CIS EMPLOYEE BENEFITS TRUST PLAN

CONFORMED COPY OF PLAN
AS AMENDED THROUGH THE EIGHTH AMENDMENT
ADOPTED EFFECTIVE AS OF JANUARY 1, 2020

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Preamble

WHEREAS, City County Insurance Services (CIS) maintains the CIS Employee Benefits Trust Plan (the "Plan") for the benefit of the eligible employees of the Participating Employers. CIS is the "Plan Sponsor" and the "Plan Administrator" for the "Plan"; and

WHEREAS, CIS, as the Plan Sponsor, desires to amend the Plan to address and comply with regulatory changes, and for other purposes.

NOW, THEREFORE, in consideration of the foregoing, CIS hereby adopts the Plan as herein amended and restated, effective as of August 1, 2010.

To evidence the adoption of this amended and restated Plan, it has been signed on behalf of CIS by its Executive Director.

CITY COUNTY INSURANCE SERVICES

By: Lynn McNamara

Lynn McNamara
Executive Director

Dated: August 27, **2010**

ARTICLE 1

General

1.1 Purpose. It is the intention of CIS to continue to maintain the CIS Employee Benefits Plan (the "Plan") for the benefit of eligible employees of the Participating Employers, and in accordance with the provisions of the Code and other applicable laws pertaining to employee benefit plans. The purpose of the Plan is to continue to provide a broad range of employee welfare benefits for eligible employees and their respective dependents through one or more welfare benefit programs. The Plan is intended to govern various Benefit Programs through the use of documents that articulate the specific benefits covering the individuals described in such documents, and the terms and conditions associated with those benefits.

1.2 Composition of Plan. The Plan document is a compilation of a number of separate documents, including insurance contracts, administrative service agreements and employee benefit booklets. The Plan document is used in determining benefits to which Participants and their dependents are entitled. An individual's entitlement to coverage under the Plan, and any Benefit Program of the Plan, and the amount of any benefits provided under the Benefit Program, will be as set forth in the insurance contract, administrative services agreement or employee benefits handbook through which such benefits are administered.

1.3 Participating Employers.

(a) A "Participating Employer" means a city, county or other public body that has applied for, and has been accepted as, a "Participant" with respect to the City County Insurance Services Trust in accordance to the Bylaws of such trust, and whose status as such a Participating Employer has not been terminated, suspended or withdrawn pursuant to such Bylaws.

(b) An eligible employer may elect to become a Participating Employer for any Plan Year or other applicable period by completing the "CIS Benefits Request for Coverage (RFC)" form and by electronically executing the Agreement that is included as part of the RFC form.

(c) A Participating Employer must indicate on the RFC form which of the available Benefit Programs, and each available option under the Benefit Program, that it is adopting on behalf of its employees for the applicable period. The Participating Employer will also indicate on the RFC form, if applicable, the classes of employees to be covered under each Benefit Program.

(d) An employer that elects to become a Participating Employer agrees to be bound by and hereby assents to all of the terms of the Plan.

(e) A Participating Employer's Plan participation election for any Plan Year may be terminated, effective as of the last day of a calendar month, by the employer or by CIS by notifying the other party thereof in writing at least sixty (60) days prior to such termination date, or within such shorter time period as may be acceptable by CIS. A participation termination election made by a Participating Employer during a Plan Year will apply to all Benefit Programs

elected by the Participating Employer for that Plan Year. The Employer may not again elect to participate in the plan until the applicable waiting period has been served.

1.4 Exemption from ERISA. The Plan is a governmental plan within the meaning of Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), and thus is exempt from coverage under that statute pursuant to ERISA Section 4(b)(1).

1.5 Effective Date. The provisions of this Plan document as herein restated are effective as of August 1, 2010, except as may be specifically provided otherwise. The terms and conditions of the Plan as set forth in this document will apply to expenses incurred on or after this effective date, except as may be specifically provided otherwise.

ARTICLE 2

Definitions

Where the following words and phrases appear in this Plan, they will have the respective meanings set forth below, unless their context clearly indicates otherwise.

Benefit Program. "Benefit Program" means any benefit program offered under the Plan for the purpose of providing benefits to Participants under the Plan. The terms and conditions of the coverage under a Benefit Program (other than the FSA Program and the Health Savings Account Program) are set forth in separate documents pertaining to that Benefit Program, and the benefits will be determined solely therefrom. The Benefit Programs currently offered under the Plan are set forth in Section 3.1.

Change in Status Event. "Change in Status Event" is an event described in Section 5.2 that may allow a Participant to make changes to a benefit election outside of the open enrollment period.

CHIPRA. "CHIPRA" means the Children's Health Insurance Program Reauthorization Act of 2009.

CIS. "CIS" means CIS Trust.

Claims Administrator. "Claims Administrator" means with respect to a Benefits Program an insurance company or other organization appointed by CIS to administer claims under the Benefit Program.

COBRA. "COBRA" means the health program continuation coverage rules prescribed under the Consolidated Omnibus Budget Reconciliation Act of 1985.

Code. "Code" means the Internal Revenue Code of 1986, as from time to time amended.

Dependent Care FSA Program. "Dependent Care FSA Program" means the component of the FSA Program prescribed in Article 8.

Eligible Employee. "Eligible Employee" means an Employee who has been designated by a Participating Employer as being eligible for coverage under a Benefits Program, as prescribed in Section 3.2.

Employee. "Employee" means an employee of a Participating Employer. However, the term "Employee" will expressly exclude, as with respect to any period, a leased employee, an independent contractor, or any other individual performing services for a Participating Employer who for the period at issue had not been treated by the Participating Employer as an employee for employment tax purposes.

Employer. "Employer" means, with respect to a Participant, the Participating Employer employing the Participant.

FMLA. "FMLA" means the Family and Medical Leave Act of 1993, as amended.

FSA Program. "FSA Program" means the Benefit Program encompassing the Healthcare FSA Program and the Dependent Care FSA Program, as prescribed in Articles 6, 7 and 8.

GINA. "GINA" means the Genetic Information Nondiscrimination Act of 2008.

Group Health Benefit Program. Except as expressly provide otherwise, a "Group Health Benefit Program" means any Benefit Program, other than the Healthcare FSA Program, providing for the payment or reimbursement of health care expenses for Participants and their eligible dependents.

Healthcare FSA Program. "Healthcare FSA Program" means the component of the FSA Program described in Article 7.

Health Savings Account Program. "Health Savings Account Program" means the Benefit Program described in Article 9.

HIPAA. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

Participant. "Participant" means with respect to a Benefit Program an Eligible Employee who has enrolled, or who has been enrolled, for coverage under the Benefit Program.

Participating Employer. "Participating Employer" means an employer that has elected to participate in the Plan as prescribed in Section 1.3.

Plan. "Plan" means the CIS Employee Benefits Plan, and all documents, including any insurance contracts, administrative service agreements, summary plan descriptions and any related terms and conditions associated with the Plan.

Plan Administrator. CIS serves as the "Plan Administrator" of the Plan.

Plan Sponsor. CIS serves as the "Plan Sponsor" of the Plan.

Plan Year. For purposes of the Plan itself, a "Plan Year" is the 12-month period beginning on January 1 and ending on December 31 of each year. The period from August 1, 2012 through December 31, 2012 will be a short Plan Year. No dates of expiration, plan year, policy year or other period of coverage contained in any Benefit Program or insurance contract or other document will have any effect on the Plan Year.

Pre-Tax Premium Program. The "Pre-Tax Premium Program" means the premium payment arrangement described in Section 4.3.

USERRA. "USERRA" means the Uniform Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE 3

Benefit Programs and Eligibility

3.1 Benefit Programs.

(a) The Benefit Programs maintained under, and forming part of, the Plan include those identified below:

- Medical Insurance Program;
- Dental Care Program;
- Vision Insurance Program;
- Long-Term Disability Insurance Program;
- Pre-Tax Premium Program;
- Flexible Spending Account ("FSA") Program;
- Health Savings Account ("HSA") Program;
- Healthy Benefits Program;
- Employee Assistance Program;
- Employer Paid Life Insurance Program;
- Accidental Death & Dismemberment ("AD&D") Insurance Program; and
- Additional Voluntary Employee, Spouse, and Dependent Life Insurance Program

(b) At the beginning of a new Plan Year, CIS will decide which Benefit Programs are to be made available to the Participating Employers for the ensuing period.

(c) CIS will have the right at any time to add, amend or eliminate a Benefit Program under the Plan, as well as the insurance policy that constitutes or forms a part of a Benefit Program. For the purposes of this Section 3.1, if a Benefit Program is added or amended, the insurance policy or other governing document establishing or amending the Benefit Program will be made a part of the Plan, and its provisions will be incorporated in the Plan by this reference.

(d) The provisions of a Benefit Program, including the requirements for enrollment and coverage, the types and amounts of benefits, the procedures for the payment of benefits, and any other conditions or limitations regarding coverage and benefits will be determined only under the governing documents establishing, constituting or forming a part of the Benefit Program as in effect from time to time.

3.2 Eligibility.

(a) Except as provided herein, an "Eligible Employee" for purposes of any Benefit Program means an Employee of a Participating Employer who is in a class of employees designated by the Participating Employer as being eligible for coverage under the Benefit Program.

(b) Unless the terms of a Benefit Program provide otherwise, if a Participant separates from service with the Participating Employer for any reason, including (but not limited to) disability, retirement, layoff, leave of absence without pay or voluntary resignation, and then is rehired by the same Participating Employer within the same Plan Year and within 30 days or less of the date of the prior termination of employment, the Participant will be reinstated under the Benefit Program in which the Participant was covered with the same elections that the Participant had prior to termination. If the Participating Employer rehires a former Participant within the same Plan Year, but more than 30 days following termination of employment, and the Participant is otherwise eligible to participate in the Plan, then the Participant may make new elections as a new hire.

3.3 Eligible Dependents.

(a) Subject to subsection (c) below, the following individuals will qualify as dependents of a Participant for purposes of the Medical Insurance Program of the Plan:

(b) The Participant's legal spouse;

(i) The Participant's eligible domestic partner (as determined under the terms of the booklet forming part of the Medical Insurance Program); and

(ii) A child of the Participant who has not attained age 26.

(c) For purposes of this Section 3.3, the term "child" means:

(d) A natural child of the Participant, spouse, or eligible domestic partner;

(i) A legally adopted child, or a child placed for adoption, with respect to the Participant, spouse, or eligible domestic partner, provided that the child is adopted or placed for adoption prior to attaining age 18;

(ii) A child for whom legal guardianship has been granted to, the Participant, spouse or eligible domestic partner, pursuant to a court order or decree; and

(iii) A child for whom the Participant, spouse or eligible domestic partner is obligated to provided benefits pursuant to a qualified medical child support order ("QMCSO").

(e) An incapacitated child of a Participant may remain covered under the Medical Insurance Program as a dependent beyond age 26 as long as the child was enrolled in a CIS plan at the time the child attained 26. A newly-eligible Participant may enroll a disabled child over the age of 26 if the child was disabled prior to attaining age 26, and the Participant enrolls the child as of the Participant's initial eligibility date. For this purpose, an incapacitated child is an unmarried child of a Participant who:

(i) Has a physical or mental developmental disability;

(ii) Is incapable of financially supporting himself or herself, and primarily depends on the Participant for support and maintenance; and

(iii) Is found to be incapacitated at the time of his or her 26th birthday. The onset of the disability must have occurred prior to that date.

