Saved Reports

View/Manage Saved Reports

Favorites

-- No favorites selected --

General Reports

New Hire
Certifications
Education
Licenses
Emergency Contacts
Beneficiaries
Dependents
Termination
Employment Eligibility Verification (I-9) Report

Enrollment Status Reports

New Hire Enrollment Reports
- Can't Start
- Not Started
- In Process
- Completed

Newly Eligible Enrollment Reports
- Can't Start
- Not Started
- In Process
- Completed

Incomplete Supplemental Information
Incomplete New Hire

Open Enrollment Reports

Open Enrollment Reports
- Can't Start
- Not Started
- In Process
- Completed

Declined Enrollments
Open Enrollment Changes
Open Enrollment Changed Elections

Import Reports

Employees Missing HR Tracking Data
Dependents Missing HR Tracking Data
Employees Missing Eligibility Rules Data

Payroll

Federal Withholding (W-4) Report

Benefit Reports

Carrier Billing Summary
Carrier Billing Employees By Plan
Carrier Billing Employees With Rates and Groups
Employee Enrollment Forms
Benefit Confirmation Statements
Total Compensation Statements
Fringe Benefit Statements
COBRA Summary
COBRA Detail
Disability Tax Options
Surcharge Adjustments
Declined Enrollments
W-2 Summary
CARES Act

Change History Reports

Enrollment Changes
Payroll Deductions Changes
Benefit Exception Overrides
Cost Exception Overrides
Demographic Changes
Event Reports
Voluntary Life Events

Carrier Reports

Self Bill Summary Report
Carrier Updates Detail Report
Bill Reconciliation
Primary Care Physicians
Coordination Of Benefits
Self Funded Enrollment Report

Audit Reports

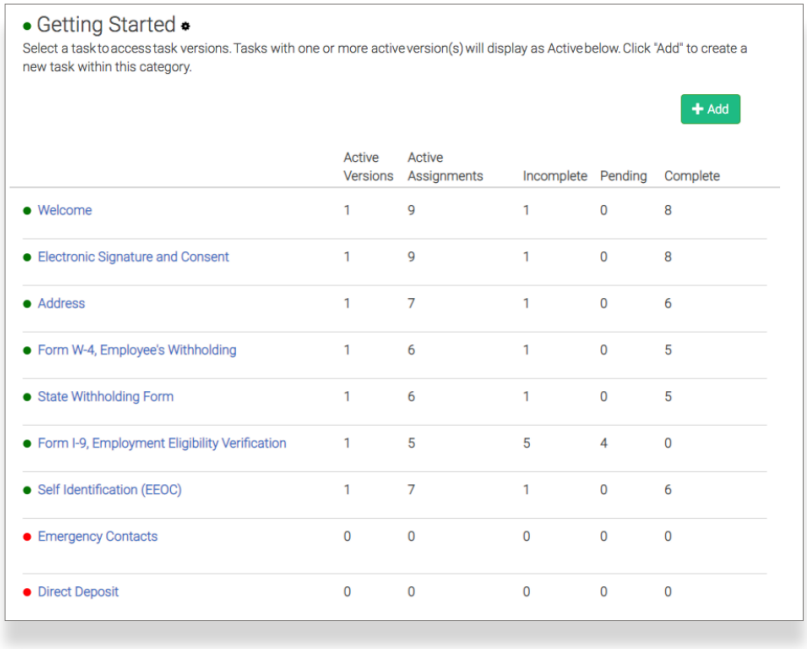
Medicare D Notification
Enrolled But Ineligible
Enrolled But Terminated
Dependents Enrolled Over Age
Dependents on Vol Life With No Employee Coverage
Scheduled Salary Changes
Scheduled Demographic Changes
Bad Export Data

New Hire Onboarding

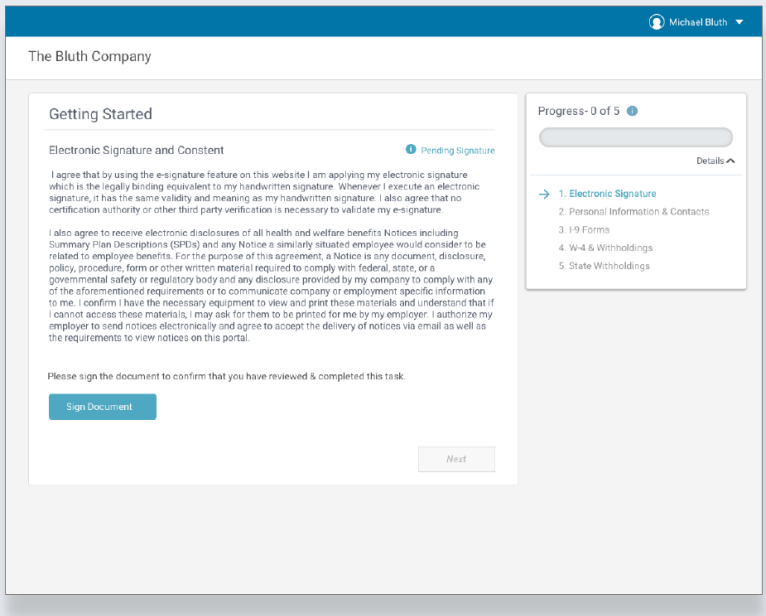
Give new hires an awesome first day, not a stack of paperwork

Superior Task Management

- Intuitive self-service tool
- Customizable for every business
- Comprehensive audit trail
- Simple to set-up and manage



	Active Versions	Active Assignments	Incomplete	Pending	Complete
Welcome	1	9	1	0	8
Electronic Signature and Consent	1	9	1	0	8
Address	1	7	1	0	6
Form W-4, Employee's Withholding	1	6	1	0	5
State Withholding Form	1	6	1	0	5
Form I-9, Employment Eligibility Verification	1	5	5	4	0
Self Identification (EEOC)	1	7	1	0	6
Emergency Contacts	0	0	0	0	0
Direct Deposit	0	0	0	0	0



Put Onboarding on Auto-Pilot

Easily complete new hire forms
We made completing new hire forms painless for employees & HR.

Compliance simplified
There's no shortage of policies that employees need to sign off on; our digital file cabinet makes tracking them a walk in the park.

Safety & training modernized
Modernize training, improve worksite safety & reduce workers comp costs.

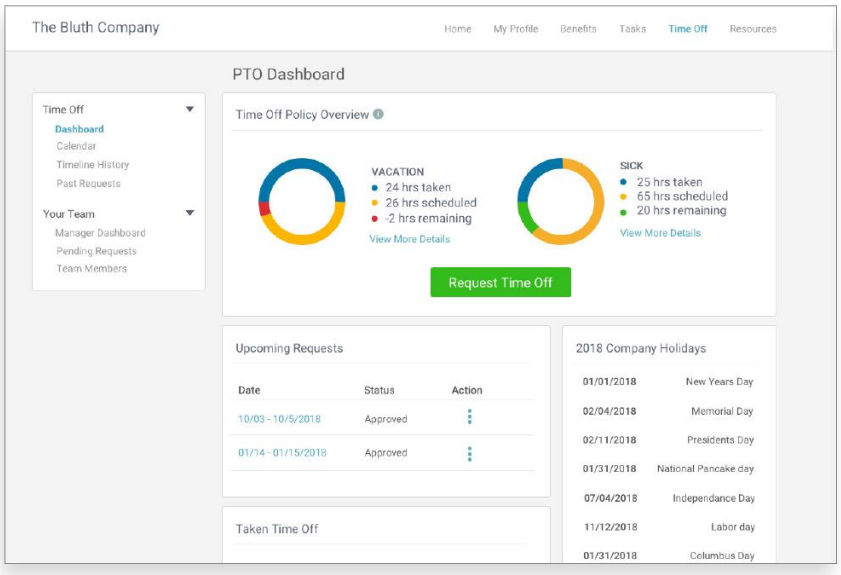
Paperless benefit elections
Don't stop with new hire forms. Benefit tasks can also be seamlessly managed online.

