

**Flexible Benefits Plan Document
For
Hope Haven Area Development Center Corp.**

Effective November 1, 2006

Amended and Revised November 1, 2010

ADMINISTERED BY



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**EMPLOYEE BENEFIT SYSTEMS
214 NORTH MAIN STREET, P.O. BOX 1053
BURLINGTON, IA 52601
319-752-3200 800-373-1327 FAX 319-753-6114
www.ebs-tpa.com
contactus@ebs-tpa.com**

ARTICLE I
Introduction

1.1 Purpose of the Plan. This document constitutes the IRC Section 125 Flexible Benefits Plan for the Employer named in the Adoption Agreement, which is attached hereto and incorporated by this reference. The purpose of the Plan (hereinafter called the Plan) is to permit employees of the Employer to choose various benefits from a menu of choices to best satisfy the individual needs of each employee. Benefits will be offered on a pre-tax basis under Section 105(b) of the Code.

1.2 Effective Date. The Plan is effective as of the date shown in Item 1.2 of the Adoption Agreement.

1.3 Plan Administration, Plan-Year. The Plan is administered by the employer on the basis of a plan year (the "plan year") as identified in Item 1.3 of the Adoption Agreement.

1.4 Benefit Programs. As of the effective date, the Plan includes various benefit programs, which have been established by the Employer as set forth in item 1.4 of the Adoption Agreement. The terms and conditions of the benefit programs are described in an applicable supplement attached to and forming a part of the Plan. Certain benefits under this Plan may be under other employee welfare benefit plans established from time to time by the Employer, which employee welfare benefit plans shall, to the extent permitted by law, supplement and form a part of this Plan. Notwithstanding the foregoing, benefits under deferred compensation arrangements shall not be offered under the Plan unless such arrangements include a qualified cash or deferred arrangement as defined in Section 401(k)(2) of the Code.

1.5 Grace Period. The FSA and DCAP benefits may include up to a two and a half month grace period to incur expenses for the plan year if selected in item 1.5 of the Adoption Agreement. A plan year that ends on December 31 would allow expenses to be incurred up to March 15 of the next plan year.

DEFINITIONS

Defined terms shall be capitalized in this Plan. As used in this Plan Document, the following terms shall have the following meanings:

“Account(s)” means the Benefit Accounts described in Section 4.1.

“Benefits” means the various Benefits offered under the Plan as outlined in the Adoption Agreement.

"Cafeteria Plan" means the 125 Cafeteria Plan offered by the Employer.

“Change in Status” as defined in Section 3.4.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

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

“Contributions” means the amount contributed to pay for the cost of the Benefits.

“Compensation” means the wages paid to an Employee by the Employer as reported in Box 1 of Form W-2, but adding back any wages forgone by virtue of any election for Salary Reduction under this Plan, any other cafeteria plan, and any compensation reduction under any Code § 132(f)(4) plan; but determined after salary deferral elections under any Code § 401(k), 403(b), 408(k) or 457(b) plan or arrangement.

"Dependent" means an individual who is a dependent of a Participant in the Plan within the meaning of the Code, as amended from time to time.

“Earned Income” means all income derived from wages, salaries, tips, self-employment, and other compensation, but only if such amounts are includible in gross income for the taxable year.

"Effective Date" as defined in Section 1.2 of the Adoption Agreement.

“Electronic Protected Health Information” has the meaning described in 45 C.F.R. § 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disrollment information and summary health information.

"Eligible Employee" means an Employee, as defined in section 2.1 below, who has met the Eligibility requirements of the Plan set out in Section 2.1 of the Adoption Agreement.

"Employee" means an individual employed by the Employer who is on the Employer's W-2 payroll, excluding independent contractors, temporary or casual employees, any self-employed individual, any partner in a partnership, and any more-than 2% shareholder by virtue of the Code Section 318 ownership attribution rules. The term “Employee” does include “former Employees” for the limited purpose of allowing continued eligibility for benefits in accordance with Section 2.5.

"Employer" means Hope Haven Area Development Center Corporation and its Affiliated Companies as identified in Adoption Agreement.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

“FMLA” means the Family and Medical Leave Act of 1993, as amended from time to time.

“Health FSA” means a Health Flexible Spending Arrangement.

“Health Savings Account (HSA)” means a Health Savings Account established under Code §223. This type of account is an individual trust or custodial account. It is established and maintained separately by an individual with a qualified trustee/custodian.

“Highly Compensated Employee (HCE)” means (for section 105 purposes) any Employee who is among the highest paid 25% of all employees, one of the highest paid officers, or a shareholder who owns more than 10% of the value of the employer’s stock.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

“Key Employee” means any Employee defined as such in Code Section 416(l).

“Open Enrollment Period” means the month preceding the beginning of a Plan Year or other such period as may be prescribed by the Administrator.

“Participant” means any Employee who has met the eligibility requirements in Article II of the Plan.

“Period of Coverage” means the Plan Year. The following exceptions may apply: (a) for Employees who are newly eligible to participate (Section 2.1), it shall mean the portion of the Plan Year following their entry date; (b) for Employees who terminate participation (Section 2.2), it shall mean the portion of the Plan Year prior to their participation termination date. A different Period of Coverage may be established by the Plan Administrator and communicated to the Participants.

“Plan” means the Hope Haven Area Development Center Corporation Flexible Benefits Plan as described herein and in any applicable Adoption Agreement, and which is intended for the exclusive benefit of Eligible Employees, and as may be amended from time to time.

“Plan Year” means the 12-consecutive month period beginning on November 1 and ending on October 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

“QMCSO” means a qualified medical child support order, as defined in ERISA Section 609(a).

“Salary Reduction” means the amount by which the Participant’s compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits before any applicable state and/or federal taxes have been deducted from the Participant’s Compensation (i.e. Pre-tax basis).

"Spouse" means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation or an individual who claims common law marriage. “Spouse” is a dependent as defined by the IRS Code and State Law definitions do not alter the definition of spouse for this plan.

“SPD” means the separate Summary Plan Description describing the terms of the Plan.