Initial proof of the child's incapacity and dependency must be furnished to the Plan Administrator within a reasonable period of time after the child reaches age 26. Thereafter, the Plan Administrator may request proof of continued incapacitated child status, but no more than once a year.

(f) The coverage of an Employee's spouse, domestic partner or child under the Medical Insurance Program, or under any other Benefit Program, is expressly conditioned upon the Employee timely providing to CIS any requested documentation substantiating the individual's eligible dependent status (for example, a marriage certificate). Accordingly, the enrollment of such an individual will not be effective unless the requested documentation is timely provided.

3.4 Medical Insurance Opt-Out Payments.

(a) An Employee who is otherwise eligible for coverage under the Medical Insurance Benefit Program may elect to opt-out of such coverage if the Employee provide reasonable evidence that the Employee, and all other individuals for whom the Employee reasonably expects to claim a personal exemption deduction for the year of coverage waiver (the "expected tax family"), will have minimum essential coverage within the meaning of Code Section 5000A(f) (other than individual coverage, whether or not obtained through the Insurance Exchange Marketplace) during the period to which the opt-out applies.

(b) An Employee who opts-out of coverage under the Medical Insurance Benefit Program will be eligible for a cash stipend in lieu of such Medical Insurance Benefit coverage, the amount of which will be subject to a limit established by CIS.

(c) Notwithstanding subsection (a) above, the opt-out of coverage will not be permitted if the Employer knows or has reason to know that the Employee or any other member of the Employee's expected tax family does not have or will not have the alternative minimum essential coverage for the period at issue.

(d) The reasonable evidence of the alternative minimum essential coverage must be provided for each Plan Year in which the opt-out of coverage applies, and must be provided during the open enrollment period for such Plan Year of coverage or otherwise within a reasonable period of time before the commencement of the period of coverage. For purposes of this Section 3.4, an Employee's written attestation as to the Employee and other expected tax family members having alternative minimum essential coverage will suffice as the reasonable evidence of such alternative coverage.

(e) The opt-out of coverage option is intended to qualify as a cafeteria plan arrangement governed by Code Section 125, and thus will be subject to the Code Section 125 irrevocability of election provisions of Section 5.1 of the Plan. Accordingly, the election must be made before the applicable Plan Year or other period of coverage, and once made is irrevocable

for the duration of the period of coverage to which it relates, unless an exception applies (such as upon the occurrence of a special enrollment or qualified change in status event).

ARTICLE 4

Contributions

4.1 Funding of Benefits. The benefits provided under any Benefit Program may be wholly or partially paid by the Participating Employers, or partially paid by Participants.

4.2 Participant Contributions. As a condition to coverage under a Benefit Program, a Participant may be required to contribute toward the cost of the coverage under such program. The amount of such contribution will depend on the Benefit Program selected, as well as a Participating Employer's requirements, and, if applicable, the coverage category selected. The contribution rates for each year will be established by individual Participating Employers for their Employees. Participant contribution rates may differ for different classes or groups of employees.

4.3 Pre-Tax Premium Program. The Pre-Tax Premium Program reduces a Participant's compensation by the amount that the Participant would otherwise be required to pay as a condition of coverage under a Benefit Program, and applies such reduction amount on a pre-tax basis toward the payment of the applicable premium contributions. A Participating Employer that selects Benefits Programs to which the Pre-Tax Premium program applies, but which does not adopt a Flexible Spending Account ("FSA") Program or a Health Savings Account ("HSA") Program, is sometimes referred to as having adopted the Plan as a "Pre-Tax Premium Plan."

(a) CIS will designate the Benefit Programs to which the Pre-Tax Premium Program will be available. A Participant is required to make the applicable contributions for each such Benefit Program on a pre-tax basis through the Pre-Tax Premium Program unless the Participating Employer of the Participant, in its discretion, allows the Participant to make the contributions on an after-tax basis, such as in the case of payments to be made while an Employee is on an unpaid leave of absence.

(b) Except in regard to the FSA Program or the HSA Program, a Participant's enrollment in the Pre-Tax Premium Program is not subject to an annual election during each open enrollment period, and will automatically remain for succeeding Plan Years.

4.4 Leaves of Absence. A Participant in a Benefit Program requiring premium contributions who takes a leave of absence remains obligated to pay the applicable premium contributions for coverage under the Benefit Program during such period of leave, unless the Participant's Employer waives such requirement in whole or in part. Unless the Participant and Participating Employer otherwise agree, the Plan's rules regarding the payment of premium contributions will be as set forth below.

(a) During the period of a paid leave of absence, a Participant's premium contributions under the Benefit Program will continue to be made on the same basis as if such Participant was otherwise actively employed by the Employer.

(b) A Participant who takes an unpaid leave of absence, including unpaid leave covered under the FMLA, may continue coverage under the Benefit Program under the rules prescribed below, or under such other rules as prescribed under the terms of the Benefit Program or by the Participant's Employer.

(c) The Participant may continue coverage by submitting the required premium to the Participant's Employer by the first of each month, or as of such other later date allowed by the Employer.

(i) Such contributions will be treated as after-tax contributions.

(ii) If the Participant does not remit the required premium for coverage under a Benefit Program for a month by the applicable deadline of that month (taking into account any grace period that may be made available to the Participant), then coverage under the Benefit Program will be revoked retroactive to the first day of the month and will not be permitted to be resumed during the remainder of that Plan Year.

(d) If so agreed upon by the Participant's Employer, the Participant will not be required to remit any contributions during the period of unpaid leave. Instead, the premium payments that would otherwise have been payable by the Participant during the leave period will be held in arrears.

(i) Upon the Participant's return from leave, the amount in arrears may be repaid by the Participant through the Pre-Tax Premium Program. Such repayment will be made as prescribed under a policy established by the Participant's Employer.

(ii) If the Participant fails to return to employment, or if after returning to employment the Participant separates from service before the total amount of the arrears has been paid, the amount of the arrears can be recovered by the Participant's Employer through the deduction of any sums due to the Participant by the Employer, including from any unpaid wages or vacation pay, provided that such deductions do not otherwise violate applicable federal or state wage payment and other laws. Alternatively, the Employer can initiate legal action against the Participant to recover such arrears.

(e) In regard to coverage under a Group Health Benefit Program, the Participant may elect to suspend participation during the period of unpaid FMLA leave.

ARTICLE 5

Permitted Election Changes

5.1 Irrevocable Status of Elections. Except as otherwise provided in this Section 5.1, any election made or deemed to have been made by an Employee with respect to any Plan Year in regard to participating or declining to participate in a Benefit Program for which Participant contributions may be paid on a pre-tax basis will be irrevocable for the duration of that Plan Year. As an exception to that rule, an Employee may revoke an election with respect to a Benefit Program to which the Pre-Tax Premium applies for a Plan Year (including the rescinding of a deemed election not to participate in the Benefit Program for that Plan Year), to take effect for the remainder of the Plan Year if the benefit election, modification or revocation, as the case may be, is on account of a permitted election change event described in this Article 5. The change in election must be requested within 31 days of the applicable event, or within such later date as allowed under applicable laws.

5.2 Change in Status Events. A change in election will be permitted to be made during a Plan Year if the change (i.e., a benefit election, modification or revocation, as applicable) is on account of and consistent with a change in status event described below:

(a) An event that changes the Employee's legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment;

(b) An event that changes the Employee's number of dependents, including the birth, adoption, placement for adoption or death of a dependent;

(c) A termination or commencement of employment by the Employee, or by a dependent of the Employee;

(d) The suspension of active employment of an Employee or dependent of the Employee due to a strike or lockout;

(e) A commencement or return from an unpaid leave of absence by the Employee or a dependent of the Employee;

(f) A change in the place of residence or worksite of the Employee or a dependent of the Employee;

(g) An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage under the Benefit Program or another employee benefit plan (including an employee benefit plan of another employer) due to attainment of age, student status or any similar circumstance;

(h) Any other change in the employment status of the Employee or a dependent of the Employee that results in the individual becoming, or ceasing to be, eligible for coverage under the Plan or another employee benefit plan; and

(i) Any of the changes listed in subsections (a) through (h) above, as applicable under the Oregon Family Fairness Act.

5.3 Election Restrictions. An effectuation, modification or revocation of a Participant's election due to a Change in Status Event will be allowed only as prescribed below.

(a) A new election, or a modification or revocation of an election, to be made with respect to coverage under a Group Health Benefit Program or the Healthcare FSA Program, or under a Benefit Program providing for group-term life insurance coverage, must be on account of and correspond with a qualified change in status that affects eligibility for such coverage under an employer's benefit plan (including, if applicable, COBRA continuation coverage). A change in status that affects eligibility under an employer's benefit plan includes a change in status that results in an increase or decrease in the number of a Participant's family members or dependents who may benefit from coverage under the plan.

(b) A new election, or a modification or revocation of an election, to be made under any other Benefit Program will be allowed only to the extent that it is on account of and corresponds with a Change in Status Event that affects eligibility for coverage under an employer's benefit plan. For purposes of the Dependent Care FSA Program, an election change is also permitted if it is on account of and corresponds with a change in status that effects the Participant's employment-related expenses (as defined in Code Section 21(b)(2)).

5.4 Special Health Plan Enrollment Rights. An Eligible Employee who CIS determines is eligible to enroll in the Medical Insurance, or in another non-excepted Group Health Benefit, Program mid-year by reason of the special enrollment rights prescribed under HIPAA or CHIPRA, may then also make or change an election pertaining to the premium contributions payable with respect to the Group Health Benefit Program for such coverage. If the special enrollment is made on a retroactive basis, the Participant may elect to increase the level of contributions to be made under the Group Health Benefit Program for the remainder of the Plan Year to account for the additional cost of the retroactive coverage.

5.5 Judgment, Decree or Order. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requires health coverage for a Participant's child who is a dependent of the Participant, the Participant may effect or change his or her election in order to:

(a) Provide coverage for the child if the order requires health coverage under the Group Health Benefit Program; or

(b) Cancel coverage for the child if the order requires the Participant's spouse, former spouse or other individual to provide health coverage for the child.

5.6 Entitlement to Medicare or Medicaid. If a Participant or a Participant's dependent becomes enrolled under Part A or Part B of Medicare or Medicaid (other than coverage solely under the federal pediatric vaccine program), the Participant may then change his or her election to reflect the cancellation or reduction of the coverage of the Participant's dependent under the Group Health Benefit Program. In addition, if a Participant or dependent subsequently loses coverage under Medicare or Medicaid, the Participant may make a prospective election to increase coverage for such individual under the Group Health Benefit Program.

5.7 Cost Changes.

(a) If the amount of premium contributions required of a Participant for coverage or benefits under a Benefit Program increases or decreases during a Plan Year (including by reason of a change in employment status), then the level of the Participant's premium contributions payable with respect to such Benefit Program will automatically be adjusted on a prospective basis to reflect the increase or decrease.

(b) If during a Plan Year the cost of a Participant's coverage under a Benefit Program (or in regard to any benefit option under that program) is increased by an amount which CIS determines to be significant (including any significant increase attributable to a change in employment status), then affected Participants will be permitted to elect to change prospectively the amount of the elected contribution rate with respect to such Benefit Program to cover the increase. Alternatively, if the Participant is given the option to terminate participation in that Benefit Program and enroll in another Benefit Program offering similar coverage and the Participant chooses to do so, then the Participant will have the right to make a change in election under the Pre-Tax Premium Program with respect to such Benefit Program to reflect the cost of the new coverage.