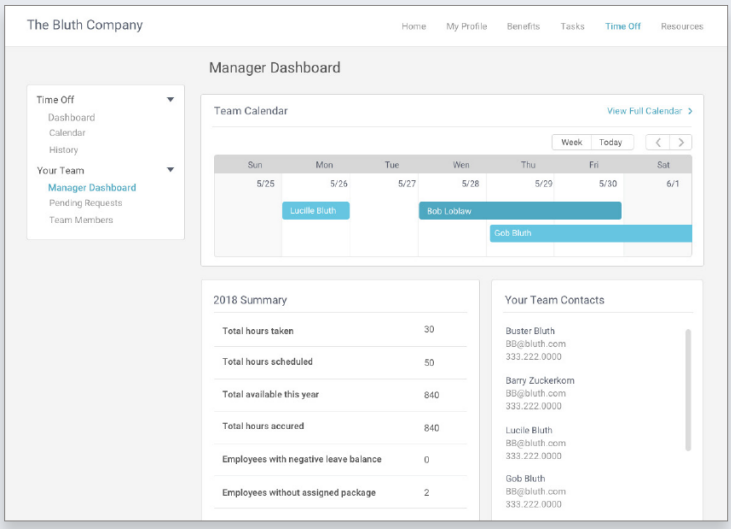
Time Off Tracking

Request, review, and approve PTO without breaking a sweat

Employee self-service

- Request time off in seconds
- View available PTO & time off history
- View pending time off requests
- Track all your company holidays
- Real-time insights





Build the perfect PTO policy

- HR & manager approvals & permissions
- Approve requested PTO in a few easy clicks
- Customize company policies
- Configure company holidays
- Ensure accurate accruals
- Review your team's time off history

ACA Compliance and Reporting

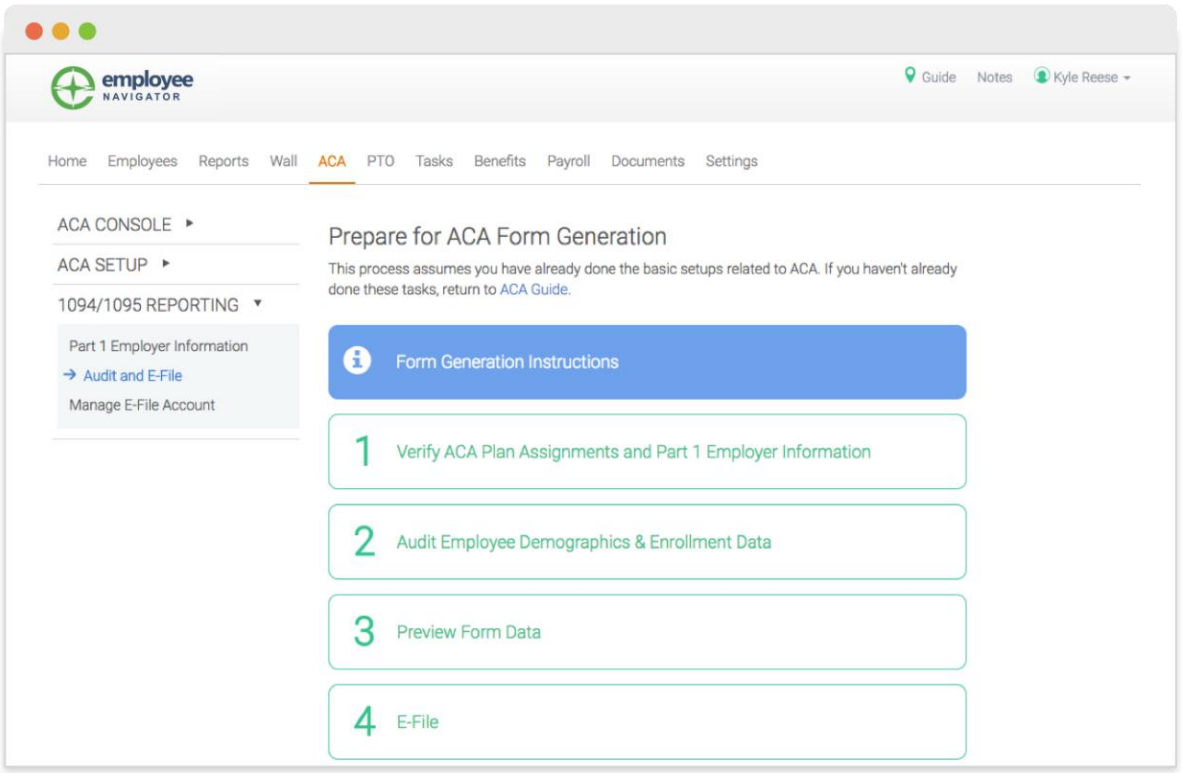
1094 & 1095 forms with a simple click.

Eligibility Tracking for Hourly Employees

- Set-up stability and administrative Periods
- Easily track hours during measurement periods
- Quickly identify eligible employees
- Simple import of hours

Tools for 1094/1095 reporting

- Track and categorize employees
- Import health plan data
- Calculate affordability & monthly FTE
- Generate and send 1094C & 1095C reports



OFFERING

Full pre-transmission audit
We guide and navigate the process step-by-step
ALE & Affordability calculators
Eligibility reports
Simple management for variable hour employees

Integrated Section 125 Plan

Full Section 125 Integration feature.

Compliance is hard we help make it easier.

- Automate communication with participants
- Eliminate error prone multi-system tracking
- One system no file transfers or feeds
-

Employee 24/7 access to all Benefits and Section 125 balances and claims.

Section 125 Services are administered by our TPA partnership with National Benefit Services (NBS). System integration centralizes administration to one single fully automated platform.

Safe and Secure

T.E.B utilizes the top of the line most advance Employee Navigator platform so you know your data is secure

Personnel Security

Employee Navigator follows a strict, formalized hiring practice verifying all potential new employees are qualified for the responsibilities of their job function. Employee Navigator conducts background checks, via a third-party vendor, on all new employees.

Information Security Managment

Employee Navigator has a Director of IT Security dedicated to protecting and monitoring the security posture of Employee Navigator. The Director of IT Security works in concert with the CEO and CTO to ensure controls are in place and operating effectively.

Access Management

Access to any and all Employee Navigator resources is tightly controlled and users are only granted access based on minimum level of access required to perform their role. All Vendors, Partners, Brokers, and Employee Navigator employees are required to utilize two-factor authentication when accessing the systems. Physical access to the data center and Employee Navigator infrastructure is expressly prohibited.

System Backup and Recovery

Storage management hardware and software are utilized to schedule and perform disk to disk on-site backups for Employee Navigator, data replication between datacenters daily, and a high availability (HA) client database cluster for continuous uptime.