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

ARTICLE II **Participation**

2.1 Eligibility. Employees of the Employer listed in Item 2.1 of the Adoption Agreement are eligible to participate in the Plan. Each employee of the Employer who has met the eligibility requirements shown in Item 2.1 of the Adoption Agreement will be eligible to participate in the Plan on the first entry date as set out in Item 2.1 of the Adoption Agreement after the employee has filed with the plan administrator any written agreement electing to participate in the Plan as is required by the plan administrator, on a form satisfactory to the plan administrator. Employees may not include any self-employed individual, a 2% or more S corporation shareholder, a sole proprietor, a partner, member of a limited liability company and any member of the board of directors that serves the Employer solely in that capacity.

2.2 Period of Coverage, Termination of Participation. A participant's period of Plan coverage with respect to any benefit under the Plan shall be the plan year (or the remaining portion of the plan year in which the participant first becomes eligible to participate in the Plan -- this is known as a “short plan year”). The plan year runs for a twelve-month period. The benefits for any participant or covered dependent will terminate on the first to occur of the following dates:

- (a) The day the participant ceases to qualify as a participant as a result of termination of employment or failure to make the required contributions, if any;
- (b) The day the participant terminates membership in a group or class of employees eligible for benefits;
- (c) With respect to a covered dependent, the date such dependent ceases to be a dependent;

(d) The date a specific coverage or benefit is discontinued; or

(e) The date the plan is terminated.

If an employee is rehired within the same Plan Year and are eligible for the Plan, the employee may make new elections, provided that the employee is rehired more than 30 days after the employee has terminated employment. If the employee is rehired within 30 days or less during the same Plan Year, the employee prior elections will be reinstated.

2.3 Notice of Eligibility. The plan administrator shall notify employees of the Employer of their eligibility to participate in the Plan and of the terms of the Plan. Each participant will be furnished with a copy of a Summary Plan Description.

2.4 Spouses and Dependents. Spouses and dependents of eligible employees may not be independent participants in the Plan. However, spouses and dependents may be eligible to receive benefits offered under the Plan.

A dependent is defined by the Code, rules and regulations and will vary depending on the specific benefit in the Plan. The Iowa law extending coverage to children under the age of 25 does not alter the definition of dependent for this Plan. The Iowa law definition of spouse does not alter the definition of spouse for this Plan.

The Internal Revenue Service Notice 2010-38 provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year. Retroactively to March 30, 2010, both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid (or reimbursed) to the employee for such coverage are excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. The Notice provides important guidance and further clarifications with regard to these issues.

2.5 Former Employees. Former employees may be permitted to participate in the Plan by the Employer, provided, however, that the Plan is not predominately maintained for the benefit of former employees.

2.6 Special Participation Rules Relating to Health Savings Accounts. In no event shall an employee or eligible dependent of an employee be permitted to participate in this Plan if the fact of such participation will result in the employee or eligible dependent being treated as not an eligible individual for purposes of making contributions to a health savings account (HSA), provided the employee or eligible dependent has established or is planning to establish a HSA. Employee shall be required to affirmatively state on the Plan's election form that employee, employee's spouse or employee's eligible dependents participation in this Plan will not cause the parties' ineligibility for the HSA.

2.7 Michelle's Law. Michelle's Law provides that a group health plan may not terminate the coverage of a dependent child who is covered as a full-time student at a post-secondary educational institution as a result of that individual ceasing to meet the

definition of full-time student due to a medically necessary leave of absence (or other change of enrollment, if medically necessary). In such a situation, the Plan is required to continue the individual's coverage for up to a year while he/she is on a medically necessary leave of absence unless coverage would otherwise terminate sooner under the terms of the Plan. The individual has to be a full-time student until the first day of the leave and must be medically certified by a treating physician. The treating physician must certify that the student's medical leave of absence or change in enrollment is medically necessary.

Michelle's Law amends ERISA. It applies to any group health plan subject to ERISA, which includes both fully-insured and self-funded plans. Michelle's Law did not amend Code section 152. Therefore reimbursements for eligible expenses of dependents under Michelle's law that do not meet the definition of dependent under Code 152 may be subject to tax.

The following FSA plans are not subject to Michelle's Law:

- a. Plans that have less than two participants who are current employees as of the first day of the Plan Year;
- b. Plans that provide coverage (reimbursements) for benefits that are limited to dental, vision, and long-term care benefits that are not an integral part of a group health plan; or
- c. The employer offers other group health plan coverage (that is not just dental, vision, or long-term care coverage) and the maximum benefit payable to a participant under the Health FSA is less than or equal to \$500.00.

ARTICLE III **Contributions**

3.1 Employer Contributions. The Employer may pay some or all of the costs of the Plan at such times and in such amounts as shall be determined from time-to-time by the Employer from its general assets. Nothing herein shall require the Employer to segregate or set aside any funds or other property for the purpose of paying any amounts under the Plan.

3.2 Participant Contributions. An Employee-Participant may elect, in writing on a form prepared by, and filed with, the Plan Administrator on or before the date he first becomes eligible, to participate in the Plan, and on or before the first day of any Plan Year thereafter, to reduce his compensation for such Plan Year and to contribute the amount of such salary reduction to the Plan as his required contribution under the Plan. Pursuant to such written election form, the participant shall also apportion his salary reduction contributions among the benefits provided for in the Plan for which the participant or his covered dependents qualify. In no event shall the sum of the amounts apportioned by the participant to each benefit exceed the total amount of his salary reduction contribution.

Salary reduction contributions will be made through payments made periodically corresponding to payroll withholding payments beginning with the first regularly scheduled payday for the plan year for which the participant's written election is made (or the first regularly scheduled payday which is on or after the date the participant first becomes eligible to participate in the plan if a salary reduction agreement has previously been properly executed). Severance pay and paid time off pay may be used to make Participant contributions.

The Plan Administrator will establish rules and regulations with respect to salary reduction agreements hereunder in accordance with applicable law and regulations issued by the Department of the Treasury under IRC Section 125 of the Code. Participant contributions shall be used to provide plan benefits under the Plan or to pay premiums to modified or fully self-funded programs, insurance companies, health maintenance organizations or other organizations or institutions to provide such benefits as soon as reasonably practical, but in no event later than 90 days after such contributions are made. A participant's salary reduction contributions which are not used to provide plan benefits for such plan year as provided in the preceding sentence shall not at any time be returned or repaid to participants but shall be forfeited.