(c) If the cost to a Participant for dependent care assistance is increased during a Plan Year by an amount which CIS determines to be significant, then the Participant may change prospectively the amount of the elected contribution rate under the Dependent Care Program to cover the cost increase. However, this change in election is available only if the cost increase is imposed by a dependent care provider who is not a relative of the Participant within the meaning of Code Section 152(d)(2).

(d) No change in election may be made under this Section 5.7 with respect to the Healthcare FSA Program.

5.8 Significant Coverage Curtailment.

(a) If the necessary scope of coverage needed by a Participant under a Benefit Program is significantly curtailed or ceases during a Plan Year, the Participant may then revoke or modify the premium contribution election with respect to coverage under such Benefit Program for the remainder of the Plan Year.

(b) If coverage under a Benefit Program is significantly curtailed or ceases during a Plan Year, and if coverage under another Benefit Program providing similar coverage is made available to affected Participants, then each such affected Participant may make a new election on a prospective basis for coverage under the other Benefit Program. Coverage under a

Benefit Program will be deemed to be significantly curtailed only if there is an overall reduction in coverage provided to Participants under the program so as to constitute reduced coverage to Participants generally.

(c) No change in election may be made under this Section 5.8 with respect to the Healthcare FSA Program.

5.9 Addition or Elimination of Benefit. If during a Plan Year a Benefit Program or other benefit option is either added or eliminated from the Plan, or if a benefit option is either added or eliminated from a Benefit Program, then CIS, in its discretion, may permit affected Participants, on a prospective basis, to elect participation in the newly-added Benefit Program, or to modify an election due to the addition or elimination of the Benefit Program or of the benefit option under the Benefit Program, as the case may be. Further, affected Participants may then be permitted to make corresponding election changes with respect to other Benefit Programs or benefit options providing similar coverage. No change in election may be made under this Section 5.9 with respect to the Healthcare FSA Program.

5.10 Family and Medical Leave Act. A Participant who takes an unpaid leave under the Family and Medical Leave Act (FMLA) during a Plan Year may disenroll in a Group Health Benefit Program or the Healthcare FSA Program, and upon returning from such leave, may make an election for coverage under the applicable Benefit Program for the remainder of the Plan Year.

5.11 Changes Under Other Employer Plan. CIS, in its discretion, may permit a Participant to make a prospective election change that is on account of and corresponds with a qualified election change made by the Participant, or by the spouse or dependent of the Participant, under a Section 125 cafeteria plan or other employee benefit plan of the Employer, or of any other employer, provided that either one of the following conditions are satisfied:

(a) The election change is being made for an event or reason described in this Article 5 and is permitted to be so made by the Participant, spouse or dependent (as applicable) pursuant to the terms of the other plan; or

(b) The other plan forms part of a cafeteria plan, and the period of coverage under that other plan is different than the period of coverage prescribed under the Benefit Program under this Plan to which the change applies.

5.12 Effective Date of Changes. Any new election made under this Article 5 will be effective at such time as CIS will prescribe, but not earlier than the first pay period beginning after the election revocation or modification form is completed and returned to CIS or its delegate. Notwithstanding the foregoing, an election pertaining to coverage under a Group Health Benefit Program effectuated by reason of a newly acquired dependent, or any other event implicating the HIPAA or CHIPRA special enrollment rules, may be made retroactively effective as of the affected individual's special enrollment date.

5.13 Revocation Due to Enrollment in Marketplace Exchange Policy.

(a) A Participant may prospectively revoke coverage under the Medical Insurance Program if the Participant is eligible for coverage under a qualified policy providing for

minimum essential coverage offered under an ACA Marketplace Insurance Exchange (the "Marketplace") during either a Marketplace special enrollment period or during the Marketplace's annual open enrollment period.

(b) The revocation of the election of coverage under the Medical Insurance Program must correspond to the intended enrollment of coverage of the Participant and any dependents under a Marketplace policy. The new coverage under the Marketplace policy must be effective beginning no later than the day immediately following the last day of the revoked coverage under the Medical Insurance Plan.

(c) CIS may rely on the reasonable representation of a Participant who has an enrollment opportunity for a policy through a Marketplace that the Participant and dependents have enrolled or intend to enroll in a policy for new coverage that is effective beginning no later than the day immediately following the last day of coverage under the Medical Insurance Program.

5.14 Revocation Due to Reduction in Hours of Service.

(a) A Participant may prospectively revoke coverage under the Medical Insurance Program if the Participant was a full-time employee (i.e., was reasonably expected to average at least 30 hours of service per week) and incurs a change in status so that the Participant will be reasonably expected to average fewer than 30 hours per week after the change. The revocation is permitted even if the reduction of hours does not result in the Participants ceasing to be eligible for coverage under the Medical Insurance Program.

(b) The revocation of the election of coverage under the Medical Insurance Program must correspond to the intended enrollment of coverage of the Participant and any dependents under a Marketplace policy or another health plan that provides minimum essential coverage. The new coverage must be effective beginning no later than the first day of the second month following the month that includes the date that the coverage under the Medical Insurance Program is revoked.

(c) CIS may rely on the reasonable representation of a Participant who has a change in status described above that the Participant and dependents have enrolled or intend to enroll in a Marketplace policy or other qualified health plan within the timeframe prescribed in subsection (a) above.

ARTICLE 6

Flexible Spending Account (FSA) Program

The provisions of this Article 6 will apply for a Plan Year to the Eligible Employees of a Participating Employer that has elected to adopt the FSA Program for the Plan Year.

6.1 Overview.

(a) The purpose of the Flexible Spending Account (FSA) Program is to allow Eligible Employees to elect to reduce their taxable compensation, and to have such elected amounts set aside for the reimbursement of qualified medical or dependent care assistance expenses. In this regard, the FSA Program is comprised of two subsidiary Benefit Programs; the Healthcare Flexible Spending Account Program (the "Healthcare FSA Program") and the Dependent Care Flexible Spending Account Program (the "Dependent Care FSA Program"). Participation in either of the FSA Programs is voluntary.

(b) Each Plan Year, a Participating Employer will elect whether to make one, neither or both of the FSA Programs available to its Eligible Employees for that Plan Year. Such election will be made in accordance with the procedures prescribed in Section 1.3.

(c) The provisions of this Article 6, and Article 7 and 8, as applicable, will apply with respect to the Participating Employer if it elects to participate in an FSA Program for any Plan Year.

6.2 Employer and Participant Contributions.

(a) Participant Contributions. A Participating Employer will withhold from a Participant's compensation by salary reduction on a pre-tax basis an amount equal to the contributions required from the Participant for the benefits elected by the Participant under the FSA Program. The maximum amount of salary reductions will not exceed the aggregate cost of the benefits elected.

(b) Non-Elective Employer Contributions. For any Plan Year, or for any period within a Plan year, a Participating Employer, in its discretion, can choose to make non-elective Employer contributions to a Participant's Healthcare FSA Account or Dependent Care FSA account, or to both accounts. The Employer is not obligated to make Employer contributions for any period, and the amount of the Employer contribution may differ among Participants or classes of Participants, and from period to period. All Employer contributions made under this Section 6.2(b) will be subject to all rules and limitations applicable to the FSA Programs under Articles 6, 7 and 8, as applicable, including the "use-it-or-lose-it" rules of Sections 7.6 and 8.7.

6.3 Computing Salary Reduction Contributions.

(a) Salary Reductions per Pay Period. The salary reduction for a pay period for a Participant is an amount equal to the annual premium for such benefits divided by the number of pay periods in the period of coverage, or an amount otherwise agreed upon between the Employer and the Participant, or an amount deemed appropriate by CIS. For purposes of both FSA Programs, the period of coverage will be the Plan Year.

(b) Adjusted Salary Reduction Amount. If a Participant increases his or her election under the Healthcare FSA Program or Dependent Care FSA Program, as permitted under Article 5, the salary reductions per pay period will be, for the benefits affected, an amount equal to the new annual amount elected pursuant to Article 5, less the aggregate premiums (if any) for the period prior to such election change, divided by the number of pay periods in the balance of the Plan Year commencing with the election change, or an amount otherwise agreed upon between the Participant and his or her Employer, or an amount deemed appropriate by CIS.

6.4 Funding. All of the amounts payable under the FSA Program will be paid from the general assets of the Participating Employers. Nothing herein will be construed to require the Participating Employers or CIS to maintain any fund or to segregate any amount for the benefit of any Participant. No Participant or any other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Participating Employers from which any payment under the FSA Program may be made.

6.5 Elections When First Eligible. An Employee who first becomes eligible to participate in the FSA Program mid-year, including an Employee who becomes eligible upon ceasing to be eligible for participation in the HSA Program during a Plan Year, can elect to commence such participation as of the eligibility effective date prescribed by the Employee's Participating Employer, provided the Employee properly submits an enrollment form to the Employer on or before such date, or, if later, within 30 days of the date of the Employee's commencement of employment with the Employer. If the Employee does not submit the enrollment form by the applicable deadline, then the Employee must wait until the next open enrollment period to elect to participate in the FSA Program (unless an event described in Article 5 occurs before such period).

6.6 Elections During Open Enrollment Period.

(a) During each open enrollment period with respect to a Plan Year, an enrollment form will be provided to each Employee who is eligible to participate in an FSA Program. The enrollment form will enable the Employee to elect to participate in the FSA Program for the next Plan Year, and to authorize the necessary salary reductions to pay for the benefits elected. The enrollment form must be returned to the Employee's Employer on or before the last day of the open enrollment period.

(b) If an Eligible Employee makes an election to participate during an open enrollment period, then the Employee will become a Participant in the applicable FSA Program on the first day of the next Plan Year. In lieu of a written enrollment form, CIS may allow or

require elections to be made through an electronic system. Such use of an electronic system will have the same effect as a signed enrollment form.

(c) An Eligible Employee who fails to timely enroll in an FSA Program during an open enrollment period applicable to a Plan Year or other period of coverage will be deemed to have elected not to participate in the FSA Program for the succeeding Plan Year or coverage period. The Eligible Employee will not be eligible to elect participation in the FSA Program until the next open enrollment period, unless an event described in Article 5 occurs before such period.

6.7 Cessation of Participation. An Employee will cease to be a Participant in an FSA Program upon the earliest of:

(a) The expiration of the Plan Year for which the Employee has elected to participate in the FSA Program (unless during the open enrollment period for the next Plan Year the Employee elects to continue participating) or if pursuant to Section 7.6(b), has a carryover of a balance of a Healthcare FSA account to the following Plan Year);

(b) The date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee with respect to the FSA Program, provided that eligibility under the Healthcare FSA Program may continue beyond such date in accordance with the COBRA continuation coverage provisions of Section 7.8(b) (but not beyond the end of the current Plan Year); or

(c) The date on which the FSA Benefit Program is terminated.

An Employee's participation in the Plan may be terminated if it has been determined that the Employee has filed a false or fraudulent claim for benefits.

6.8 COBRA. Under the COBRA rules, the Participant's spouse and dependent(s) may be able to continue to participate under the Healthcare FSA Program through the end of the Plan Year in which the Participant dies. The Participant's spouse and dependent(s) will be required to make contributions to the Plan to continue their participation.