Audit reports and evaluations are available upon request

Proposal Cost

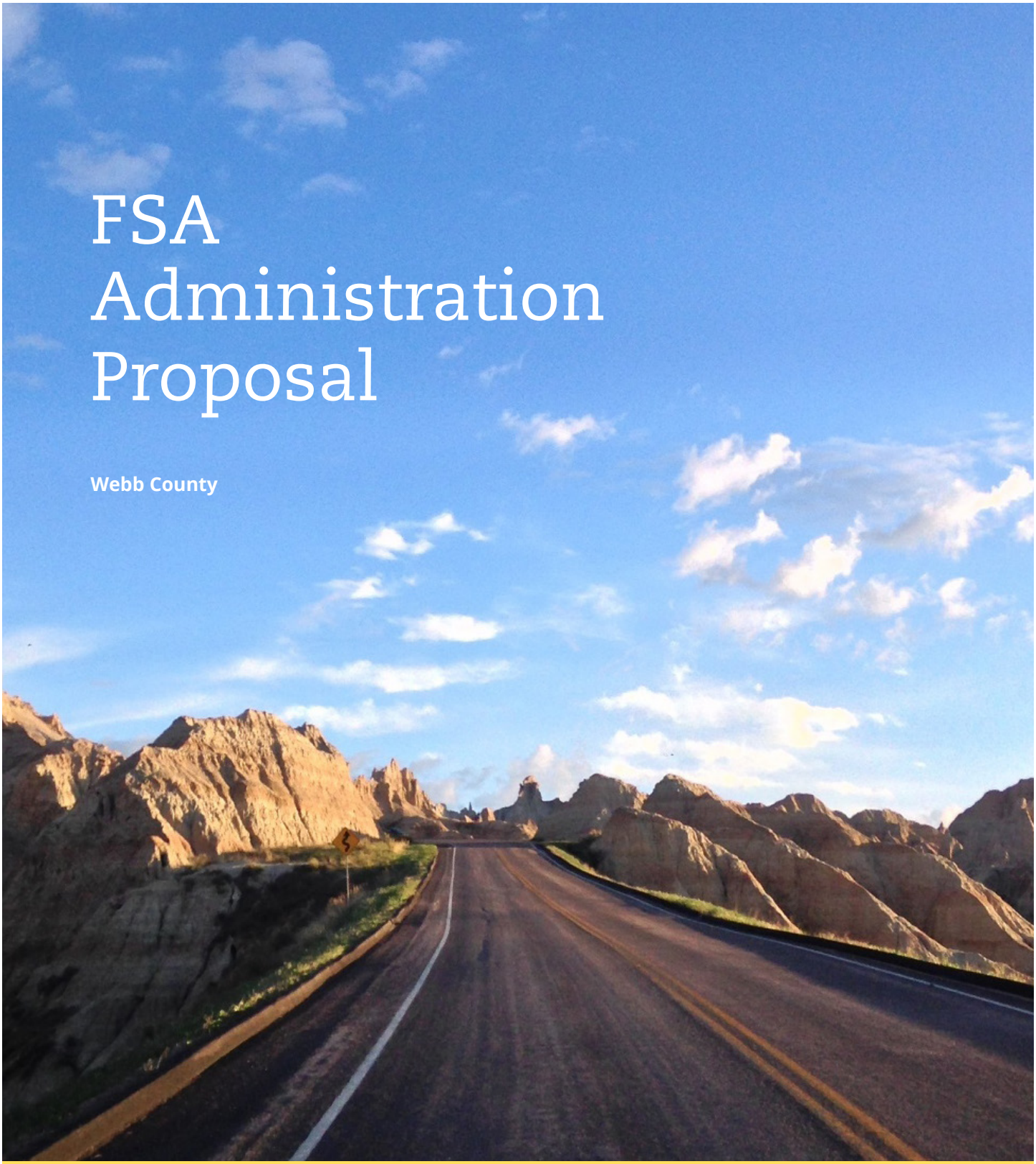
Includes:

- Complete benefits enrollment and administration system with unlimited EDI feeds and carrier integration.
- Dedicated technical account representative
- Full enrollment support
- HR/Benefits staff training
- No cost setup

Benefits Administration System Cost:

$ 1.95 PEPM

We remain open to negotiations on different scenarios based on the County's needs.



FSA Administration Proposal

Webb County

NBS Proposal Contact Information:

T.E.B. Benefits Group Inc. 855.687.9887

nbs national benefit services

Flexible Benefit Plan Administration

Flexible benefit plans provide significant tax savings for employees and employers. NBS has provided quality administration on these plans for more than 30 years. Our team environment combines years of experience with technological innovation, providing plan administration through a single-source solution that is efficient and accurate.

- HSA: Health Savings Accounts
- FSA: Flexible Spending Accounts
- HRA: Health Reimbursement Arrangements
- Qualified Transportation and Parking Plans

Flexible Benefit Plan Services

- Plan design and consultation
- Preparation and maintenance of plan documents
- Dedicated relationship manager
- Daily claim processing and payment
- Fully integrated Web-based system and reporting for plan sponsor & participants
- Access to real-time information 24/7
- Service center for participants
- Completion of IRS Form 5500, when applicable
- NBS Debit Card

Integrated Plans

One-stop solution for all consumer-driven healthcare accounts

Health Savings Account

- Cash Account
- Investment Accounts

Health Reimbursement Account

- Stacked Card
- Over 1,400 Plan Designs

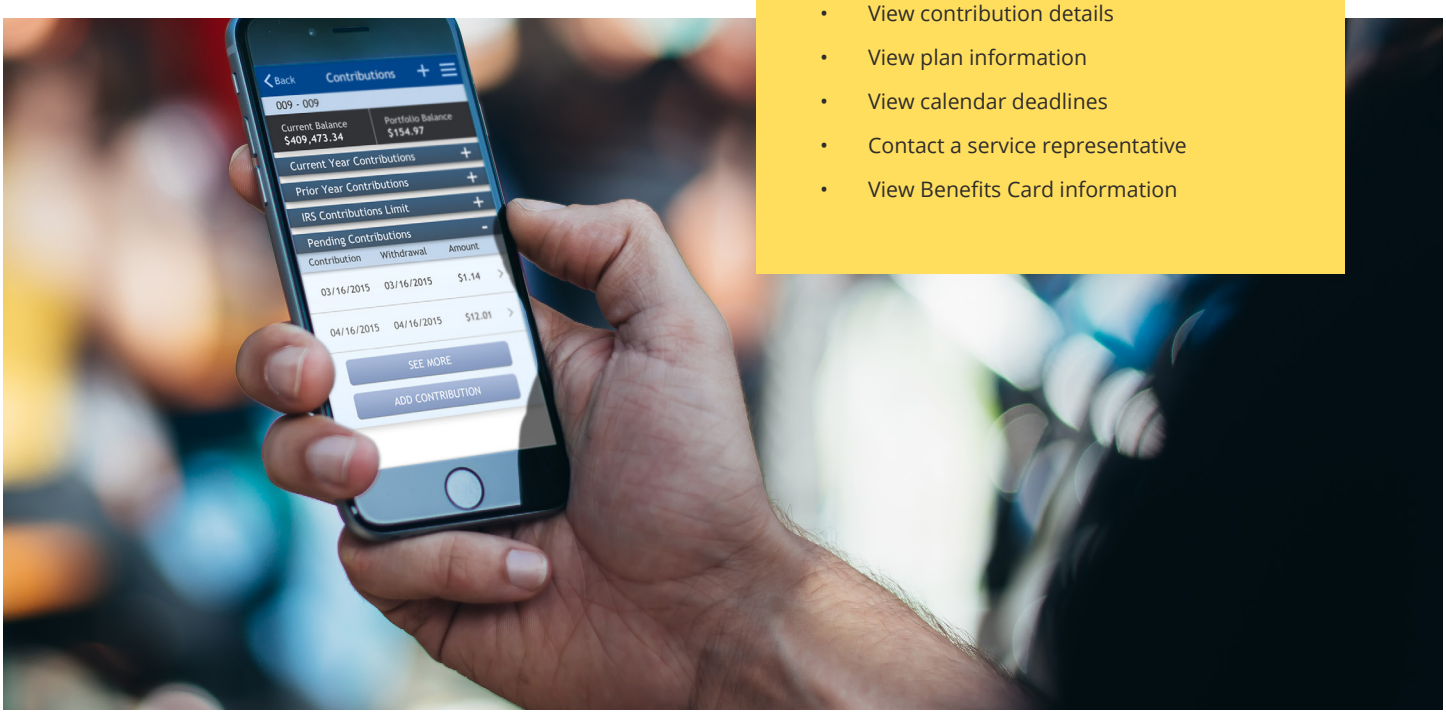
Flexible Spending Account

- Stacked Card with HSA, HRA
- Standard and Limited Purpose
- Dependent Care FSA

Mobile app features

The NBS mobile app supports a wide variety of features, empowering you to more proactively manage your account.