3.3 Re-Enrollment Period. At the annual Re-Enrollment Period, a Change of Coverage/Election Form will be made available and Participants will be allowed to change their elected benefits for the next Plan Year.

3.4 Changes or Discontinuance of Participant Contributions. A participant may not revise the rate of his salary reduction contributions or discontinue making salary reduction contributions except as follows:

- (a) The participants may file a written election form with the Plan Administrator on or before the end of any plan year revising the rate of their contributions or discontinuing such contributions effective as of the first regularly scheduled payday of the next following plan year.
- (b) The participant's contributions will automatically terminate as of the date his plan participation terminates in accordance with Section 2.2 above.
- (c) The participant may file a written mid-year election change form with the Plan Administrator to revoke any prior election and to make a new election with respect to the remaining portion of a plan year on account of, and consistent with an Event that allows an exception to the Irrevocability Rule. The new election must be made within thirty (30) days of the family status change and be effective as of the date it is approved by the Plan Administrator. Exceptions to the Irrevocability Rule would include the following events:
 1. FMLA (Family Medical Leave Act) as described in Article IX.
 2. Change in status as described below including any changes to Code § 125 or regulations issued there under.
 - Change in marital status (such as marriage, death of a spouse, divorce).

- Change in number of dependents (such as a birth of a child, adoption or placement for adoption, or death of a dependent).
 - An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement (such as a specific age, full-time student status).
 - A change in the Participant's, Participant's Spouse's or Participant's Dependent's place of residence that affects eligibility in the network service area.
 - Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent and that affects benefit eligibility under this or any other plan of your spouse or dependent. Such events include termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly paid, fulltime to part-time (or vice versa); incurring a reduction or increase in hours or any other similar change which; makes the individual become (or cease to be) eligible for a particular benefit.
3. Gains in coverage eligibility under another employer's plan. (excludes FSA changes)
 4. Certain judgments, decrees and orders.
 5. Medicare or Medicaid.
 6. Change in cost such as a significant change in premium. (excludes FSA changes)
 7. Change in coverage such as a significant curtailment of coverage, addition or significant improvement of plan option, loss of other group coverage, change in election under another employer plan, or DCAP coverage changes. (excludes FSA changes)
 8. Change in the participant, participant's spouse or participant's dependent ceases to be eligible for Medicaid or SCHIP coverage or becomes newly eligible for premium assistance under Medicaid or SCHIP. For purposes of these events only, the new election must be made within sixty (60) days of the termination of coverage or eligibility for premium assistance.

For purposes of this Section, any election by a plan participant to change the apportionment of his/her salary reduction contributions among the various benefits provided for in the Plan will be considered a revision of the rate of his contributions.

3.5 Special Rules regarding HSA Benefit Elections. If the employer offers the ability to make HSA contributions through the Plan, employees may make prospective salary reduction elections or change or revoke an election at any time during the plan year. Such mid-year election must be applied only to salary not yet currently available to the employee, and shall be effective as of the first of the month following the month in which the election is made.

3.6 FSA Rollover to HSA. Consistent with Notice 2007-22, as may be modified from time to time, the Plan permits a one-time participant roll over of the participant's flexible spending account (FSA) balance to a HSA established by the participant. The participant must make a written election of the roll over using the roll over election form of the Plan. The roll over election is limited to a participant who had a FSA in effect as of September 21, 2006, and shall not exceed an amount which is the lesser of the amount in the FSA on that date or the amount in the FSA account as of the date of the roll over. Such roll over shall be administered consistent with the Notice and any other applicable U.S. Treasury Department guidance.

ARTICLE IV **Participants' Accounts, Benefit Claims, Payment of Benefits**

4.1 Participant's Benefit Accounts. For the purpose of providing participants with the choice of which one or more of the benefits under the Plan are to be provided to the participant, the Plan Administrator shall establish with respect to each participant a bookkeeping account to reflect each benefit elected by the participant (all such accounts are sometimes collectively referred to herein as the "benefit accounts" and individually as a "benefit account").

For purposes of adjusting participant's benefit accounts to reflect participant's salary reduction contributions and distributions of plan benefits, benefit accounts shall be described as "premium payment benefit accounts" (if the applicable benefit is a premium payment benefit) or "reimbursement benefit accounts" (if the applicable benefit is a reimbursement benefit or direct payment benefit). Immediately following the payroll processing date (or the date the participant first becomes eligible to participate), the Plan Administrator will credit the appropriate reimbursement benefit accounts of participants electing reimbursement benefits under the Plan with the total amount apportioned by the participant on his salary reduction agreement to provide such reimbursement benefit to the participant or, if applicable, his covered dependents for such plan year. As of each regularly scheduled payday, or such other day as provided by the Employer, the Plan Administrator will credit the appropriate premium payment benefit accounts of participants making salary reduction contributions with the portion of each participant's salary reduction contribution which such participant previously designated to be apportioned to provide such premium payment benefit to the participant or, if applicable, his covered dependents. The participant's premium payment benefit account or reimbursement benefit account shall be charged by the Plan Administrator when the amounts allocated to such accounts are applied to provide benefits. In the event that benefit payments charged to any benefit account exceed the balance of such account, the employer shall be responsible for paying

the full amount of the vouchered and verified expense as long as the request does not exceed the total benefit allocated for that account for that plan year. No interest shall be credited on participants' account balances. Any positive balance in a participant's benefit account on the last day of any plan year, which is not used to provide benefits incurred during such Plan Year, shall be forfeited by the participant. The Employer will not be liable if an insurance company fails to pay for any of the insured benefits.

Any unclaimed (un-cashed) benefit payments by the close of the Plan Year following the Period of Coverage in which the Medical/Dependent Care Expense was incurred shall be forfeited back to the Employer.