6.9 USERRA.

(a) Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA"), then, to the extent required by USERRA, the Employer will continue to maintain the Participant's Healthcare FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid USERRA leave, a Participant may elect to continue his or her Healthcare FSA Benefits during the leave. If the Participant elects to continue coverage while on USERRA leave, then the Participant may pay his or her share of the premium with after-tax dollars, by sending monthly payments to his or her Employer by the due date established by the Employer, or with pre-tax dollars, by having such amounts withheld from the Participant's ongoing compensation (if any, including unused sick days and vacation days).

(b) Coverage under a Participant's Healthcare FSA Program will terminate if premium payments are not received by the due date established by his or her Employer. If a

Participant's Healthcare FSA Program or Dependent Care FSA Program coverage ceases while on USERRA leave for any reason (including for non-payment of premiums), the Participant will be entitled to re-enter the applicable Benefit Program upon return from such leave on the date of such resumption of employment, and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of any provision to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.

6.10 Limitation on Benefits for Key Employees.

(a) Notwithstanding any provision of the FSA Program to the contrary, in no event will the aggregate amount of (i) reimbursements provided to Key Employees of a Participating Employer under the FSA Program and (ii) the amount of compensation elected to be reduced and applied under the Pre-Tax Premium Program for such Key Employees for a Plan Year, exceed 25% of the aggregate amount of such reimbursements and compensation reduction amounts for all Participants employed by the Participating Employer for such Plan Year.

(b) For purposes of this Section 6.10, a "Key Employee" for any Plan Year is any Employee of a Participating Employer who at any time during the Plan Year is (or was) an officer of the Participating Employer if such individual's compensation from the Employer for that Plan Year exceeds $130,000 (or such greater amount as may be prescribed by the Internal Revenue Service).

(c) CIS or a Participating Employer may adopt such rules as it deems necessary or desirable to assure that the foregoing limitation is satisfied, including imposing restrictions on the amount of contributions which a Key Employee may elect to have set aside under the FSA Program and the Pre-Tax Premium Program for a Plan Year. Any such rules will be uniformly applied to similarly situated individuals.

6.11 Claims Procedure.

(a) Any person who believes that he or she is entitled to receive a benefit under the FSA Program, including one greater than that initially determined to be payable, may file a claim in writing with the Claims Administrator for the FSA Program.

(b) The Claims Administrator will within 30 days of the receipt of a claim either allow or deny the claim in writing. A denial of a claim will be written in a manner calculated to be understood by the claimant.

(c) A claimant whose claim is denied may, within 180 days after receipt of denial of his or her claim, submit a written request for review to the Claims Administrator. The Claims Administrator will notify the claimant of its decision on review within 60 days of receipt of a request for review.

(d) The Claims Administrator is granted the discretionary authority and powers in regard to the review and disposition of claims, and for appeals of denied claims for benefits made under the FSA Program. Such authority and powers include, but are not limited to,

construing and interpreting the terms of the FSA Program and of any documents pertaining to the FSA Program.

(e) If a Participant dies while covered under the Plan, the Participant's spouse or other dependent, or the representative of the Participant's estate, may submit claims under the FSA Program for expenses that the Participant incurred through the end of the month in which the Participant died. Claims incurred by the Participant's spouse, or any other of the Participant's covered dependents, prior to the end of the month in which the Participant dies, may also be submitted for reimbursement.

ARTICLE 7

Healthcare FSA Program

The provisions of this Article 7 will apply for a Plan Year to the Eligible Employees of a Participating Employer that has elected to adopt the Healthcare FSA Program for the Plan Year.

7.1 Benefits. An Eligible Employee can elect to participate in the Healthcare FSA Program for a Plan Year by electing to receive benefits in the form of reimbursements for Qualified Healthcare Expenses. The election to participate will be made in accordance with the procedures prescribed in Article 6. Benefits elected will be funded by Participant contributions as provided in Section 6.2.

7.2 Benefit Contributions. The annual contributions made with respect to a Participant under the Healthcare FSA Program for any Plan Year will be equal to the annual amount elected by the Participant pursuant to Section 6.2(a), plus any additional non-elective Employer contributions made on the Participant's behalf pursuant to Section 6.2(b).

7.3 Qualified Healthcare Expenses. Under the Healthcare FSA Program, a Participant may receive reimbursement for Qualified Healthcare Expenses incurred during the Plan Year for which an election is in force.

(a) Incurred. A Healthcare Expense is incurred at the time the care or service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for, the healthcare. Notwithstanding the foregoing, a Participant is eligible to be reimbursed for orthodontia services before the services are provided, but only to the extent that the Participant has actually made the payments in advance of the orthodontia services in order to receive the services.

(b) Qualified Healthcare Expenses. "Qualified Healthcare Expenses" means expenses incurred by a Participant, or by the Participant's spouse or dependent(s), for medical care and other healthcare, as defined in Code Section 213(d), other than expenses that are excluded by subsection (c) and (d) below, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other accident or health plan.

(c) Over-the-Counter Medical Care Products**.** Over-the-counter medical care products, including menstrual care products, incurred after December 31, 2019 are eligible for reimbursement under the Healthcare FSA Program, subject to other applicable terms of such program.

(d) Non-Reimbursable Expenses. Insurance premiums and long-term care expenses are not reimbursable from the Healthcare FSA Program.

(e) Dependent Status. For purposes of establishing the status of an expense as a Qualified Healthcare Expense, the term "dependent" as with respect to a Participant means:

(i) An individual who is related to the Participant by blood or marriage, or who resides with and is a member of the Participant's household, and who satisfies other

applicable requirements prescribed by Code Section 152, determined without regard to the gross income limitation condition of Code Sections 152(b)(1), (b)(2) and (d)(1)(B); and

(ii) A natural child, adopted child, stepchild or an eligible foster child (within the meaning of Code Section 152(f)(i)(C)) of the Participant who does not otherwise meet the standards prescribed in paragraph (i) above, but only for the period ending on the last day of the calendar year within which the child turns age 26.

7.4 Maximum and Minimum Benefits.

(a) Maximum Reimbursement Available. The maximum dollar amount elected by the Participant for reimbursement of Qualified Healthcare Expenses incurred during a Plan Year (reduced by prior reimbursements during the Plan Year) will be available at all times during the Plan Year, regardless of the actual amounts credited to the Participant's Healthcare FSA account. Notwithstanding the foregoing, no reimbursements will be available for Healthcare Expenses incurred after coverage under the FSA Program has terminated (taking into account any extension of coverage pursuant to COBRA or USERRA).

(b) Maximum and Minimum Dollar Limits. The maximum annual amount that a Participant may elect to contribute under the Healthcare FSA Program for any Plan Year is $2,550 (or such greater amount as may be prescribed by the Internal Revenue Service). There is no minimum annual benefit amount.

(c) Changes; No Proration. If a Participant enrolls in the Healthcare FSA Program mid-year, or wishes to increase his or her election mid-year as permitted under this Benefit Program, then there will be no proration rule (i.e., the Participant may elect coverage up to the maximum dollar limit, or may increase coverage to the maximum dollar limit, as applicable).

(d) Effect on Maximum Benefits if Election Change Permitted. Any change in an election affecting annual contributions to a Participant's Healthcare FSA account will also change the maximum reimbursement benefits for the balance of the Plan Year commencing with the effective date of the election change. Such maximum reimbursement benefits for the balance of the Plan Year will be calculated by adding:

- The aggregate premium paid for the Plan Year prior to such election change to;
- The total premium payable by the Participant to the Healthcare FSA Program for the remainder of such Plan Year; reduced by
- All reimbursements made during the entire Plan Year.

7.5 Establishment of Account. The Claims Administrator will establish and maintain a Healthcare FSA account with respect to each Participant who has elected to participate in the Healthcare FSA Program, but will not create a separate fund or otherwise segregate assets for this purpose. The account established hereto will merely be a record keeping account with the purpose of keeping track of contributions and reimbursements, under the Healthcare FSA Program on behalf of the Participant.

(a) Crediting of Accounts. A Participant's Healthcare FSA account will be credited following each salary reduction actually made during each Plan Year with an amount equal to the salary reduction actually made.

(b) Debiting of Accounts. A Participant's Healthcare FSA account will be debited during each Plan Year for any reimbursement of Qualified Healthcare Expenses incurred during the Plan Year.

(c) Available Amount Not Based on Credited Amount. The amount available for reimbursement of Qualified Healthcare Expenses is the amount as calculated according to Section 6.3(a). It is not based on the amount credited to the Healthcare FSA account at a particular point in time.

7.6 Use-It-or-Lose-It and Limited Carryover Rules.

(a) Use-It-or-Lose It Rule. Except as provided in subsection (b) below, if for a Plan Year any balance remains in a Participant's Healthcare FSA account after all reimbursements have been made for the Plan Year, then such balance will not be carried over to reimburse the Participant for Qualified Healthcare Expenses incurred during a subsequent Plan Year. The remaining amounts will be forfeited and retained by the Plan Administrator as a component of its compensation for its services to the Plan. In addition, any Healthcare FSA Benefit payments that are unclaimed by the close of the Plan Year following the Plan Year in which the Qualified Healthcare Expense was incurred will be applied as described above.

(b) Limited Carryover. Notwithstanding subsection (a) above, a limited amount of the remaining balance of the Participant's Healthcare FSA account for the Plan Year (determined after the payment of expenses during the 3-month run-out period for that Plan Year prescribed in Section 7.7(b)) will be carried over to the subsequent Plan Year. The amount to be carried over will be the lesser of (i) the remaining balance of the Participant's Healthcare FSA account for the Plan Year, or (ii) $500. The amount that is eligible to be carried over may not be cashed out or converted to any other taxable or nontaxable benefit. In addition, the carryover with respect to a Participant who has not elected to enroll in the Healthcare FSA Program for the following Plan Year is available only for that carryover Plan Year. Any remaining balance of the Participant's Healthcare FSA carryover as of the end of the following Plan Year (determined after the payment of expenses during the 3-month run-out period for that Plan Year) will be forfeited as described in subsection (a) above.

(c) Recipient Carryover Program. The carryover with respect to a Participant who has not elected to enroll in a high deductible health plan ("HDHP") made available under the Plan for the following Plan Year will be credited to an account established for the Participant under the Plan's general Healthcare FSA Program. The carryover with respect to a Participant who has elected to enroll in an HDHP made available under the Plan for the following Period Plan Year will be credited to an account established for the Participant under the Limited Purpose Healthcare FSA Program described in subsection (d) below.

(d) Limited Purpose Healthcare FSA Program. The Limited Purpose Healthcare FSA Program solely provides for the reimbursement of dental, vision, and preventive

care incurred by a Participant (or by the Participant's spouse or dependents) that qualify as medical care or other healthcare, as defined in Code Section 213(d) or for reimbursement of medical expenses that are incurred after the minimum annual HDHP deductible for the Plan Year under Code Section 223(d)(2(A)(i) has been satisfied. For this purpose, "preventive care" includes, but is not limited to, periodic health evaluations, including test and diagnostic procedures ordered in connection with routine examinations, such as annual physicals, routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight-loss programs, and screening services.

(e) No Effect on Salary Reduction Election. The amount of the Healthcare FSA account balance carryover made pursuant to subsection (b) above will be in addition to, and will not reduce, the maximum amount that the Participant may elect to contribute to the Healthcare FSA Program for the carryover Plan Year.