- View account balances
- View claims
- View reimbursement history
- Submit claims
- Submit documentation using your device's camera
- Pay providers
- Setup a variety of SMS alerts
- Edit your personal information
- View contribution details
- View plan information
- View calendar deadlines
- Contact a service representative
- View Benefits Card information



FSA Fee Schedule

Plan Document Services	Price
Includes: • Consultation • Plan Document • Summary Plan Description	$300

Administration Services	Price
Includes: • Daily Claim Processing • Choice of Direct Deposit of Claim Payments, or Checks Mailed to Participant's Home • Toll Free Fax Number and Email address for Claim Submission • On-line access to Forms, Questions & Answers, Government Publications, etc. • Internet Access System for Participants to Check: Balances, Last Claims Paid, Annual Amount Remaining, etc. • Electronic Monthly Reports to HR Contact • ACH and Direct Debit Available for payroll	$3.50/Month/Participant ($75 Minimum)
Annual Reports: • Required Discrimination Tests • Annual Re-Enrollment of Plan • Annual Tax Savings Report	$200
Form 5500, if required.	N/A - Government

Miscellaneous Services	Price
Mid-Year Plan Takeover	$150/hour
Debit Card - *May be billed to company or participant.*	Included
Plan Amendment (Only when/if required)	$150

*Additional fees may apply for services or customization outside the normal administration

NBS is with you all the way

Who We Are

National Benefit Services, LLC (NBS) is a fee for service firm specializing in the design and administration of all types of Retirement Plans, Cafeteria Plans & COBRA Administration. Founded in 1986, NBS continues to experience rapid growth while maintaining our focus on excellent customer service. Currently NBS services more than 8,500 retirement and benefit plans in all 50 states, and is ranked by Utah Business Magazine as the #1 Employee Group Benefits Provider.

Our mission, as pension and benefit professionals partnered with service advisors and vendors, is to help employees achieve financial security and peace of mind through employer provided-plans. NBS endeavors to provide the very best customer care, be the most knowledgeable experts in the industry and achieve excellence in our organizational process and delivery.

Customer Care

We genuinely care about the people we serve. Our goal is to take care of plan sponsors, participants and advisors with attentiveness, understanding and interest.
Plan sponsors are assigned a dedicated account manager and administrative team to take care of their daily compliance needs and plan requirements. NBS has an internal Customer Care Program focused on continually increasing our ability to serve our clients.

Knowledge and Expertise

Our clients deserve the very best benefits industry knowledge and expertise. We seek to provide the most knowledgeable staff to take care of plan design, document, accounting, governmental reporting and administrative needs. We maintain a high level of expertise through regular internal and external education and use this knowledge to better serve and inform our clients.

Organizational Excellence

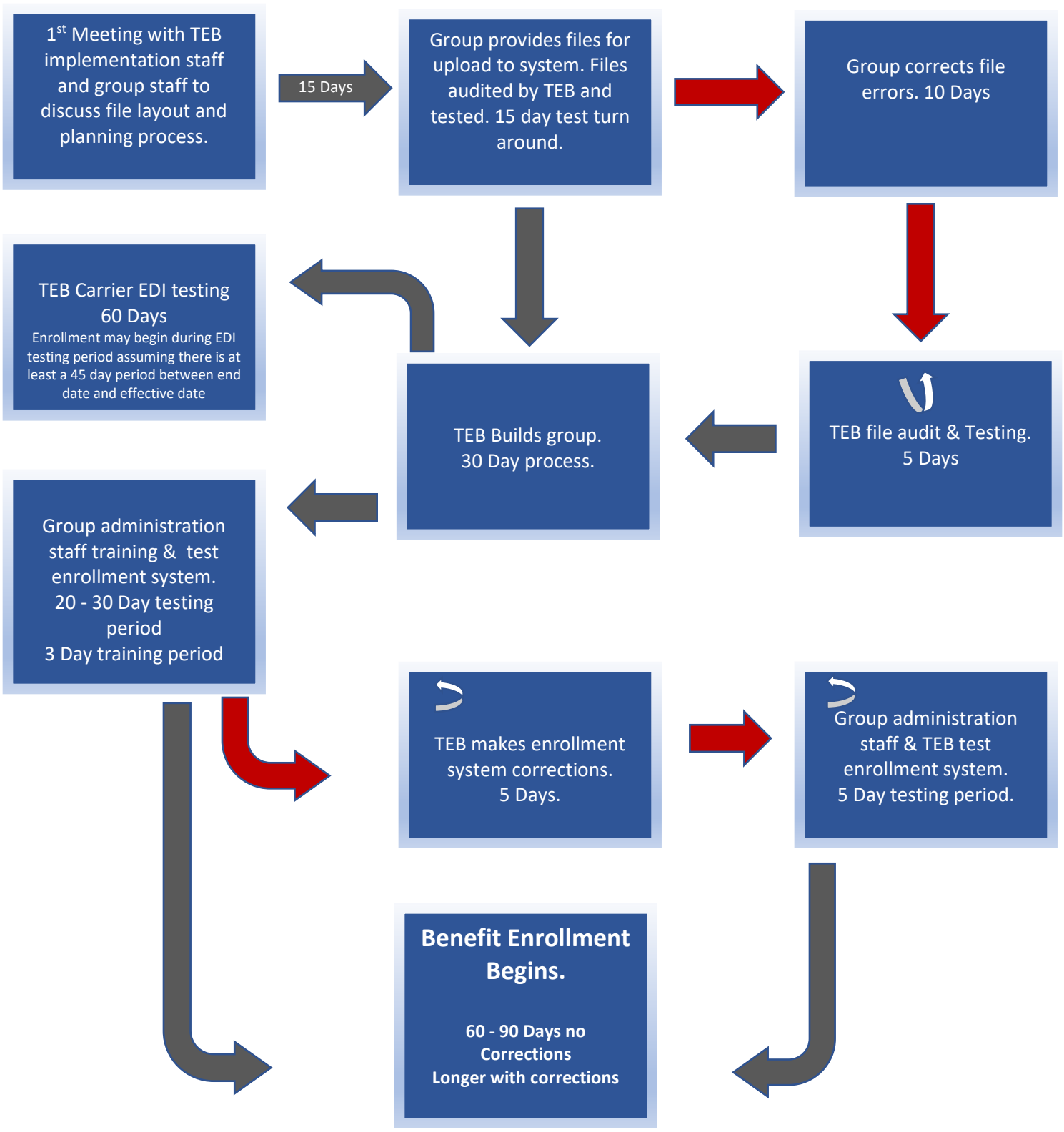
We are committed to achieving excellence in all we do. Using the best technology and processes, we provide timely and accurate administration for our clients. Our goal is to deliver peace of mind that each client's plan is right for them and in compliance, and that plan participants are well taken care of.

In partnership with T.E.B. Benefits Group Inc

nbs national benefit services

T.E.B. BENEFITS GROUP INC.

Benefit Administration Implementation Timeline (pre-enrollment)



Process may need to be repeated adding additional time

WEBB COUNTY PURCHASING DEPT.
QUALIFIED PARTICIPATING VENDOR CODE OF ETHICS
AFFIDAVIT FORM

STATE OF TEXAS *

KNOW ALL MEN BY THESE PRESENTS:

COUNTY OF WEBB *

BEFORE ME the undersigned Notary Public, appeared Marc Hernandez, the herein-named "Affiant", who is a resident of El Paso County, State of Texas, and upon his/her respective oath, either individually and/or behalf of their respective company/entity, do hereby state that I have personal knowledge of the following facts, statements, matters, and/or other matters set forth herein are true and correct to the best of my knowledge.

I personally, and/or in my respective authority/capacity on behalf of my company/entity do hereby confirm that I have reviewed and agree to fully comply with all the terms, duties, ethical policy obligations and/or conditions as required to be a qualified participating vendor with Webb County, Texas as set forth in the Webb County Purchasing Code of Ethics Policy posted at the following address: http://www.webbcountytx.gov/PurchasingAgent/PurchasingEthicsPolicy.pdf

I personally, and/or in my respective authority/capacity on behalf of my company/entity do hereby further acknowledge, agree and understand that as a participating vendor with Webb County, Texas on any active solicitation/proposal/qualification that I and/or my company/entity failure to comply with the Code of Ethics policy may result in my and/or my company/entity disqualification, debarment or make void my contract awarded to me, my company/entity by Webb County. I agree to communicate with the Purchasing Agent or his designees should I have questions or concerns regarding this policy to ensure full compliance by contacting the Webb County Purchasing Dept. via telephone at (956) 523-4125 or e-mail to the Webb County Purchasing Agent to joel@webbcountytx.gov .