4.2 Benefit Claims. A Participant shall file the forms prescribed by the Employer to make claims for benefits under the Plan. All claims must be substantiated as required under the Treasury regulations applicable to IRC Section 125 plans. Such substantiation must occur before the claim can be paid or reimbursed. Advanced reimbursement shall not be permitted. Employer shall establish from time to time when claims may be submitted, pursuant to applicable Treasury regulations and guidance.

4.3 Payment of Benefits. Benefits payable under the Plan for, or on behalf of, a participant or covered dependent shall be paid as soon as practicable in such amounts, at such times and to such persons as shall be determined in accordance with the Plan. The form and manner of payment shall comply with the terms and conditions of the Plan. Benefits may be paid directly from the general assets of the Employer. All or a portion of the benefits provided under the Plan may be paid directly to the person or institution on whose charges a claim is based.

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It is the responsibility of the Participant to determine whether each payment under this Plan is excludable from their gross income for federal, state and local income tax purposes. The Participant must notify the Plan Administrator if he/she believes that such payment is not so excludable.

If a Participant receives payment or reimbursement under this Plan on a tax-free basis and such payments do not qualify for such treatment under the Code, then the Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes or other such taxes from such payments or reimbursements.

4.4 Designation of Beneficiaries. Each participant or covered dependent from time to time may name any person (who may be named concurrently, contingently, or successively) to whom the participant's or covered dependent's benefits under the Plan are to be paid if the participant or covered dependent dies before he receives all such benefits. Each such beneficiary designation will revoke all prior designations by the participant or covered dependent; shall not require the consent of any previously named beneficiary; shall be in a

form prescribed by the Plan Administrator; and will be effective only when filed with the Plan Administrator during the participant's or covered dependent's lifetime.

If a participant or covered dependent fails to designate a beneficiary before his death, as provided above, or if the designated beneficiary dies before the date of the participant's or covered dependent's benefits, the Plan Administrator, in its discretion, may pay such benefits to either (a) one or more of the participant's or covered dependent's relatives by blood, adoption, or marriage and in such proportions as the plan administrator determines, or (b) the legal representative or representatives of the estate of the last to die of the participant or the covered dependent and his designated beneficiary. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

4.5 Facility of Payment. When a person entitled to benefits under the Plan is under a legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his affairs, the Plan Administrator may direct the payment of benefits to such person's legal representative, or to a relative or friend of such person for such person's benefit; or the Plan Administrator may direct the application of such benefits for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment made in accordance with the preceding sentence shall be a full and complete discharge of any liability for such payment under the plan.

4.6 Use of Debit Card. The Employer may elect, as part of the Adoption Agreement, to provide for debit cards to be used by a participant to pay for or to reimburse a participant for medical and dependent care expenses. The Plan Administrator limits debit card use to medical care providers and stores with merchant category codes (MCC) for drugstores and pharmacies that meet the 90% gross receipts test for items that qualify as section 213(d) expenses. A participant's use of the debit card shall follow all of the requirements governing debit card use, including but not limited to applicable Treasury regulations as defined in Section 213(d) of the Code. Before a participant may use a debit card, the participant will be required to agree in writing to the rules governing its use. The Participant shall acquire and retain sufficient documentation to substantiate any expense paid with the debit card. Any improper payment of a benefit using the debit card will require the participant to repay the amount of the improper payment to the Plan. The card will automatically be cancelled when the employee ceases participation in the Plan. The following steps will be taken (in order) to collect funds for repayment of ineligible expenses incurred by a Participant.

- (a) A letter or e-mail is generated and mailed within twenty four hours of expense being deemed ineligible requesting immediate repayment of expense to the Flexible Spending Account. The Participant and any Dependents' cards are temporarily inactivated pending payment. If payment is received within a reasonable amount of time, the debit card(s) is reactivated and no further action is needed. If repayment is not made the Plan Administrator will proceed with the next step.
- (b) The Employer will withhold the ineligible expense amount from the Participant's future pay and apply the amount to the Flexible Spending Account. Once this action is taken, the Participant's card(s) will be

reactivated and no further action is required. If this is not an option the next step will be taken.

- (c) If the Participant has submitted eligible expenses to be reimbursed manually, the Claims Administrator will apply these expenses to the ineligible expenses first and pay any remaining available eligible expenses to the Participant. [Example: Jason has \$250 of ineligible expenses pending repayment and has terminated employment with the Employer. Jason has not repaid his account and has no future pay to collect from. Jason has submitted \$300 worth of eligible expenses to be reimbursed by check. The Claims Administrator will off-set the \$250 of ineligible expenses with the manual claim and give Jason a check for \$50] If the Participant has not and will not submit eligible expenses manually then the next step will be taken.
- (d) The Employer may choose to treat this ineligible expense as any other indebted business expense and file a lawsuit or garnishment of wages from a future employer to recoup the expense.
- (e) The last step is for the employer to "write off" the expense as bad debt as they would any other outstanding debt. The write-off would be for the current plan year, not the plan year the expense was incurred. The Employer may choose to claim this amount as taxable income on the Employee's income tax documents.

4.7 Reimbursements after Termination of Participation; COBRA. When a participant ceases to be a participant under Section 2.1, the Participant's salary reductions and election to participate will terminate. He/She will not be able to receive reimbursements for Medical and Dependent Care Expenses incurred after the date the Participant's employment terminates or he/she ceases to be eligible to participate in the Plan. The Participant will have 90 days from the date that he/she is no longer eligible to submit claims for reimbursement of expenses incurred prior to the date of ineligibility.

A Participant and his/her Spouse and Dependents whose coverage terminates because of a COBRA qualifying event shall be given the opportunity to continue on a self-pay basis the same coverage that he/she had the day before the qualifying event as described by COBRA. Reference Article VIII of this Plan.

4.8 Procedure if Benefits Are Denied Under This Plan. If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan.

Article V **Administration**

5.1 The Plan Administrator. The Employer named in the Adoption Agreement is responsible for the administration of the Plan (the "plan administrator").

5.2 Plan Administrator's Duties. Except as otherwise specifically provided and in addition to the powers, rights, and duties specifically given to the Plan Administrator elsewhere in the Plan, the Plan Administrator shall have the following powers, rights, and duties.