7.7 Reimbursement Procedure.

(a) Timing. Within 30 days after receipt by the Claims Administrator of a reimbursement claim from a Participant, the Participant will be reimbursed for the Participant's Qualified Healthcare Expenses (if approved by the Claims Administrator), or the Claims Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Claims Administrator, including in cases where a reimbursement claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) Claims Substantiation. A Participant who has elected to receive Healthcare FSA benefits for a Plan Year may apply for reimbursement by submitting an application to the Claims Administrator by no later than March 31 following the close of the Plan Year in which the Qualified Healthcare Expense was incurred. The reimbursement application must include the following information and statements:

(i) The person or persons on whose behalf the Qualified Healthcare Expenses have been incurred;

(ii) The nature and date of the Qualified Healthcare Expenses incurred;

(iii) The amount of the requested reimbursement;

(iv) A statement that such Qualified Healthcare Expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source; and

(v) Other such details about the Qualified Healthcare Expenses that may be requested by the Claims Administrator in the reimbursement request form or otherwise (for example, a statement from a medical practitioner that the expense was incurred to treat a specific medical condition, or a more detailed certification from the Participant).

The application must be accompanied by bills, invoices, or other statements from an independent third party (such as an "explanation of benefits" (EOB) from an insurance company) showing that the Qualified Healthcare Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Claims Administrator may request.

(c) Appeal of Denied Claims. A claim that has been denied can be appealed under the procedures prescribed in Section 6.11.

7.8 Reimbursements After Termination; Limited COBRA Continuation.

(a) The Participant will not be able to receive reimbursements for Qualified Healthcare Expenses incurred after his or her participation terminates. However, such Participant (or in the case of a deceased Participant, the spouse, dependent or estate representative) may claim reimbursement for any Qualified Healthcare Expenses incurred during the Plan Year prior to termination, provided that the claim is filed by March 31 following the close of the Plan Year in which the Qualified Healthcare Expense arose.

(b) Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her spouse and dependent(s) whose coverage terminates under the Healthcare FSA Program because of a COBRA qualifying event, will be given the opportunity to continue the same coverage that he or she had under the Healthcare FSA Program the day before the qualifying event (subject to all conditions and limitations under COBRA). The premiums for such continuation coverage will be equal to the cost of providing the same coverage to an active employee taking into account all costs incurred by the Employee and the Employer plus two percent (2%) administration fee. Specifically, an individual will be eligible for COBRA continuation coverage only if the Participant's remaining available amount is greater than the Participant's remaining premium payments at the time of the qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individual will be notified if the individual is eligible for COBRA continuation coverage. If COBRA is elected, COBRA will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA continuation coverage for the Healthcare FSA will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Coverage may terminate sooner if the premium payments for a Plan Year are not received by the due date established by the Claims Administrator for that Plan Year. COBRA continuation coverage is only granted after the Claims Administrator has received the premium payment for that Plan Year.

7.9 Compliance with COBRA, HIPAA, etc.

(a) Laws Applicable to Group Health Plans. The Healthcare FSA Program is a group health plan, and will comply with the applicable provisions of COBRA, HIPAA, CHIPRA, GINA and the Code.

(b) Coordination of Benefits. The Healthcare FSA Program is intended to pay benefits solely for Qualified Healthcare Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Healthcare FSA Program will not be considered a group health plan for coordination of benefits purposes, and the Healthcare FSA Program will not be taken into account when determining benefits payable under any other plan.

7.10 Qualified Reservist Distributions. Notwithstanding any provision of the Healthcare FSA Program to the contrary, a qualified reservist distribution ("QRD") will be made to a qualified Participant, subject to the terms and conditions prescribed below.

(a) A Participant who is a "reservist," and who by reason thereof is ordered or called to active duty for a period of 180 days or more or for an indefinite period, is eligible to request a QRD from the Healthcare FSA Program. For this purpose, a "reservist" is a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service. An order or call to active duty by the spouse or other family member of a Participant does not entitle the Participant to receive a QRD.

(b) A reservist must request a QRD on or after the date of the order or call to active duty, and before the last day of the reimbursement grace period for the Plan Year during which the order or call to active duty occurred. A request for a QRD must be made to CIS, and must be accompanied by a copy of the order or call to active duty.

(c) CIS or the Claims Administrator may rely on the period indicated in the order or call to active duty to determine the reservist's eligibility for a QRD.

(i) If the order or call to active duty specifies that the period of active duty is for 180 days or more, or is indefinite, the reservist is eligible for a QRD, and the reservist's eligible status will not be affected if the actual period of active duty is less than 180 days, or is otherwise changed.

(ii) A request for a QRD will not be granted if the period specified in the order or call to active duty is less than 180 days. However, subsequent calls or orders that increase the total period of active duty to 180 days or more may result in the reservist becoming qualified for a QRD. Thus, for example, if a reservist is ordered or called to active duty for 120 days, and his or her order or call is subsequently extended for an additional 60 days, the reservist will then be eligible for a QRD.

(d) The amount available to be paid as a QRD is the amount contributed by the reservist to the Healthcare FSA Program for the Plan Year at issue through the date of the QRD request, reduced by any reimbursements made under the Healthcare FSA Program for the Plan Year as of the date of the QRD request.

(e) A reservist who receives a QRD will remain eligible to be reimbursed for Qualified Healthcare Expenses incurred before the date a QRD is requested. The amount reimbursed will reduce the amount of the available QRD. However, if a QRD request is approved, the reservist will not be eligible for reimbursement for any Qualified Healthcare Expenses incurred after the date the QRD was requested. Accordingly, the reservist will not be permitted to elect COBRA continuation coverage with respect to expenses incurred after the QRD request date.

(f) The Plan will pay the QRD to the reservist within a reasonable time after the date that the QRD has been approved, and in all events within sixty days after a proper and complete request for a QRD has been received by CIS.

(g) The amount of any QRD paid during a Plan Year will be disregarded for purposes of applying the benefit limitation provisions of Section 6.10 of the Plan, and for any other Code Section 125 nondiscrimination rule.

(h) A QRD is included in the gross income and wages of the reservist, and will be subject to applicable employment taxes. The reservist's Employer will report the QRD as wages on the reservist's Form W-2 for the year in which the QRD is paid to the reservist. The amount reported as wages will be reduced by any amount in the reservist's Healthcare FSA Program account representing after-tax contributions.

ARTICLE 8

Dependent Care FSA Program

The provisions of this Article 8 will apply for a Plan Year to the Eligible Employees of a Participating Employer that has elected to adopt the Dependent Care FSA Program for the Plan Year.

8.1 Benefits. An Eligible Employee can elect to participate in the Dependent Care FSA Program by electing to receive benefits in the form of reimbursements for Qualified Dependent Care Expenses. The election to participate will be made in accordance with the procedures prescribed in Article 6. Benefits elected will be funded by the Participant on a pre-tax salary reduction basis.

8.2 Benefit Contributions. The annual contributions made with respect to a Participant under the Dependent Care FSA Program for any Plan Year will be equal to the annual amount elected by the Participant pursuant to Section 6.2(a), plus any additional non-elective Employer contributions made on the Participant's behalf pursuant to Section 6.2(b).

8.3 Qualified Dependent Care Expenses. Under the Dependent Care FSA Program, a Participant may receive reimbursement for Qualified Dependent Care Expenses incurred during the Plan Year for which an election is in force.

(a) Incurred. A Qualified Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense are furnished, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.

(b) Qualified Dependent Care Expenses.

(i) "Qualified Dependent Care Expenses" means expenses that are considered to be employment-related expenses under Code Section 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and spouse), and expenses for incidental household services, if incurred by the Eligible Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the remaining portion of such expense can be reimbursed from the Participant's Dependent Care FSA account if it otherwise meets the requirements of this Article 8.

(ii) Qualified Dependent Care Expenses paid for a period during only part of which the Participant is gainfully employed or in active search of gainful employment must be allocated on a daily basis. However, the expenses of a Participant who is gainfully employed are not required to be allocated in the case of a short, temporary absence from work, such as for vacation or minor illness, provided that the care-giving arrangement requires the Participant to pay for care during the absence. An absence of 2 (two) consecutive calendar weeks is a short, temporary absence. Whether an absence

longer than 2 (two) consecutive calendar weeks is a short, temporary absence will be determined by CIS on the basis of all the facts and circumstances.

(iii) The Dependent Care Expenses of a Participant who is employed part-time generally must be allocated between days worked and days not worked. However, if a part-time Participant is required to pay for dependent care on a periodic basis (such as weekly or monthly) that includes both days worked and days not worked, the allocation of the expenses is not required. A day on which the Participant works at least 1 (one) hour is a day of work.

(c) Qualifying Individual.

(i) A "Qualifying Individual" is (A) a dependent of a Participant who is under the age of 13, who is a qualifying child of the Participant within the meaning of Code Section 152, and who lives with the Participant at least one half of the year, or (B) the Participant's spouse or older dependent who is mentally or physically incapable of self-care, who resides with the Participant for more than one half of the year, and is a qualifying relative or child of the Participant under Code Section 152.

(ii) A child of divorced or separated parents, or parents living apart, at all times during the last 6 (six) months of the calendar year who otherwise statisfies the conditions described above, and who is in the custody of one or both parents for more than one-half of the calendar year, is the Qualifying Individual of the custodial parent even if the noncustodial parent may claim the dependency exemption for that child for that year. The status of an individual as a Qualifying Individual is determined on a daily basis.

(d) Qualifying Dependent Care Services. "Qualifying Dependent Care Services" means services that both relate to the care of a Qualifying Individual that enable the Participant and spouse (if applicable) to remain gainfully employed after the date of participation in the Dependent Care FSA Program and during the Plan Year, and are performed:

(i) In the Participant's home; or

(ii) Outside the Participant's home for:

(A) The care of a Participant's dependent who is under age 13, and who resides with the Participant at least one half of the year; or

(B) The care of any other Qualifying Individual who is a qualifying child or relative of the Participant under Code Section 152, who is mentally or physically incapable of self-care, who resides with the Participant for more than one-half of the year and who regularly spends at least 8 hours each day in the Participant's household.

In addition, if the expenses are incurred for services provided by a facility that provides care for more than six (6) individuals not residing at the facility, and that receives a fee, payment or grant for such services, then the facility must comply with all applicable state and local laws and regulations.

(e) Exclusions. Qualified Dependent Care Expenses for a Plan Year do not include amounts paid to a care provider who is or that is:

(i) An individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant or Participant's spouse for that year;

(ii) An individual who is the Participant's spouse at any time during the year;

(iii) A Participant's child who is under 19 years of age at the end of the year in which the expenses were incurred;

(iv) A Participant's spouse's child who is under l9 years of age at the end of the year in which the expenses were incurred;

(v) The parent of the child;

(vi) An overnight camp;

(vii) A summer school or tutoring program; or

(viii) Kindergarten or other higher-grade educational expenses (however, expenses for before- or after-school care are not exluded).

8.4 Maximum and Minimum Benefits.

(a) Maximum Reimbursement Available and Statutory Limits. The maximum dollar amount elected by the Participant for reimbursement of Qualified Dependent Care Expenses incurred during a Plan Year (reduced by prior reimbursements during the Plan Year) will only be available during the Plan Year to the extent of the actual amounts credited to the Participant's Dependent Care FSA account, less amounts debited to the Participant's Dependent Care FSA pursuant to Section 8.5.