Executed and dated this 26 day of May, 2021.

Signature of Affiant

Marc Hernandez, TEB Benefits Group Inc
Printed Name of Affiant/Company/Entity

SWORN to and subscribed before me, this 26 day May, 2021

Erika Vargas Gonzalez
NOTARY PUBLIC, STATE OF TEXAS

ERIKA VARGAS GONZALEZ
Notary Public, State of Texas
Comm. Expires 04-25-2024
Notary ID 130632626

WEBB COUNTY PURCHASING DEPT.
QUALIFIED PARTICIPATING VENDOR CODE OF ETHICS
AFFIDAVIT FORM

STATE OF TEXAS *

KNOW ALL MEN BY THESE PRESENTS:

COUNTY OF WEBB *

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Erika Vargas Gonzalez
NOTARY PUBLIC, STATE OF TEXAS

ERIKA VARGAS GONZALEZ
Notary Public, State of Texas
Comm. Expires 04-25-2024
Notary ID 130632626

TRAVELERS

Travelers 1st Choice SM

INSURANCE PROFESSIONALS LIABILITY COVERAGE DECLARATIONS

POLICY NO. PL106865097

St. Paul Fire and Marine Insurance Company

St. Paul, Minnesota

(A Stock Insurance Company, herein called the Company)

Important note: This is a claims-made policy. To be covered, a claim must be first made against an Insured during the policy period or any applicable extended reporting period.

The limit of liability available to pay settlements or judgments will be reduced by defense expenses.

The deductible applies to defense expenses.

This policy is composed of the Declarations, the Insurance Professionals Liability Coverage, the Professional Liability Terms and Conditions, and any endorsements attached thereto.

ITEM 1	NAMED INSURED: TEB Benefits Group Inc Principal Address: 702 Wyoming Avenue El Paso, TX 79902
ITEM 2	POLICY PERIOD: Inception Date: 03/23/2021 Expiration Date: 03/23/2022 12:01 A.M. standard time both dates at the Principal Address stated in ITEM 1.
ITEM 3	ALL NOTICES PURSUANT TO THE POLICY MUST BE SENT TO THE COMPANY BY EMAIL, FACSIMILE, OR MAIL AS SET FORTH BELOW: Email: bsiclaims@travelers.com PHONE: 800-842-8496 FAX: 888-460-6622 Travelers Bond & Financial Products Claim 385 Washington Street Mail Code: 9275-NB03F St. Paul, MN 55102

ITEM 4	COVERAGE INCLUDED AS OF THE INCEPTION DATE IN ITEM 2: Insurance Professionals Liability Coverage Services Performed for Others: ☒ Life, Health and Accident Insurance Agent or Broker ☐ Property and Casualty Insurance Agent or Broker ☐ Sale and Servicing of Mutual Funds
ITEM5	PROFESSIONAL LIABILITY COVERAGE LIMITS Professional Services and Network and Information Security Offenses Coverage Limits: $1,000,000 for each Claim; not to exceed $3,000,000 for all Claims Deductible: $5,000 each Claim N/A all Claims Retroactive Date: N/A Knowledge Date: 03/23/2012
ITEM 6	ADDITIONAL BENEFITS LIMITS: Crisis Event Expenses Limits: $10,000 for each **Crisis Event** $30,000 for all **Crisis Events** Disciplinary or Regulatory Proceeding Expenses Limits: $25,000 for each **Disciplinary or Regulatory Proceeding** $50,000 for all **Disciplinary or Regulatory Proceedings**

ITEM 7	PREMIUM FOR THE POLICY PERIOD: State Tax $3396.00 Policy Premium N/A Annual Installment Premium
ITEM 8	OPTIONAL EXTENDED REPORTING PERIODS: Additional Premium Percentage: Additional Months: 100% 12 150% 24 185% 36 240% 60 N/A UNLIMITED
ITEM 9	FORMS AND ENDORSEMENTS ATTACHED AT ISSUANCE: IPL-1001 Ed. 07-10, PTC-1001 Ed. 11-08, IPL-2003 Ed. 07-10, PTC-2067 Ed. 12-15, IPL-2000 Ed. 07-10, PTC-3043 Rev. 12-14, IPL-2018 Ed. 5-11, PTC 2011 ED 11-08, PTC 2020 Ed. 11-08, PTC-19006 Ed.03-15,

The Declarations, the Professional Liability Terms and Conditions, the Insurance Professionals Liability Coverage, and any endorsements attached thereto, constitute the entire agreement between the Company and the Insured.

Countersigned By

IN WITNESS WHEREOF, the Company has caused this policy to be signed by its authorized officers.

President

Corporate Secretary

Texas Department of Insurance

CERTIFICATE NO. 15037 COMPANY NO. 30-096220

CERTIFICATE OF AUTHORITY

THIS IS TO CERTIFY THAT

TEB BENEFITS GROUP INC.
EL PASO, TEXAS

has complied with the laws of the State of Texas applicable thereto and is hereby authorized to transact the business of

ADMINISTRATOR

within the State of Texas. This Certificate of Authority shall be in full force and effect until it is revoked, canceled, or suspended according to law.

IN TESTIMONY WHEREOF witness my

hand and seal of office at Austin, Texas, this

20th day of October A.D. 2010

MIKE GEESLIN
COMMISSIONER OF INSURANCE

BY David Moskowitz

DAVID MOSKOWITZ
ASSISTANT CHIEF EXAMINER
FINANCIAL PROGRAM
COMMISSIONER'S ORDER NO 09-0957

Western Surety Company

DISHONESTY BOND
(FOR ANY TYPE OF BUSINESS)

Bond No. 71147059

In consideration of the agreed premium, Western Surety Company, a South Dakota corporation (the "Surety"), hereby agrees to indemnify TEB Benefits Group, Inc.
702 WYOMING AVE., EL PASO, TX 79902
(the "Insured"), against any loss of money or other property which the Insured shall sustain or for which the Insured shall incur liability to any Customer or Subscriber of the Insured through any fraudulent or dishonest act or acts committed by any Employee or Employees of the Insured acting alone or in Collusion with others, the amount of indemnity on each of such Employees being

ONE HUNDRED THOUSAND AND NO/100 DOLLARS ($ $100,000.00).

THE FOREGOING AGREEMENT IS SUBJECT TO THE FOLLOWING CONDITIONS AND LIMITATIONS:

TERM OF BOND:

SECTION 1. The term of this bond begins with the 01 day of August, 2011, standard time at the address of the Insured above given, and ends at 12:00 o'clock night, standard time, on the effective date of the cancellation of this bond in its entirety.

EXCLUSION:

SECTION 2. This bond does not apply to loss, or to that part of any loss, as the case may be, the proof of which, either as to its factual existence or as to its amount, is dependent upon an inventory computation or a profit and loss computation. In addition, the policy does not apply to the defense of any legal proceedings brought against the Insured, or to fees, costs or expenses incurred or paid by the Insured in prosecuting or defending any legal proceedings whether or not such proceedings results or would result in a loss to the Insured covered by this policy. In addition, the Company shall not be liable for any costs, fees and other expenses incurred by the Insured in establishing the existence or the amount of loss covered under this policy.

DISCOVERY PERIOD:

SECTION 3. Loss is covered under this bond only (a) if sustained through any act or acts committed by any Employee of Insured while this bond is in force as to such Employee, and (b) if discovered prior to the expiration or sooner cancellation of this bond in its entirety as provided in Section 10, or from its cancellation or termination in its entirety in any other manner, whichever shall first happen.