- (a) To construe and interpret the Plan, to decide all questions of eligibility and to determine the amount, manner, and time of payment of any benefits hereunder and to remedy ambiguities, inconsistencies, or omissions.
- (b) To adopt such rules of procedure as may be necessary for the efficient administration of the Plan and as are consistent with its terms and such rules.
- (c) To make a determination as to the right of any person to a benefit; to afford any person dissatisfied with such determination the right to a hearing thereon; and to direct payments in accordance with the provisions of the Plan.
- (d) To furnish the Employer with such information as it may require for tax or other purposes in connection with the Plan.
- (e) To enroll participants in the Plan; distribute and receive plan administration forms and comply with all applicable governmental reporting and disclosure requirements; and to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan.
- (f) To employ any agents, attorneys, accountants, or other persons (who also may be employed by the Employer) and to allocate or delegate to them such powers, rights, and duties as the plan administrator considers necessary or advisable to properly carry out the administration of the Plan, provided that any such allocation or delegation, and the acceptance thereof, shall be in writing.
- (g) To report after the end of each plan year to the Employer or to such person or persons as the Employer designates, regarding the administration of the Plan, any significant problems which have developed in connection with the new administration of the Plan, and any recommendations which the Plan Administrator may have as to the amendment of the Plan or the modification of plan administration.

The Plan Administrator, in its capacity as Plan Administrator, shall have no power to add to, subtract from, or modify any of the terms of the Plan; nor to change or add to any benefits provided by the Plan; nor to waive or fail to apply any requirement of eligibility for the receipt of benefits under the Plan. Notwithstanding the preceding sentence, the Plan Administrator shall have the power to take such actions, as it shall consider necessary or appropriate to satisfy the nondiscrimination requirements of IRC Section 125 of the Code.

5.3 Information Required for Plan Administration. The records of the Employer as to an employee's or participant's period or periods of employment, termination of employment and reason therefore, leaves of absence, re-employment, and compensation will be conclusive on all persons. Participants and other persons entitled to benefits under the Plan also shall furnish the Plan Administrator with such evidence, data, or information, as the Plan Administrator considers necessary or desirable to perform its duties.

5.4 Decision of Plan Administrator Final. Subject to applicable law and the provisions of Section 5.5, any interpretation of the provisions of the Plan, and any decision on any matter within the discretion of the Plan Administrator, made by the Plan Administrator in good faith, shall be binding on all persons. A miss-statement or other mistake of facts shall be corrected when it becomes known and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable.

5.5 Review of Benefit Determinations. If a claim for benefits made by a participant or his beneficiary is denied, the Plan Administrator shall, within 90 days (or 180 days if special circumstances require an extension of time) after the claim is made, furnish the person making the claim with a written notice specifying the reasons for the denial. Such notice shall also refer to the pertinent plan provisions on which the denial is based, describe any additional material or information necessary for properly completing the claim and explain why such material or information is necessary, and explain the Plan's claim review procedures. If requested in writing, the Plan Administrator shall afford each claimant whose claim has been denied a full and fair review of the Plan Administrator's decision and, within 60 days (120 days if special circumstances require additional time) of the request for reconsideration of the denied claim, the Plan Administrator shall notify the claimant in writing of its final decision.

5.6 Coordination of Benefits with HSA. Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not previously been reimbursed and will not seek reimbursement elsewhere. The Health FSA shall not be considered a group health plan for coordination of benefits purposes. These benefits shall not be taken into account when determining benefits payable under any other plan.

Participants with contributions to their Health Savings Account (HSA) during the year may only elect a Limited Purpose FSA.

5.7 Uniform Rules. The Plan Administrator shall perform its duties on a reasonable and nondiscriminatory basis and shall apply uniform rules to all participants similarly situated based on prevailing IRS guidance.

5.8 Indemnity. To the extent permitted by applicable law, and to the extent that they are not indemnified or saved harmless under any liability coverage contracts, any present or former officers, directors, or employees of the Employer and each of them shall be indemnified and saved harmless by the Employer from and against any and all liabilities or allegations of liability to which they may be subjected by reason of any act done or omitted to be done in good faith in the administration of the Plan, including all expenses reasonably

incurred in their defense in the event that the Employer fails to provide such defense after having been requested in writing to do so.

5.9 Mistakes and Errors. It is recognized that in the administration of the Plan certain mathematical and accounting errors may be made or mistakes may arise by reason of factual errors in information supplied to the Employer or the Sponsor. The Sponsor shall have power to cause such equitable adjustments to be made to correct for mathematical, accounting, or factual errors made in good faith, as the Sponsor in its discretion deems appropriate.

ARTICLE VI **Funding, Amendment, and Termination of the Plan**

6.1 Funding. The Plan shall be maintained on an unfunded basis and benefits shall be paid solely as required out of the general assets of the Employer or under any contract issued by a modified or fully self-funded program, insurance company, health maintenance organization, or other organization or institution.

6.2 Amendment. The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which participants and covered dependents otherwise have become entitled under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer shall have the right to make any amendment retroactively, which is necessary to bring the Plan into conformity with any federal and state laws unless prohibited by such law. In addition, the Employer may amend any provisions of any benefit supplements to the Plan, merge or combine benefit supplements, and add or delete benefit supplements. Any such Plan amendment shall be effective for periods the later of the adoption date or the effective date of the amendment, unless otherwise required by law. If such amendment adds a new benefit to the Plan, only those expenses incurred after the amendment date may be eligible for reimbursement under the Plan.

6.3 Termination. The Employer shall have the right at anytime to terminate this Plan, with a 30-day notice provided that such termination shall not eliminate any obligations of the Employer, which theretofore have arisen under the Plan. Upon termination, the grace period, or 90-day run out – whichever applies, can be continued at the normal monthly fees.

6.4 Named Fiduciary. The Employer is the named fiduciary for purposes of ERISA § 402(a).

ARTICLE VII **General Provisions**

7.1 Nonassignability. Benefits under the Plan are not in any way subject to the debts or other obligations of the persons entitled thereto and may not voluntarily or involuntarily be sold, transferred, or assigned. Any participant or covered dependent may, however, with the Plan Administrator's consent, authorize the Plan Administrator to pay benefits under the plan directly to the person or institution on whose charges a claim is based. The Employer shall be discharged from all liability to the extent of any payment made in accordance with such authorization. No person shall have any right, title, or interest in, or to, any amount provided under this Plan prior to the payment thereof to such person or in any property of the Employer.