Payment will be made to the Participant in cash as reimbursement for Qualified Dependent Care Expenses incurred during the Plan Year for which the Participant's election is effective, provided that the other requirements of this Article 8 have been satisfied.

Notwithstanding the foregoing, no reimbursement otherwise due to a Participant hereunder will be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the applicable statutory limit. The applicable statutory limit for a Participant is the smallest of the following amounts:

(i) The Participant's earned income for the calendar year;

(ii) The earned income of the Participant's spouse for the calendar year (a spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense; and (2) is either physically or mentally incapable of self-care or a full-time student will be deemed to have earned income in the amount of $250 per month

per Qualifying Individual for whom the Participant incurs Qualified Dependent Care Expenses, up to a maximum amount of $500 per month); or

(iii) $5,000 for the calendar year, if:

(A) The Participant is married and files a joint federal income tax return; or

(B) The Participant is married, files a separate federal income tax return, and meets the following conditions:

- The Participant maintains as his or her home a household that constitutes, for more than half of the taxable year, the principal abode of a Qualifying Individual;
- The Participant furnishes over half of the cost of maintaining such household during the taxable year; and
- During the last six months of the taxable year, the Participant's spouse is not a member of such household; or

(C) The Participant is single or is the head of the household for federal income tax purposes.

(iv) $2,500 for the calendar year if the Participant is married and resides with the spouse, but files a separate federal income tax return.

(b) Maximum and Minimum Dollar Limits. The maximum annual benefit amount that a Participant may elect to receive under the Dependent Care FSA Program in the form of reimbursements for Qualified Dependent Care Expenses incurred in any Plan Year will be $5,000 (subject to the other limitations described above). There is no minimum annual benefit amount.

(c) Changes; No Proration. If a Participant enrolls in the Dependent Care FSA Program mid-year and wishes to increase his or her election mid-year when permitted under this Benefit Program, then there will be no proration rule (i.e., the Participant may elect coverage up to the maximum dollar limit, or may increase coverage to the maximum dollar limit, as applicable).

(d) Effect on Maximum Benefits if Election Change Permitted. Any change in an election affecting annual contributions to a Participant's Dependent Care FSA will also change the maximum reimbursement benefits for the balance of the Plan Year, commencing with the election change effective date. Such maximum reimbursement benefits for the balance of the Plan Year will be calculated by adding:

- The aggregate premium paid for the Plan Year prior to such election change to;
- The total premium to be paid by the Participant to the Dependent Care FSA Program for the remainder of such Plan Year; reduced by

- All reimbursements made during the entire Plan Year.

8.5 Average Benefits Test Limitation.

(a) No reimbursements will be made under the Dependent Care FSA Program for a Plan Year to Participants who are Highly Compensated Employees of a Participating Employer if and to the extent that such reimbursements would result in the Average Benefits Percentage (as described below) of Employees of the Participating Employer who are not Highly Compensated Employees for any Plan Year to be less than 55% of the Average Benefits Percentage of Employees of the Participating Employer who are Highly Compensated Employees for such Plan Year.

(b) Subject to subsection (c) below, the "Average Benefits Percentage" of a group of Employees for a Plan Year means the average of the ratios (determined separately for each Employee in such group) of A to B where A equals the reimbursements made under the Dependent Care FSA Program to the Employee for such Plan Year, and where B equals the Employee's compensation for such Plan Year. The Average Benefits Percentage of an Employee who receives no reimbursements under the Dependent Care FSA Program for a Plan Year, including an Employee who declines to participate in the Dependent Care FSA Program for a Plan Year, will be zero.

(c) For purposes of applying the foregoing Average Benefits Test for a Plan Year, an Employee whose compensation for the Plan Year is less than $25,000 will not be taken into account.

(d) For purposes of this Section 8.5, a "Highly Compensated Employee" of a Participating Employer means with respect to any Plan Year an Employee of the Employer who during the preceding Plan Year received compensation from the Employer in excess of $110,000 (or such greater amount as may be prescribed by the Internal Revenue Service).

(e) CIS or a Participating Employer may adopt such rules as it deems necessary or desirable to impose limitations on the amount of contributions elected to be made by Participants under the Dependent Care FSA Program for the purpose of assuring that the limitations prescribed under this Section 8.5 are satisfied.

8.6 Establishment of Account. The Claims Administrator will establish and maintain a Dependent Care FSA account with respect to each Participant who has elected to participate in the Dependent Care FSA Program, but will not create a separate fund or otherwise segregate assets for this purpose. The account so established will merely be a record keeping account with the purpose of keeping track of contributions and reimbursements made under the Dependent Care FSA Program on behalf of the Participant.

(a) Crediting of Accounts. A Participant's Dependent Care FSA account will be credited following each salary reduction actually made during each Plan Year with an amount equal to the salary reduction actually made to the account.

(b) Debiting of Accounts. A Participant's Dependent Care FSA account will be debited during each Plan Year for any reimbursement of Qualified Dependent Care Expenses incurred during the Plan Year.

(c) Available Amount is Based on Credited Amount. The amount available for reimbursement of Qualified Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's Dependent Care FSA account, less any prior reimbursements.

8.7 Unused Year End Balance. If any balance remains in the Participant's Dependent Care FSA account after all reimbursements have been made for the Plan Year, the balance will not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The remaining amounts will be forfeited, and retained by the Participant's Employer. Alternatively, the Employer may elect to either return the remaining amounts to Participants, or to apply the remaining amount as a salary reduction credit for Participants. In either event, the allocation will be made on a reasonable and uniform basis. In addition, any Dependent Care FSA Program benefit payments that are unclaimed by the close of the Plan Year following the Plan Year in which the Qualified Dependent Care Expense was incurred will be applied as described above.

8.8 Reimbursement Procedure.

(a) Timing. Within 30 days after receipt by the Claims Administrator of a reimbursement claim from a Participant, the Participant will be reimbursed for the Participant's Qualified Dependent Care Expenses (if the Claims Administrator approves the claim), or the Claims Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Claims Administrator, including in cases where a reimbursement claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) Claims Substantiation. A Participant who has elected to receive Dependent Care FSA Program benefits for a Plan Year may apply for reimbursement by completing, signing, and returning an application to the Claims Administrator by no later than March 31 following the close of the Plan Year in which the Qualified Dependent Care Expense was incurred. The application must include the following information and statements:

(i) The person or persons on whose behalf Qualified Dependent Care Expenses have been incurred;

(ii) The nature and date of the expenses incurred;

(iii) The amount of the requested reimbursement;

(iv) The name of the person, organization or entity to whom the expense was or is to be paid;

(v) A statement that such expenses have not otherwise been reimbursed, and the Participant will not seek reimbursement through any other source; and

(vi) Other such details about the expenses that may be requested by the Claims Administrator.

The Participant will include bills, invoices or other statements from an independent third party showing that the Qualified Dependent Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Claims Administrator may request.

(c) Appeal of Denied Claims. A claim that has been denied can be appealed under the procedures prescribed in Section 6.11.

8.9 Reimbursements After Death. In the case of a deceased Participant, the spouse, dependent or estate representative may claim reimbursement for any Qualified Dependent Care Expenses incurred through the end of the month in which the Participant dies, provided that the claim is filed by March 31 following the end of the Plan Year in which the death occurred.

8.10 Report to Participants. On or before January 31 of each year, the Participating Employer for the Participant will furnish to each Participant who has received reimbursement for, or made premium payments for, Qualified Dependent Care Expenses during the prior calendar year a written statement showing the Qualified Dependent Care Expenses paid during such year with respect to the Participant, or showing the salary reductions for the year for the Dependent Care FSA, as the Employer deems appropriate. This written statement obligation will be satisfied by the reporting of the Participant's salary reductions under the Dependent Care FSA Program for the calendar year in the Participant's Form W-2 Wage and Tax Statement for that year.

ARTICLE 9

Health Savings Account Program

The provisions of this Article 9 will apply for a Plan Year to the Eligible Employees of a Participating Employer that has selected a High Deductible Health Plan and an associated Health Savings Account arrangement for the Plan Year.

9.1 Eligibility. Each Eligible Employee of a Participating Employer who is enrolled in the Employer's High Deductible Health Plan (HDHP), and who otherwise qualifies as an "eligible individual" within the meaning of Code §223(c)(1) for a period, is eligible to participate in the Health Savings Account ("HSA") Program for that period. The Employer's responsibility for establishing an Employee's eligible individual status under Code §223(c)(1) is limited to determining:

(a) Whether the Employee is enrolled in the HDHP;

(b) The maximum annual contribution limit on contributions that may be made by or for the Employee under the HSA Program for a Plan Year; and

(c) The Employee's age (for catch-up contribution purposes). The Employer may rely on the Employee's representation as to his or her date of birth.

9.2 Participant Salary Reduction Contributions.

(a) The Participating Employer will withhold from a Participant's compensation by salary reduction on a pre-tax basis an amount equal to the HSA benefits elected by the Participant under the HSA Program.

(b) Subject to subsection (c) below, the maximum salary reduction contribution permitted to be made to the HSA Program for any Plan Year for any Employee is equal to the limit in effect under Code §223(b)(2) with respect to such Employee for the year, but reduced by the HSA Program contribution made by the Employer on the Employee's behalf for the Plan Year, pursuant to Section 9.3 below.

(c) Notwithstanding subsection (b) above, each Employee who is eligible to make salary reduction contributions under the HSA Program for a Plan Year, and who will have attained age 55 on or before the last day of the Plan Year, is eligible to make catch-up contributions for that Plan Year. The amount of a Participant's catch-up contributions for a Plan Year may not exceed the applicable dollar limit on catch-up contributions for the Plan Year. The applicable dollar limit on catch-up contributions is $1,000 for the Plan Year beginning in 2010. After 2010, the $1,000 catch-up contribution limit will be subject to adjustment for cost-of-living increases pursuant to Code §223(g).

(d) Notwithstanding the general restriction on election changes prescribed in Section 5.1 of the Plan, a Participant who elects to make HSA contributions for a Plan Year under this Plan may start or stop such election, or increase or decrease the election, in accordance with

policies and procedures established by the Participant's Employer as long as the change is effective prospectively (i.e., after the request for the change is received).

9.3 Employer Contributions. For any Plan Year, or for any period within a Plan Year, a Participating Employer, in its discretion, can choose to make Employer contributions to the Health Savings Account of Participants who are enrolled in the Employer's HDHP for the applicable period. The maximum Employer contribution permitted to be made to the HSA Program for any Plan Year on behalf of any Participant is equal to the annual deductible for the category of coverage applicable to the Participant under the HDHP for the Plan Year. The Employer is not obligated to make Employer contributions for any period, and the amount of the Employer contribution may differ from period to period.

9.4 Limited Purpose Healthcare FSA Program.

(a) A Participating Employer which has made an HSA Program available to Eligible Employees for any period will not be permitted to make the Healthcare FSA Program described in Article 7 available to any Employees for the period of their eligibility under the HSA Program. However, the Participating Employer may elect to make available to such Eligible Employees for any Plan Year:

(i) A Limited Purpose Healthcare FSA Program that solely provides for the reimbursement of Limited Qualified Healthcare Expenses.