DEFINITION OF EMPLOYEE:

SECTION 4. The word Employee or Employees, as used in this bond, shall be deemed to mean, respectively, one or more of the natural persons (except directors or trustees of the Insured, if a corporation, who are not also officers or employees thereof in some other capacity) while in the regular service of the Insured in the ordinary course of the Insured's business during the term of this bond, and whom the Insured compensates by salary, or wages and has the right to govern and direct in the performance of such service, and who are engaged in such service within any of the States of the United States of America, or within the District of Columbia, Puerto Rico, the Virgin Islands, or elsewhere for a limited period, but not to mean brokers, factors, commission merchants, consignees, contractors, or other agents or representatives of the same general character.

FRAUDULENT OR DISHONEST ACT:

SECTION 5. A FRAUDULENT OR DISHONEST ACT OF AN EMPLOYEE OF THE INSURED SHALL MEAN AN ACT WHICH IS PUNISHABLE UNDER THE CRIMINAL CODE IN THE JURISDICTION WITHIN WHICH ACT OCCURRED, FOR WHICH SAID EMPLOYEE IS TRIED AND CONVICTED BY A COURT OF PROPER JURISDICTION.

MERGER OR CONSOLIDATION:

SECTION 6. If any natural persons shall be taken into the regular service of the Insured through merger or consolidation with some other concern, the Insured shall give the Surety written notice thereof and shall pay an additional premium on any increase in the number of Employees covered under this bond as a result of such merger or consolidation computed pro rata from the date of such merger or consolidation to the end of the current premium period.

NON-ACCUMULATION OF LIABILITY:

SECTION 7. Regardless of the number of years this bond shall continue in force and the number of premiums which shall be payable or paid, the liability of the Surety under this bond shall not be cumulative in amounts from year to year or from period to period.

WESTERN SURETY COMPANY • ONE OF AMERICA'S OLDEST BONDING COMPANIES

LIMIT OF LIABILITY UNDER THIS BOND AND PRIOR INSURANCE:

SECTION 8. With respect to loss or losses caused by an Employee or which are chargeable to such Employee as provided in Section 5 and which occur partly under this bond and partly under other bonds or policies issued by the Surety to the Insured or to any predecessor in interest of the Insured and terminated or cancelled or allowed to expire and in which the period for discovery has not expired at the time any such loss or losses thereunder are discovered, the total liability of the Surety under this bond and under such other bonds or policies shall not exceed, in the aggregate, the amount carried under this bond on such loss or losses or the amount available to the Insured under such other bonds or policies, as limited by the terms and conditions thereof, for any such loss or losses, if the latter amount be the larger.

SALVAGE:

SECTION 9. If the Insured shall sustain any loss or losses covered by this bond which exceed the amount of coverage provided by this bond, the Insured shall be entitled to all recoveries, except from suretyship, insurance, reinsurance, security or indemnity taken by or for the benefit of the Surety, by whomsoever made, on account of such loss or losses under this bond until fully reimbursed, less the actual cost of effecting the same; and less the amount of the deductible carried on the Employee causing such loss or losses; and any remainder shall be applied to the reimbursement of the Surety.

CANCELLATION AS TO ANY EMPLOYEE:

SECTION 10. This bond shall be deemed cancelled as to any Employee: (a) immediately upon discovery by the Insured, or by any partner or officer thereof not in collusion with such Employee, of any fraudulent or dishonest act on the part of such Employee; or (b) at 12:00 o'clock night, standard time, upon the effective date specified in a written notice served upon the Insured or sent by mail. Such date, if the notice be served, shall be not less than ten days after such service, or, if sent by mail, not less than fifteen days after the date of mailing. The mailing by Surety of notice, as aforesaid, to the Insured at its principal office shall be sufficient proof of notice.

CANCELLATION AS TO BOND IN ITS ENTIRETY:

SECTION 11. This bond shall be deemed cancelled in its entirety at 12:00 o'clock night, standard time, upon the effective date specified in a written notice served by the Insured upon the Surety or by the Surety upon the Insured, or sent by mail. Such date, if served by the Surety, shall be not less than ten days after such service, or if sent by the Surety by mail, not less than fifteen days after the date of mailing. The mailing by the Surety of notice, as aforesaid, to the Insured at its principal office shall be sufficient proof of notice. The Surety shall refund to the Insured the unearned premium computed pro rata if this bond be cancelled at the instance of the Surety, or at short rates if cancelled or reduced at the instance of the Insured.

PRIOR FRAUD, DISHONESTY OR CANCELLATION:

SECTION 12. No Employee, to the best of the knowledge of the Insured, or of any partner or officer thereof not in collusion with such Employee, has committed any fraudulent or dishonest act in the service of the Insured or otherwise. If prior to the issuance of this bond, any fidelity insurance in favor of the Insured or any predecessor in interest of the Insured and covering one or more of the Insured's Employees shall have been cancelled as to any of such Employees by reason of (a) the discovery of any fraudulent or dishonest act on the part of such Employees, or (b) the giving of written notice of cancellation by the insurer issuing said fidelity insurance, whether the Surety or not, and if such Employees shall not have been reinstated under the coverage of said fidelity insurance or superseding fidelity insurance, the Surety shall not be liable under this bond on account of such Employees unless the Surety shall agree in writing to include such Employees within the coverage of this bond.

LOSS-NOTICE-PROOF-LEGAL PROCEEDINGS:

SECTION 13. At the earliest practical moment, and at all events not later than fifteen days after discovery of any fraudulent or dishonest act on the part of any Employee by the Insured, or by any partner or officer thereof not in collusion with such Employee, the Insured shall give the Surety written notice thereof and within four months after such discovery shall file with the Surety affirmative proof of loss, itemized and duly sworn to, and shall upon request of the Surety render every assistance, not pecuniary, to facilitate the investigation and adjustment of any loss. No suit to recover on account of loss under this bond shall be brought before the expiration of two months from the filing of proof as aforesaid on account of such loss, nor after the expiration of fifteen months from the discovery as aforesaid of the fraudulent or dishonest act causing such loss. If any limitation in this bond for giving notice, filing claim or bringing suit is prohibited or made void by any law controlling the construction of this bond, such limitation shall be deemed to be amended so as to be equal to the minimum period of limitation permitted by such law.

PART-TIME OR TEMPORARY EMPLOYEES:

SECTION 14. The named Insured shall not at any time while this bond is in force direct any temporary or part-time Employee(s) to any subscriber's premises unless such Employee(s) is accompanied by a foreman who is in the regular employ of the Insured.

SIGNED, SEALED AND DATED August 03, 2011.

WESTERN SURETY COMPANY

By _____

PAUL T. BRUFLAT, SENIOR VICE PRESIDENT

71147059

Texas

Western Surety Company

DISHONESTY BOND RIDER

It is hereby mutually agreed and understood by and between the Insured and WESTERN SURETY COMPANY that the following sections of policy forms 1432, 1650 and 1651 are hereby amended as follows:

SECTION 9 is amended to read as follows:

If the Insured shall sustain any loss or losses covered by this bond which exceed the amount of coverage provided by this bond, the Insured shall be entitled to all recoveries, except from suretyship, insurance, reinsurance, security or indemnity taken by or for the benefit of the Company, by whomsoever made, on account of such loss or losses under this bond until fully reimbursed, less the actual cost of effecting the same; and any remainder shall be applied to the reimbursement of the Company.

SECTION 5 is amended by **adding** the following paragraph:

The amount to be paid under the terms of this bond will be the amount of restitution required by the court in the criminal proceedings subject to the amount of the bond. No additional payments will be made under the terms of this bond unless the Insured presents evidence beyond a reasonable doubt that the employee was guilty of a crime causing a loss greater than that for which the court has required restitution. The Insured shall have the burden of proof. The degree of proof that is required is found in Vernon's Texas Statutes Annotated, Code of Criminal Procedure, Article 38.03.

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, limits or conditions of the bond, except as herein above set forth.

Signed this 03 day of August, 2011.