7.2 No Employment Guarantee. Neither the establishment of the Plan nor any modification thereof, nor the creation of any fund or account, nor the payment of any benefits shall be construed as giving to any participant or other person any legal or equitable right against the Employer except as herein provided. The Plan shall not be deemed to constitute a contract of employment between the Employer and any Participant.

7.3 Gender and Number. Words denoting the masculine gender shall include the feminine and neutral genders and the singular shall include the plural and plural shall include the singular wherever required by the context.

7.4 Limitation on Liability. It is expressly understood and agreed by each participant that, except for its or their willful misconduct or gross neglect, the Employer shall not in anyway be subject to any legal liability to any participant for any cause or reason or thing whatsoever in connection with this Plan, and each such participant hereby releases the Employer and its agents from any and all liability or obligation, except as in this section provided and except as provided by applicable federal law.

7.5 Participant Litigation. In any action or proceeding involving the Plan, or the administration thereof, employees or former employees of the Employer or any other person having or claiming to have an interest in this Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof except as required by applicable law. Any final judgment, which is not appealed or appealable, that may be entered in any such action or proceeding, shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Employer, or a modified or fully self-funded program, insurance company, health maintenance organization, or other organization or institution providing benefits under the Plan, by or on behalf of any person, and such action results adversely to such person; or, if a legal action arises because of conflicting benefit claims, the cost to the Employer, or such modified or fully funded program, insurance company, health maintenance organization or other organization or institution, of defending the action, will be charged to the sums, if any, which were involved in the action or were payable to the participant, covered dependent or person concerned. To the extent permitted by applicable law, election to become a participant under the Plan shall constitute a release of the Employer and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

7.6 Addresses, Notice, Waiver of Notice. Each participant must file with the Plan Administrator, in writing, his/her current mailing address. Any communication, statement, or notice addressed to such a person at his last post office address, as filed with the Plan Administrator, will be binding upon such person for all purposes of the Plan, and the Employer shall not be obliged to search for or ascertain the whereabouts of any such person. Any notice required under the Plan may be waived by the person entitled to notice.

7.7 Data. Each participant or covered dependent must furnish the Employer such documents, evidence, or information as the Employer considers necessary or desirable for the purpose of administering the Plan or to protect the Employer or any modified or fully self-funded program, insurance company, health maintenance organization or other organization or institution providing benefits under the Plan. Evidence required of anyone under the Plan shall be signed, made or presented by the proper party or parties, and may be by certificate, affidavit, document or other information, which the person acting thereon considers pertinent and reliable.

7.8 Mistake of Fact. Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof.

7.9 Withholding for Taxes. Plan participation will reduce the amount of the Participant's taxable compensation. Accordingly, there could be a decrease in the Participant's Social Security and/or other benefits (e.g., pension, disability and life insurance), which are based on taxable compensation. However, the tax savings that the Participant would realize through Plan participation will often more than offset any reduction in other benefits.

The Employer believes this Plan is written in accordance with section 105 of the Code and that it provides certain benefits to Employees which are free from Federal income tax. By accepting a benefit under this Plan, the Participant agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

7.10 Severability. In case any provisions of the Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan, and the Plan shall be construed and enforced as if such illegal and invalid provisions had never been set forth in the Plan.

7.11 Applicable Law. The Plan shall be construed according to ERISA and the Internal Revenue Code of 1954, as amended from time to time and as construed, interpreted and modified by regulations or rulings promulgated thereunder. The Plan is intended to constitute a cafeteria plan meeting the requirements of IRC Section 125 of the Code. The Plan shall be construed and enforced according to the laws of the State of Iowa to the extent not pre-empted by any federal law.

7.12 Elections of Highly Compensated. Consistent with Non-Discrimination rules pertaining to this plan, elections of Highly Compensated and Key employees shall automatically be cut back, if needed, to comply with such non-discrimination rules. All

other nondiscrimination rules applicable to the plan, as promulgated by the Department of Treasury, shall be applied to the plan.

7.13 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom payment is due because it cannot ascertain the identity or whereabouts of such Participant/other person after reasonable efforts have been made to identify and locate such person, then the payment and all subsequent payments due to such person shall be forfeited.

7.14 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated, except as provided pursuant to a Qualified Medical Child Support Order pursuant to Section 609 of ERISA.

7.15 Headings and Captions. The heading and captions used in the Plan are for convenience only.

ARTICLE VIII
Continuation Coverage Under COBRA
(Consolidated Omnibus Budget Reconciliation Act of 1985)

8.1 COBRA Defined. Under COBRA, this Section shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain instances when coverage under a group health plan would otherwise end. A group health plan includes any major medical plan, dental plan, vision plan, health FSA, or other plan that we may maintain and that provides medical care. For simplicity, any such group health plan is referred to in this section as the “Plan.” You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay the entire premium for your continuation coverage.

IRS Notice 2010-38 states that the applicable Treasury Regulations will be amended retroactively to March 30, 2010 to include Change in Status events covering children under age 27 who do not otherwise qualify as dependent children, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

8.2 Qualifying Events. If you are an **employee** of the Employer and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two “qualifying events”:

1. Termination of your employment (for reasons other than gross misconduct).
2. Reduction in the hours of your employment.

If you are the **spouse** of an employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four “qualifying events:

1. The death of your spouse.
2. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the Employer.
3. Divorce or legal separation from your spouse.
4. Your spouse becomes entitled to Medicare benefits.

In the case of a **dependent child** of an employee covered by the Plan, the dependent child has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five “qualifying events”:

1. The death of the employee-parent.
2. The termination of the employee-parent’s employment (for reasons other than gross misconduct) or reduction in the employee-parent’s hours of employment with the Employer.
3. Parents’ divorce or legal separation.
4. The employee-parent becomes entitled to Medicare benefits.
5. The dependent ceases to be a “dependent child” under the Plan.