(ii) A Post-Deductible Healthcare FSA Program that solely provides for the reimbursement of expenses for preventive care and the reimbursement for medical expenses (other than for preventive services) after the Participant (or the Participant's family in the case of a Participant who elects family coverage under the HDHP) has satisfied the minimum annual deductible prescribed under Code §223(c)(2)(A)(i) for the applicable Plan Year; or

(iii) Both a Limited Purpose and Post-Deductible Healthcare FSA Program.

(b) "Limited Qualified Healthcare Expenses" means expenses for dental, vision and preventive care incurred by a Participant (or by the Participant's spouse or dependents) that qualify as medical care or other healthcare, as defined in Code §213(d), but only to the extent that the Participant or other person incurring the expenses is not reimbursed for the expenses through any other accident or health plan.

(c) For purposes of this Section 9.4, "preventive care" is as defined below.

(i) Preventive care includes, but is not limited to, the following:

Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals;

- Routine prenatal and well-child care;

- Child and adult immunizations;
- Tobacco cessation programs;
- Obesity weight-loss programs; and
- Screening services.

(ii) Preventive care generally does not include any service or benefit intended to treat an existing illness, injury, or condition. However, in situations where it would be unreasonable or impracticable to perform another procedure to treat the condition, any treatment that is incidental or ancillary to a safe-harbor preventive care service or screening as described in IRS Notice 2004-23 also qualifies as preventive care.

(iii) Drugs or medications will qualify as preventive care when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic), or to prevent the reoccurrence of a disease from which a person has recovered. In addition, drugs or medications used as part of procedures providing preventive care services specified in IRS Notice 2004-23, including obesity weight-loss and tobacco cessation programs, are also preventive care.

(d) Subject to the rules prescribed below, the Post-Deductible Healthcare FSA Program will reimburse a Participant for the cost of preventive services, and for medical expenses incurred after the minimum annual HDHP deductible under Code §223(c)(2)(A)(i) is satisfied, that are incurred by the Participant, or by the Participant's spouse or dependents.

(i) The minimum annual HDHP deductible for a Plan Year is determined by reference to the coverage elected under the HDHP (i.e., self-only or family coverage).

(ii) Only expenses covered by the HDHP may be taken into account in determining whether the HDHP deductible has been satisfied. For example, if the HDHP does not cover chiropractic care, expenses incurred for chiropractic care do not count toward satisfying the minimum annual HDHP deductible.

(iii) For self-only HDHP coverage, only the covered medical expenses of the covered individual count toward satisfying the minimum annual HDHP deductible.

(iv) Medical expenses incurred before the minimum annual HDHP deductible is satisfied may not be reimbursed under the Post-Deductible Healthcare FSA Program, regardless of whether the HDHP covers the expense or whether the deductible is later satisfied.

(e) Over-the-Counter Medical Care Products**.** Over-the-counter medical care products, including menstrual care products, incurred after December 31, 2019 are eligible for reimbursement under the Limited Purpose Healthcare FSA Program and the Post-Deductible Healthcare FSA Program, subject to other applicable terms of such programs.

ARTICLE 10

HIPAA Privacy and Security Rules

10.1 Overview.

(a) HIPAA and its implementing regulations include provisions designed to protect the privacy of health information concerning individuals covered under a group health plan. However, these laws recognize that a plan sponsor and certain of its employees have the need for access to, and the use of, such health information in order to perform administrative functions with respect to the plan. The laws thus permit the use and disclosure of such health information by the Plan Sponsor and its designated employees, subject to prescribed restrictions that are required to be expressly identified and acknowledged in the governing plan document. Toward that end, the use or disclosure of protected health information of persons covered under a Group Health Benefit Program will be subject to the terms and conditions prescribed in this Article 10.

(b) The Plan is a hybrid plan consisting of Benefit Programs that provide group health benefits and Benefit Programs that provide other forms of benefits. The HIPAA Privacy Rules apply solely to health plans. Accordingly, as used in this Article 10, the term "Plan" refers only to a Benefit Program under the Plan that provides group health benefits and is otherwise deemed to be a health plan for purposes of the HIPAA Privacy and Security Rules.

10.2 Definitions. When used in this Article 10 certain terms have the respective meanings set forth in this Section 10.2, or in certain other Sections of this Article 10.

(a) Covered Individual. "Covered Individual" means a person who is covered under the Group Health Benefit Program and who is the subject of the PHI at issue.

(b) Group Health Benefit Program. A "Group Health Benefit Program" means any Benefit Program that provides group health benefits, including the following:

- Medical Insurance Program
- Dental Care Program
- Vision Insurance Program
- Healthcare FSA Program component of the FSA Program
- Employee Assistance Program

(c) HIPAA Privacy Rules. "HIPAA Privacy Rules" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

(d) Privacy Official. "Privacy Official" means the person appointed under the Plan to undertake responsibility for the development and implementation of policies and procedures relating to the Group Health Benefit Programs' use and disclosure of PHI.

(e) Protected Health Information (PHI). "Protected Health Information" or "PHI" means with respect to any Covered Individual any information (including information of persons living or deceased) that:

- Is created or received by the Plan;
- Relates to the past, present or future physical or mental health or condition of the Covered Individual, the provision of health care to the Covered Individual, or the past, present or future payment for the provision of health care to the Covered Individual; and
- Identifies the Covered Individual, or for which there is a reasonable basis to believe the information can be used to identify the Covered Individual.

(f) Security Official. "Security Official" means the person appointed under the Plan to undertake responsibility for the development and implementation of policies and procedures required by the Security Rules.

(g) Security Rules. "Security Rules" will mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

10.3 Use and Disclosure Restrictions. CIS and its authorized employees will use and disclose a Covered Individual's PHI only as prescribed below.

(a) Disclosures made directly to the Covered Individual;

(b) For Plan administration functions;

(c) Pursuant to the Covered Individual's authorization;

(d) In a manner that is incidental to a permitted or required use or disclosure; or

(e) When required to do so by federal, state or local law.

10.4 Employees with PHI Access. The employees or other persons under the control of CIS who are to have access to PHI of Covered Individuals are described below.

(a) An employee or person having oversight responsibility for the management of the Plan or of any component of the Plan; and

(b) Any such employee or person who receives PHI in the ordinary course of the individual's employment or business duties.

10.5 Privacy Commitments. In connection with its commitment to safeguard the privacy of the PHI of Covered Individuals, CIS will:

(a) Not use or further disclose the PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom it provides PHI created or received by the Plan agree to the same restrictions and conditions that apply to CIS with respect to such information;

(c) Not use or disclose the PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan maintained by CIS;

(d) Report to the Privacy Official any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted under this Article 10 of which it becomes aware;

(e) Pursuant to and as required under the HIPAA Privacy Rules:

(i) Allow each Covered Individual access to his or her own PHI;

(ii) Allow Covered Individuals to request an amendment of their PHI; and

(iii) Make available to the Privacy Official the information necessary to provide an accounting of disclosures of PHI;

(f) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS upon request for purposes of the agency's determination of the Plan's compliance with the HIPAA Privacy Rules; and

(g) Return or destroy all PHI received from the Plan that CIS still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or, if such return or destruction is not feasible, to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible).

10.6 Security Commitments. For purposes of safeguarding any PHI that CIS may transmit or maintain in the form of electronic media (hereinafter referred to as "Electronic Protected Health Information"), CIS will:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan;

(b) Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information pertaining to the Plan agrees to implement reasonable and appropriate safeguards to protect such information;

(c) Ensure that the safeguarding of Electronic Protected Health Information available to and used by its authorized employees is supported by reasonable and appropriate security measures; and

(d) Report to the Security Officer any Security Incident involving any Electronic Protected Health Information of which it becomes aware. For this purpose, a "Security Incident" means an attempted or successful unauthorized access, use, disclosure, modification or destruction of information, or interference with system operations in an information system.

10.7 Plan Restrictions. Notwithstanding any provision of the Plan to the contrary, the Plan will:

(a) Disclose a Covered Individual's PHI to CIS to carry out Plan administration functions that CIS performs on behalf of the Group Health Benefit Program, but only to the extent consistent with the provisions of this Article 10;

(b) Not permit a health insurance issuer with respect to the Group Health Benefit Program to disclose a Covered Individual's PHI to CIS except as permitted by this Article 10;

(c) Not disclose, and will not permit a health insurance issuer to disclose, a Covered Individual's PHI to CIS as otherwise permitted by this Article 10 unless Covered Individuals are provided a Notice of Privacy Practices that advises of such permissive disclosures; and

(d) Not disclose a Covered Individual's PHI to CIS for the purpose of employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of CIS.

ARTICLE 11

Restrictions on Use of Genetic Information

11.1 Overview. The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits a group health plan from discriminating in regard to health insurance premiums on the basis of genetic information. GINA further places limitations on the authority of group health plans to request genetic testing and collect genetic information. It is the intention of the Plan Sponsor that the Plan acknowledge and fully comply with the group health plan provisions of GINA. Toward that end, each Group Health Benefit Program maintained under the Plan shall be subject to the terms and conditions prescribed in this Article 11

11.2 Affected Benefit Programs. The provisions of this Article 11 shall apply to each Group Health Benefit Program under the Plan, other than a program providing for "excepted benefits" prescribed under 42 U.S.C. 300gg-91(c)(2) and regulations thereunder. Such excepted benefit programs include a separate dental or vision care program that is not an integral part of a medical plan, or a qualified health flexible spending account arrangement.

11.3 Definitions. When used in this Article 11, certain terms have the respective meanings set forth in this Section 11.3.

(a) Collect. "Collect" means, with respect to information, to request, require, or purchase such information.

(b) Family Member. "Family Member" means, with respect to any Participant or covered dependent:

(i) A dependent of such individual as a result of marriage, birth adoption, or placement for adoption; and

(ii) Any other individual who, with respect to the Participant or covered dependent, or with respect to a dependent determined under paragraph (i) above, is a first-degree, second-degree, third-degree, or fourth-degree relative as defined below.

(A) First-degree relatives are an individual's parents, siblings, children, and half-siblings.

(B) Second-degree relatives are an individual's grandparents, grandchildren, uncles, aunts, nephews, and nieces.

(C) Third-degree relatives are an individual's great-grandparents, great grandchildren, great uncles and aunts, and first cousins.

(D) Fourth-degree relatives are an individual's great-great grandparents, great-great grandchildren, and first cousins once-removed (i.e., the children of the individual's first cousins).

(iii) Relatives by affinity (such as by marriage or adoption) will be treated the same as relatives by consanguinity (i.e., relatives who share a common biological ancestor).

(iv) In determining the degree of the relationship, relatives by less than full consanguinity (i.e., half-siblings, who share only one parent) will be treated the same as relatives by full consanguinity (i.e., siblings who share both parents).

(c) Genetic Information.

(i) "Genetic Information" with respect to an individual means information concerning:

(ii) Genetic Tests of the individual or of the individual's Family Members;

(iii) The manifestation of a disease or disorder in a Family Member of the individual (i.e., family medical history);

(iv) A request for, or receipt of, Genetic Services by the individual or Family Member; and

(v) The individual's participation in clinical research that includes Genetic Services.

(vi) Genetic Information also constitutes information relating to:

(A) A fetus carried by a Participant or a covered dependent, or by a Family Member of such an individual; or

(B) Any embryo legally held by the Participant or a covered dependent, or by a Family Member of such an individual using an assisted reproductive technology.