WESTERN SURETY COMPANY

By _____
Paul T. Bruflat, Senior Vice President

Form 1701-10-2002

71147059

Figure: 28 TAC §1.601(a)(3)

1 **IMPORTANT NOTICE**

To obtain information or make a complaint:

2 You may contact Western Surety Company, Surety Bonding Company of America or Universal Surety of America at 605-336-0850.

3 You may call Western Surety Company's, Surety Bonding Company of America's or Universal Surety of America's toll-free telephone number for information or to make a complaint at:

1-800-331-6053

4 You may also write to Western Surety Company, Surety Bonding Company of America or Universal Surety of America at:

P.O. Box 5077
Sioux Falls, SD 57117-5077

5 You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

6 You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-Mail: ConsumerProtection@tdi.state.tx.us

7 **PREMIUM OR CLAIM DISPUTES:**
Should you have a dispute concerning your premium or about a claim, you should contact Western Surety Company, Surety Bonding Company of America or Universal Surety of America first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

8 **ATTACH THIS NOTICE TO YOUR POLICY:**
This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Puede comunicarse con Western Surety Company, Surety Bonding Company of America o Universal Surety of America al 605-336-0850.

Usted puede llamar al numero de telefono gratis de Western Surety Company's, Surety Bonding Company of America's o Universal Surety of America's para informacion o para someter una queja al:

1-800-331-6053

Usted tambien puede escribir a Western Surety Company, Surety Bonding Company of America o Universal Surety of America:

P.O. Box 5077
Sioux Falls, SD 57117-5077

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-Mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Western Surety Company, Surety Bonding Company of America o Universal Surety of America primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

SAMPLE PLAN DOCUMENT
SECTION 125
FLEXIBLE BENEFIT PLAN

Version 01/17 of the Sample Plan Document includes the following changes:

Updated Section F, #7 – Changed wording for maximum to not exceed the limit as indicated by the IRS in accordance with the law.

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

SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

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

A. EMPLOYER INFORMATION

Name of Employer:	Quitman Separate School District
Address:	104 E Franklin St Quitman, MS 39355
Employer Identification Number:	64-0442029
Nature of Business:	Public School
Name of Plan:	Quitman Separate School District Flexible Benefit Plan Flex Plan
Plan Number:	502

B. EFFECTIVE DATE

Original effective date of the Plan:	June 1, 2008
If Amendment to existing plan, effective date of amendment:	April 1, 2017

C. ELIGIBILITY REQUIREMENTS FOR PARTICIPATION

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

Length of Service:	First day of employment
Retiree Wording:	N/A
Minimum Hours:	All employees with 20 hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 0 years.

D. PLAN YEAR

The current plan year will begin on April 1, 2017 and end on March 31, 2018. Each subsequent plan year will begin on April 1 and end on March 31.

E. EMPLOYER CONTRIBUTIONS

Non-Elective Contributions:

The maximum amount available to each Participant for the purchase of elected benefits with non-elective contributions will be:

Employer contributes $3.88 per employee per month.

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

Elective Contributions (Salary Reduction):

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

100% of compensation per entire plan year.

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

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

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

Blue Cross/Blue Shield

American Fidelity Assurance Company
Accident, GAP

Aflac
Accident

Eligibility Requirements for Participation, if different than Item C.

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

American Fidelity Assurance Company

Eligibility Requirements for Participation, if different than Item C.

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

American Fidelity Assurance Company
C Series

Aflac

Eligibility Requirements for Participation, if different than Item C.

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

Ameritas
Dental

Superior Vision

Eligibility Requirements for Participation, if different than Item C.

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

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

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, may not exceed $50,000.

USAble
AD&D

American Fidelity Assurance Company

Eligibility Requirements for Participation, if different than Item C.

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

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

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

Recordkeeper: American Fidelity Assurance Company

Eligibility Requirements for Participation, if different than Item C.

N/A

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

Minimum Coverage - $**0.00** per Plan Year or a Prorated Amount for a Short Plan Year.

Maximum Coverage - $**2400.00** per Plan Year or a Prorated Amount for a Short Plan Year. In no event can the maximum exceed the limit as indicated by the IRS in accordance with the law.

Recordkeeper: American Fidelity Assurance Company

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

Grace Period: The Provisions in Section 8.06 of the Plan to permit a

Grace Period with respect to the Medical Expense Reimbursement Plan are elected.

Carryover: The Provisions in Section 8.07 of the Plan to permit a Carryover with respect to the Medical Expense Reimbursement Plan are not elected.

Eligibility Requirements for Participation, if different than Item C.

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

HSA Trustee – **N/A**

Maximum Contribution – **N/A**

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

N/A

Eligibility Requirements for Participation, if different than Item C.

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

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

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

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

This Plan is hereby adopted this _____ day of _____, 20_____.

Quitman Separate School District - 502
(Name of Employer)

Witness:_____ **By:_____**

Title:_____ **Title:_____**

APPENDIX A

Related Employers that have adopted this Plan

Name(s):

SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

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

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

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

SECTION II

DEFINITIONS

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

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

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

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

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

2.04 **Dependent** Any of the following:

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

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

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

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

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

2.05 **Effective Date** The effective date of this Plan as shown in Item B of the Adoption Agreement.

2.06 **Elective Contribution** The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.

2.07	**Eligible Employee**	Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.
2.08	**Employee**	Any person employed by the Employer on or after the Effective Date.
2.09	**Employer**	The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan with the approval of the Employer. Related Employers who participate in this Plan are listed in Appendix A to the Adoption Agreement. For the purposes of Section 11.01 and 11.02, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.
2.10	**Employer Contributions**	Amounts that have not been actually received by the Participant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.
2.11	**Entry Date**	The date that an Employee is eligible to participate in the Plan.
2.12	**ERISA**	The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).
2.13	**Fiduciary**	The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.
2.14	**Health Savings Account**	A “health savings account” as defined in Section 223(d) of the Internal Revenue Code of 1986, as amended established by the Participant with the HSA Trustee.
2.15	**HSA Trustee**	The Trustee of the Health Savings Account which is designated in Section F.8 of the Adoption Agreement.
2.16	**Highly Compensated**	Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.
2.17	**High Deductible Health Plan**	A health plan that meets the statutory requirements for annual deductibles and out-of-pocket expenses set forth in Code section 223(c)(2).
2.18	**HIPAA**	The Health Insurance Portability and Accountability Act of 1996, as amended.
2.19	**Insurer**	Any insurance company that has issued a policy pursuant to the terms of this Plan.
2.20	**Key Employee**	Any Participant who is a "key employee" as defined in Section 416(i) of the Code.

2.21 **Non-Elective Contribution** — A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.

2.22 **Participant** — An Employee who has qualified for Plan participation as provided in Item C of the Adoption Agreement.

2.23 **Plan** — The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.

2.24 **Plan Year** — The Plan Year as specified in Item D of the Adoption Agreement.

2.25 **Policy** — An insurance policy issued as a part of this Plan.

2.26 **Preventative Care** — Medical expenses which meet the safe harbor definition of "preventative care" set forth in IRS Notice 2004-23, which includes, but is not limited to, the following: (i) periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations); (ii) well-baby and/or well-child care; (iii) immunizations for adults and children; (iv) tobacco cessation and obesity weight-loss programs; and (v) screening devices. However, preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.

2.27 **Recordkeeper** — The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Plan and/or the Dependent Care Reimbursement Plan.

2.28 **Related Employer** — Any employer that is a member of a related group of organizations with the Employer shown in Item A of the Adoption Agreement, and as specified under Code Section 414(b), (c) or (m).

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date of the Plan, whichever is later. Dependent eligibility to receive benefits under any of the plans listed in Item F of the Adoption Agreement will be described in the documents governing those benefit plans. To the extent a Dependent is eligible to receive benefits under a plan listed in Item F, an Eligible Employee may elect coverage under this Plan with respect to such Dependent. Notwithstanding the foregoing, life insurance coverage on the life of a Dependent may not be elected under this Plan.

3.02 ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during an enrollment period, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's Election Form shall be completed prior to the beginning of the Plan Year, and

shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.