8.3 Your Important Notice Obligations. If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child’s losing dependent status under the Plan, then you (the employee) or your spouse or dependent has the responsibility to notify the Plan Administrator of the divorce, legal separation, or the child’s losing dependent status. You or your spouse or dependent *must* provide this notice no later than 60 days after the date coverage terminates under the plan. *If you or your spouse or dependent child fails to provide this notice to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered the option to elect continuation coverage.* Furthermore, if you or your spouse or dependent child fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child’s losing dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

8.4 Election Procedures. You (the employee) and/or your spouse and dependent children must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. *If you or your spouse and dependent children*

do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. A COBRA election mailed to the Plan Administrator is considered to be made on the date of mailing.

You (the employee) and/or your spouse and dependent children may elect continuation coverage for all qualifying family members. You, your spouse and dependent children each have an independent right to elect continuation coverage even if the covered employee does not elect it.

You (the employee) and/or your spouse and dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.

8.5 Type of Coverage. The continuation coverage that is offered will be the same coverage that you, your spouse or dependent children had on the day before the qualifying event. Therefore, an employee, spouse, or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, when there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage is modified for similarly situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If the Employer maintains a health flexible spending arrangement (health FSA) under which you are reimbursed for medical expenses, you (or your spouse or dependent children) may elect to continue the health FSA coverage under COBRA, but only if there is a positive account balance (i.e. year-to-date contributions exceed year-to-date claims) on the day before the qualifying event. COBRA coverage under the health FSA will continue only for the remainder of the Plan year in which the qualifying event occurred. If there is a negative account balance, then no qualified beneficiary may elect COBRA coverage under the health FSA.

8.6 COBRA Premiums That You Must Pay. The initial premium must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the 1st of the month with a 30-day grace period for payments. The Plan will not send monthly premium notices. If you do not make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month, with no possibility of reinstatement.

8.7 Shorter Maximum for Health FSAs. If qualified for coverage under COBRA, the maximum COBRA period for a Health Flexible Spending Arrangement (health FSA) maintained by the Employer (if there is a positive account balance as of the date of the qualifying event, as explained above) ends on the last day of the Plan year in which the qualifying event occurred. If there is a negative account balance as of the date of the qualifying event, no COBRA coverage will be offered.

8.8 Termination of COBRA Coverage Before the End of Maximum Coverage Period. Continuation coverage of the employee, spouse and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following three events occurs.

1. The Employer no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not paid timely.
3. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

8.9 Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes. If you or your spouse's address changes, you *must* promptly notify the Plan Administrator in writing. The Plan Administrator needs up-to-date addresses in order to mail important COBRA notices and other information. Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or dependent *must* promptly notify the Plan Administrator in writing within 60 days of the event. Such notification is necessary to protect COBRA rights for your spouse and dependent children. In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

8.10 COBRA Administrator. All notices and other communications regarding COBRA must be directed to your Employer.

ARTICLE IX **General Information**

9.1 FMLA. The Family Leave Act of 1993, regulated by the Department of Labor, allows certain election changes mid-year on account of leaves of absence. For an employer to be subject to the Family Medical Leave Act, there must be employed by the Employer *50 or more* active employees. An employee taking leave under the FMLA may continue or revoke an existing election of accident or health plan coverage including the Health Flexible Spending Account. If the employee elects to continue, the employee must also have the option of suspending payment for such coverage during the leave. If the employer continues coverage during an unpaid leave, the employer may recover the employee's share of the premiums when the employee returns to work. The employee has a right to be reinstated in the group health plan coverage upon returning from FMLA leave if such coverage terminated during the leave (either by revocation or due to non-payment of premiums). The reinstatement right includes being

reinstated on the same terms as before the FMLA leave, subject to any changes in benefit levels. The employee's reinstatement right includes the right to revoke or change elections under the election changes regulations on the same terms as employees who are working and not on FMLA leave. An employee who elects to continue health coverage while on unpaid FMLA leave may do so in one of three ways: pre-pay, pay-as-you-go, and catch-up. If applicable, the Employer will provide detailed information upon the employee taking the FMLA leave.

9.2 ERISA Provisions. It is intended that this Plan meet all applicable requirements of the Code and ERISA (Employee Retirement Income Security Act of 1974), and of all regulations issued thereunder. ERISA applies to the Health Insurance Plan and the Health Flexible Spending Account Component but not to the Dependent Care Assistance Plan. The Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause or provision of the Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of the Plan shall be deemed superseded to the extent of the conflict. The ERISA General Information for your Employer's Plan is set forth at 9.2 of the Adoption Agreement.

9.3 QMCSO. This plan extends benefits to a Participant's non-custodial child, as required by any qualified medical child support order (QMCSO), as defined in ERISA 609(a). The plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Administrator.

9.4 NMHPA. The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

9.5 HEART. The Heroes Earnings Assistance and Relief Tax Act of 2008 (Heroes Act or HEART Act), amends the cafeteria plan rules to allow health FSAs to provide for qualified reservist distributions of all or a portion of the health FSA account balances of participants who are reservists called to active duty for 180 days or more (or for an indefinite period). Distributions may be made at any time from the date of the call to duty through the last date on which reimbursements may be made for the plan year in which the call occurred.

9.6 Uniformed Service Under USERRA. A Participant who is absent from employment on account of being in "uniformed service" as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 may elect to continue

participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. It is the responsibility of the Participant to make the required contributions during the USERRA Leave. Payments shall be made in the same manner as FMLA Leave as stated above in Section 9.1.

ARTICLE X **HIPAA Use and Disclosure of Protected Health Information**

10.1 Use and Disclosure of Protected Health Information. The Plan will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures as defined in 45 CFR § 160.103 permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HIPAA Privacy rules, as amended from time to time. The Plan will use and disclose PHI as defined in 45 CFR § 164.520 for purposes related to health care treatment, payment for health care and health care operations without the consent of the Plan Participants, including but not limited to disclosures to business associates of the Plan (for example, the third party administrator for the Plan, Employee Benefit Systems).