(vii) The term "Genetic Information" does not include information about the sex or age of a Participant, dependent or Family Member.

(d) Genetic Services. "Genetic Services" means:

(i) A Genetic Test;

(ii) Genetic counseling (including obtaining, interpreting, or assessing Genetic Information); or

(iii) Genetic education.

(e) Genetic Test. In general, the term "Genetic Test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. However, a Genetic Test does not include:

(i) An analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes;

(ii) An analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved;

(iii) A medical examination that tests for the presence of a virus that is not composed of human DNA, RNA, chromosomes, proteins, or metabolites, an HIV test, a complete blood count, a cholesterol test, or a liver function test.

(iv) A test for the presence of alcohol or drugs is not a Genetic Test. However, a test to determine whether an individual has a genetic predisposition for alcoholism or drug use is a Genetic Test.

(f) Group Health Benefit Program. A "Group Health Benefit Program" means a Benefit Program that provides for health care.

(g) Manifested. A disease, disorder, or pathological condition of an individual is considered to have been "Manifested" if the individual has been or could reasonably be diagnosed with the disease, disorder, or pathological condition by a health care professional with appropriate training and expertise in the field of medicine involved. A disease, disorder, or pathological condition of an individual is not manifested if the diagnosis is based principally on Genetic Information, or on the results of one or more Genetic Tests.

(h) Underwriting Purposes. "Underwriting Purposes" means with respect to a Group Health Benefit Program, or health insurance coverage offered in connection with the Group Health Benefit Program:

(i) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the Group Health Benefit Program (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program);

(ii) The computation of premium or contribution amounts under the Group Health Benefit Program or coverage (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program);

(iii) The application of any pre-existing condition exclusion under the Group Health Benefit Program or coverage; and

(iv) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

For purposes of this Article 11, if a participant or dependent seeks a benefit under a Group Health Benefit Program that is conditioned on its medical appropriateness, and such determination depends on the Genetic Information of the individual, then the Plan is permitted to condition the benefit on the Genetic Information and that determination will not be within the meaning of Underwriting Purposes, provided the Plan requests only the minimum amount of Genetic Information necessary to make the determination. If the individual does not provide the Genetic Information required to determine medical appropriateness, the Plan may deny the benefit. However, if an individual is not seeking a benefit under a Group Health Benefit Program, this medical appropriateness exception to the definition of Underwriting Purposes will not apply.

11.4 Prohibited Discrimination in Premiums or Contributions. In general, the amount of the premiums or contributions otherwise payable by members of, or with respect to, any group covered under a Group Health Benefit Program may not be adjusted on the basis of Genetic Information. The foregoing prohibition does not restrict a health insurance issuer offering health insurance coverage in connection with a Group Health Benefit Program from increasing the premium or contribution due to the manifestation of a disease or disorder of an individual covered under the Group Health Benefit Program. However, the manifestation with respect to one individual cannot be used as Genetic Information about other covered individuals to further increase the premium for the covered group.

11.5 Restriction on Genetic Testing.

(a) The Plan shall not require or request an individual who is enrolled in, or who is eligible to be enrolled in, a Group Health Benefit Program, or a Family Member of any such individual, to undergo a Genetic Test. However, a health care professional providing health care services to an individual is free to recommend that such individual undergo a Genetic Test.

(b) Notwithstanding subsection (a) above, the Plan is not prevented from obtaining and using the results of a Genetic Test in making a payment determination under a Group Health Benefit Program, but only if it requests no more than the minimum amount of information necessary to accomplish the intended purpose. For this purpose only, if a Group Health Benefit Program conditions payment for an item or service based on its medical appropriateness, and such determination depends on the genetic makeup of a participant or dependent, then the Plan is permitted to condition payment for the item or service on the outcome of a Genetic Test. In this context only, the Plan may refuse payment on that particular item or service if the patient refuses to undergo the Genetic Test.

11.6 Restriction on Collection of Genetic Information.

(a) The Plan shall not request, require, or purchase Genetic Information for Underwriting Purposes.

(b) The Plan also shall not request, require or purchase Genetic Information with respect to any Participant or dependent prior to that individual's effective date of coverage under that Group Health Benefit Program (as determined at the time of collection), or in connection with that individual's eligibility for enrollment in a Group Health Benefit Program.

(c) If the Plan obtains Genetic Information incidental to obtaining other information concerning any individual and that information is not used for Underwriting Purposes, such acquisition shall not be considered a violation of subsection (b). However, the incidental collection exception of this subsection (c) will not apply to any collection of information where it is reasonable to anticipate that health information will be received, unless the collection documents explicitly state that Genetic Information should not be provided.

ARTICLE 12

Plan Fiduciaries and Administration

12.1 Named Fiduciaries. The persons identified in this Section 12.1 are named as fiduciaries under this Plan, and will be the only named fiduciaries with respect to the Plan.

(a) Sponsor. CIS, as Sponsor of the Plan, will have full authority and powers in regard to the establishment and maintenance of the Plan and of each Benefit Program under the Plan. Such powers include matters pertaining to the design of the Plan and the benefits provided hereunder, including the right to amend and to terminate the Plan or any Benefit Program. CIS will further be responsible for all fiduciary functions under the Plan except insofar as any such authority or responsibility is assigned to another named fiduciary, or is delegated to another fiduciary pursuant to subsection (b) below. Such authority and responsibility will include the following:

(i) The designation of all named fiduciaries of the Plan, including the right to remove or replace any of them;

(ii) The periodic monitoring and evaluation of the performance of all named fiduciaries;

(iii) The employment of persons to provide services and advice necessary to the performance of the foregoing functions; and

(iv) All rights and powers necessary or convenient to carry out its functions hereunder, whether or not such rights and powers are specifically enumerated herein.

(b) Delegates. CIS may delegate to a committee, or to any other person or organization, any authority or responsibility reserved or assigned to CIS pursuant to the Plan. In the event of any such delegation, any references to the authority, right or power of CIS to act which are contained in any notice, disclosure or communication intended to effectuate the purposes of the Plan will be construed to include authority for such actions by the committee or officer to whom CIS has delegated its authority. Notwithstanding any other provision of the Plan, in the event that an action or direction of any person to whom authority has been delegated conflicts with an action or direction of CIS, then the authority of CIS will supersede that of the delegate with respect to such action or direction.

(c) Plan Administrator. CIS will serve as the Plan Administrator. As the Plan Administrator, it will have the powers and duties prescribed under Section 12.2.

(d) Insurance Company. The insurance company providing benefits on an insured basis under any Benefit Program, or an administrative service organization that is administering the benefits under a self-insured Benefit Program pursuant to an administrative services agreement, is expressly delegated the discretionary authority and powers in regard to all facets of any claims for benefits made under the Benefit Program.

12.2 Powers and Duties of Plan Administrator. Except to the extent any fiduciary powers have been delegated to a committee or officer pursuant to Section 12.1(b), or to an insurance company or administrative service organization pursuant to Section 12.1(d), CIS will have final and binding discretionary authority to control and manage the operation and administration of the Plan, including all rights and powers necessary or convenient to carry out its functions hereunder, whether or not such rights and powers are specifically enumerated herein. In exercising its responsibilities hereunder, CIS may manage and administer the Plan through the use of agents (who may include employees of a Participating Employer). Without limiting the generality of the foregoing, and in addition to the other powers set forth in this Article 10, the authorities and responsibilities held by CIS include the following:

(a) Construing and interpreting the terms of the Plan and of any documents pertaining to the Plan;

(b) Construing and interpreting all laws and regulations as applicable to the administration of the Plan;

(c) Making any factual determinations, and applying such determinations to the terms of the Plan and issues arising in connection with the administration of the Plan;

(d) Preparing and filing of all reports required to be filed with any agency of government, except such reports as must be prepared or filed by other fiduciaries as required by applicable law, and preparing such other reports with respect to the Plan as are reasonable and appropriate;

(e) Complying with all disclosure requirements imposed by state or federal law upon the administrator of the Plan;

(f) Maintaining all records of the Plan;

(g) Issuing instructions to the appropriate party, as may be required or appropriate, to pay any fees, taxes, charges or other costs incidental to the operation and management by the administrator of the Plan, and to pay benefits as provided in the Plan; and

(h) Receiving from the Participating Employers and from covered individuals such information as may be necessary for the proper administration of the Plan.

12.3 Indemnification. To the full extent permitted by law, CIS will indemnify each employee of CIS for any liability or expenses, including attorneys' fees, incurred in the defense of any threatened or pending action, suit or proceeding by reason of their status as fiduciaries of the Plan or as an authorized delegate thereof.

12.4 Right to Amend or Terminate.

(a) CIS reserves the right to amend this Plan, in whole or in part, or discontinue or terminate the Plan, or to amend or terminate any Benefit Program; provided, however, that any such amendment, discontinuance or termination will not affect any right of any Participant to make a claim for benefits for events occurring prior to the date of such amendment, discontinuance or termination.

(b) An amendment to or termination of a Benefit Program may be made by any employee of CIS with authority to enter into contractual arrangements with providers of Benefit Programs, and will be effectuated by the renegotiation or revision of any such Benefit Program and distribution of a summary plan description, notice of material modification, or any other written notice to affected Employees.

(c) In the event of a termination or reduction of benefits under the Plan, the Plan will be liable only for benefit payments due and owing as of the effective date of such termination or reduction, and no payments scheduled to be made on or after such effective date will result in any liability to the Plan, CIS, the Participating Employers or any agent thereof.

ARTICLE 13

Miscellaneous

13.1 No Guarantee of Employment, etc. Neither the maintenance of the Plan nor any part thereof will be construed as giving any Participant or any other employee any right to remain in the employ of a Participating Employer. No director, trustee or employee of CIS, in any way, guarantees to any individual the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

13.2 Benefits Not Transferable. The right to receive benefits under this Plan is not assignable or transferable to any other party. Any attempted assignment or transfer will not be binding on this Plan.

13.3 No Verbal Modifications of Plan Provisions. No verbal statement made by anyone involved in administering this Plan can waive any of the terms or conditions of this Plan, or prevent CIS from enforcing any provision of this Plan. Waivers are valid only if they are contained in a written instrument signed by an authorized individual on behalf of CIS. Any such written waiver will be valid only as to the specific Benefit Program, term or condition set forth in the written instrument. Unless specifically stated otherwise, a written waiver will be valid only for the specific claim involved at the time, and will not be a continuing waiver of the term or condition in the future.

13.4 Recovery of Benefits Paid by Mistake. If payment is mistakenly made by the Plan for a covered individual to which that individual is not entitled, or if benefits are paid for an individual who is not eligible for benefits, CIS and the Plan have the right to recover the payment from the individual paid or anyone else who benefited from such payment, including a provider of services. The right to recovery includes the right of CIS to deduct the amount paid by mistake from future benefits.

13.5 Controlling Law. To the extent not preempted by the laws of the United States of America, the laws of the State of Oregon will be the controlling state law in all matters relating to the Plan and will apply.

13.6 Severability. If any provisions of the Plan will be held illegal or invalid for any reason, said illegality or invalidity will not affect the remaining parts of the Plan, but the Plan will be construed and enforced as if said illegal and invalid provisions had never been included herein.

13.7 Headings. All article and section headings in the Plan are intended merely for convenience and will in no way be deemed to modify or supplement the actual terms and provisions set forth thereunder.