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

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

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

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

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

SECTION IV

CONTRIBUTIONS

4.01 EMPLOYER CONTRIBUTIONS: The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer

Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary reduction basis.

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

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

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

(b) Special Enrollment Rights. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances: (i) a Participant or his or her spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted, or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; (ii) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; (iii) the Participant's or his or her spouse's or Dependent's coverage under a Medicaid plan or under a

children's health insurance program (CHIP) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage; or (iv) the Participant, his or her spouse or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than 60 days after the date the Participant, his or her spouse or Dependent is determined to be eligible for such assistance. An election change under (iii) or (iv) of this provision must be requested within 60 days after the termination of Medicaid or state health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

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

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

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

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

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

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

(i) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to

average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

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

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

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

(ii) The cancellation of the election of coverage under the Employer's group health plan coverage corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the cancellation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is cancelled.

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

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

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

(b) Significant curtailment of coverage.

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

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

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

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

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

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

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

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

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

SECTION V

GROUP MEDICAL INSURANCE BENEFIT PLAN

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

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

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

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

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

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

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

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

SECTION VI

DISABILITY INCOME BENEFIT PLAN

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

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

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

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

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

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

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

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

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

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

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

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

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

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections 105 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

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

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

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

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

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

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

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

f. COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA (‘COBRA”), a Participant and a Participant’s Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of

desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

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

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

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

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

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

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

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

8.04 ELIGIBLE MEDICAL EXPENSES:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

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

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

9.03 TERMS, CONDITIONS, AND LIMITATIONS:

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

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

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

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

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

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

f. Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.

9.04 DEFINITIONS:

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

(i) a Participant's qualifying child (as defined in Code Section 152 (c)) who has not attained the age of 13; or

(ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.

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

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

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

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

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

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

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

SECTION X

HEALTH SAVINGS ACCOUNTS

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

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

10.03 TERMS, CONDITIONS AND LIMITATION:

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

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

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

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

SECTION XI

AMENDMENT AND TERMINATION

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

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

SECTION XII

ADMINISTRATION

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

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

12.03 POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:

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

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

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

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

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

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

The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

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

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

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

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

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

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

shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

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

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

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

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

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

1. the specific reason or reasons for the denial;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION XIII

MISCELLANEOUS PROVISIONS

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

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

13.03 NO GUARANTEE OF TAX CONSEQUENCES: Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant or Dependent.

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

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

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

13.07 CONSTRUCTION:

a. Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.
b. Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

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

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

END USER LICENSE AND SERVICE AGREEMENT

This End-User License and Service Agreement (the "EULSA") is a **legal agreement** between _____ (the "Licensee"), an individual, and T.E.B. Benefits Group Inc, the administrator of Employee Navigator Benefits Administration and Enrollment System (the "Software"), which may include associated media, printed materials, and "online" or electronic documentation.

By utilizing Software, Licensee agrees to be **bound by the terms and conditions set forth in this EULSA**. If Licensee does not agree to the terms and conditions set forth in this EULSA, then Licensee may not utilize the Software.

1. Definitions

a) "Company" shall refer to the licensor: T.E.B. Benefits Group Inc. located in El Paso, Texas.

b) "Licensee" shall mean _____, the individual or entity that utilizes and uses the Software.

c) "Software" shall mean the Employee Navigator Benefits Administration and Enrollment System and the deliverables provided pursuant to this EULSA.

2. Grant of License

d) **Software Product License.** Subject to the terms of this EULSA, Company hereby grants to Licensee a non-exclusive right to utilize the Software.

e) **Installation and or Use.** Licensee and all employees and or associates of licensee may access the Software on any computer at any time.

3. Description of Rights and Limitations

a) **Limitations.** Licensee may not reverse engineer, decompile, or disassemble Software, except and only to the extent that such activity is expressly permitted by applicable law notwithstanding the limitation.

b) **Update and Maintenance.** Company shall provide updates and maintenance on an as needed basis / every six months / every year / Other.

4. Intellectual Property. All rights, title, interest, and copyrights in and to the Software, including but not limited to all images, photographs, animations, video, audio, music, text, data, computer code, algorithms, and information, are owned by Company. The Software is protected by all applicable copyright laws and international treaties. Therefore, Licensee is required to treat Software like any other copyrighted material, except as otherwise provided for in this EULSA.

5. Support. Company will provide On Site / Phone Support during normal business hours Monday to Friday 8:00 am to 5:00 pm.

6. Services. In addition to providing software access to Licensee Company will provide the following administrative services:

a) Send EDI and non EDI file feeds to carriers as needed for enrollment purposes.
b) Provide support for file errors that the licensee is unable to resolve.
c) Assist with voluntary benefit integrations if applicable.
d) Customize benefit deduction reports in .xls or .csv format to integrate with the licensee's payroll platform.
e) Provide assistance on issues with the system.
f) Work with the licensee's onsite Open Enrollment schedule to provide assistance for employees wanting to enroll through the system.
g) Additional systems training is at an extra cost.

7. Terms of Agreement. This EULSA is effective until:

a) Automatically terminated if Licensee fails to comply with any of the terms and conditions set forth in this EULA; or

b) Terminated by Company.

Company may term terminate this EULA immediately upon written notice, including e-mail, to Licensee, with or without cause.

8. Integration. Both parties agree that this EULSA is the complete and exclusive statement of the mutual understanding of the parties and supersedes and cancels all previous written and oral agreements and communications relating to the subject matter of this EULA.

9. Jurisdiction. This EULSA shall be deemed to have been made in, and shall be construed pursuant to the laws of the State of Texas, without regard to conflicts of laws provisions thereof. Any legal action or proceeding relating to this EULSA shall be brought exclusively in courts located in El Paso, Texas, and each party consents to the jurisdiction thereof. The prevailing party in any action to enforce this EULSA shall be entitled to recover costs and expenses including, without limitation, attorneys' fees. This EULSA is made within the exclusive jurisdiction of the United States, and its jurisdiction shall supersede any other jurisdiction of either party's election.

10. Non-Transferable. This EULSA is not assignable or transferable by Licensee without the prior written consent of Company; any attempt to do so shall be void. Any notice, report, approval or consent required or permitted hereunder shall be in writing and will be deemed to have been duly given if delivered personally or mailed by first-class, registered or certified mail, postage prepaid to the respective addresses of the parties as set forth herein (or such other address as a party may designate by ten (10) days notice):

T.E.B. Benefits Group Inc.
El Paso, Texas 79902

Licensee: _____

11. Severability. No failure to exercise, and no delay in exercising, on the part of either party, any privilege, any power or any rights hereunder will operate as a waiver thereof, nor will any single or partial exercise of any right or power hereunder preclude further exercise of any other right hereunder. If any provision of this EULSA shall be adjudged by any court of competent jurisdiction to be unenforceable or invalid, that provision shall be limited or eliminated to the minimum extent necessary so that this EULSA shall otherwise remain in full force and effect and enforceable.

12. Warranty Disclaimer. Company, and author of Software, hereby expressly disclaim any warranty for the Software. Software and any related documentation is provided “as is” without warranty of any kind, either express or implied, including, without limitation, the implied warranties of merchantability, fitness for a particular purpose, or non-infringement. Licensee accepts any and all risk arising out of use or performance of Software.

13. Limited Liability. Company shall not be liable to Licensee, or any other person or entity claiming through Licensee any loss of profits, income, savings, or any other consequential, incidental, special, punitive, direct or indirect damage, whether arising in contract, tort, warranty, or otherwise. Even if Company has been advised of the possibility of such damages. These limitations shall apply regardless of the essential purpose of any limited remedy. Under no circumstances shall Company’s aggregate liability to Licensee, or any other person or entity claiming through Licensee, exceed the financial amount actually paid by Licensee to Company for the Software.

14. Entire Agreement. This Agreement constitutes the entire agreement between Company and Licensee and supersedes all prior understandings of Company and Licensee, including any prior representation, statement, condition, or warranty.

15. Additional Provisions and/or Disclosures.

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SIGNATURE PAGE