10.2 Notice of HIPAA Privacy Practices. Each Participant will receive a copy of the Plan's Notice of HIPAA Privacy Practices at the time of enrollment. A Participant may request another copy of the Notice by contacting the Employer.

10.3 Disclosures for Treatment. The Plan may use a Participant's PHI to permit the provision, coordination or management of health care and related services. The Plan may disclose PHI to health care providers that are involved in a Participant's care. In addition, the Plan may disclose PHI for purposes of consultations and referrals between one or more providers.

10.4 Disclosures for Payment Activities. The Plan may disclose a Participant's PHI for purposes of payment under the Plan. Payment activities of the Plan may include activities undertaken by the Plan to determine or fulfill its responsibility for payment of claims for services provided to a Participant, Spouse or Dependent. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and reimbursement amounts;
- Coordination of benefits between this Plan and other plans providing coverage to Participant;
- Adjudication of benefit claims under the Plan (including claims appeals and other payment disputes);
- Subrogation of claims with other payors;
- Activities related to claims processing;
- Billing, claims management and related claims data processing, including auditing payments, investigating and resolving claim payment disputes and responding to Participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss insurance);

- Medical review of the claim to determine whether charge is medically necessary or customary and reasonable;
- Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to the collection of reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Reimbursement to the Plan.

10.5 Health Care Operations Disclosures. The Plan may need to disclose PHI to conduct the health care operations of the Plan. Such disclosures may occur as part of the following activities:

- Quality assessment of the Plan operations or of provider care;
- Activities related to improving health or reducing health care costs for Participants, development of Plan protocols, case management and care coordination for targeted Participants, contacting health care providers and Participants with information about treatment alternatives and related functions;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of insurance for the Plan or a health benefit offered by the Plan;
- Securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions for the Plan, including compliance programs;
- Business planning and development, such as conducting cost-management and planning analysis related to managing and operating the Plan, and developing and improving payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including but not limited to management activities relating to the implementation of and compliance with HIPAA; and
- Disclosures to third parties in connection with due diligence related to the sale or transfer of assets to a potential successor-in-interest.

10.6 Disclosures as Required by Law. The Plan will disclose PHI as required by law and which are permitted or required under the HIPAA Privacy rules. Such disclosures include, but are not limited to, requests for PHI related to worker's compensation claims, to health oversight agencies, in response to lawsuit or administrative agency requests, and to law enforcement officials. Such disclosures are outlined in greater detail in the Plan's Notice of HIPAA Privacy Practices.

10.7 Written Authorization to Disclose. The Plan will obtain a written authorization from Participant in the event PHI that requires a written authorization needs to be disclosed by the Plan to the Plan Sponsor or another third party.

10.8 Disclosures of Mental Health, HIV and Substance Abuse Information. The Plan will disclose mental health information, substance abuse information and HIV information as permitted under federal and state law.

10.9 Disclosures to Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan Sponsor will abide by the following conditions relating to the use and disclosure of PHI. The Plan Sponsor must agree to the following:

- Not to use or further disclose Participants' PHI, other than as permitted or required by this Plan document or as required by law;
- Ensure that any agents, including a business associate, to whom the Plan Sponsor provides PHI, which it has received, from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not to use or disclose PHI for employment-related actions and decisions unless authorized in writing by a Participant;
- Not use or disclose PHI in connection with any other benefit offered by or employee benefit plan of the Plan Sponsor unless authorized by a Participant;
- Report to the Plan any use or disclosure of a Participant's PHI that is inconsistent with the uses or disclosures provided for by the Plan or permitted by law of which the Plan Sponsor becomes aware;
- Permit a Participant to inspect and copy PHI retained by the Plan and Plan Sponsor in accordance with HIPAA's access requirements;
- Permit a Participant to request amendment of the Participant's PHI retained by Plan or Plan Sponsor, and incorporate any amendments to, or in the case of a denial of the request, the request to amend, PHI in accordance with HIPAA;
- Provide a Participant with an accounting of PHI disclosures in accordance with HIPAA;
- Provide, upon request of the United States Secretary of Health and Human Services, the internal practices, books and records of the Plan Sponsor relating to the use and disclosure of PHI received from the Plan; and
- If feasible, return or destroy all PHI (in any form, including all copies) received from the Plan when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI not feasible.

10.10 Access to PHI by Plan Sponsor. The Plan and Plan Sponsor will take reasonable steps to ensure that Participants' PHI shall be disclosed for the purposes set forth in this section or as required by law. The Plan Sponsor intends to use the PHI disclosed to it by the Plan for purposes of Plan administration. To facilitate the administration of the Plan, the classifications of Plan Sponsor employees listed on the Adoption Agreement at Section 10.10 may be given access to PHI. In addition, the Plan Sponsor may disclose PHI to its accountants, attorneys, the third party administrator of

the Plan, insurance brokers or other entities providing quotes for future services to the Plan (including but not limited to insurance products, stop loss insurance, administration services, carve out benefit programs including prescription drug coverage), other health plans that provide health benefits to a Participant for purposes of subrogation and coordination of benefits and all business associates of the Plan. The Plan Sponsor may provide PHI to the above named classes of employees, individuals and entities to permit treatment, payment or health care operations under the Plan (as described above).

10.11 Non-Compliant Disclosures of PHI. In the event an employee, individual or entity to whom the Plan Sponsor has disclosed PHI does not comply with the requirements set forth in this Section, the Plan Sponsor shall report the non compliant activity to the Plan through the Plan's privacy officer. The Plan's privacy officer shall conduct or oversee an investigation into the allegations of improper disclosure. If the improper disclosure is found to have occurred, the privacy officer shall recommend to the Plan Sponsor a procedure that can be implemented to reduce the opportunity for an improper disclosure to occur in the future. The Plan Sponsor may adopt the procedure in whole or in part, and shall take those actions reasonably necessary to ensure that type of improper disclosure does not occur in the future. The privacy officer may also recommend disciplinary sanctions against the non-compliant party, which the Plan Sponsor may implement in whole or in part.

10.12 Plan HIPAA Privacy Officer. For purposes of this Plan, the Plan's HIPAA privacy officer shall be as set forth at Section 10.12 of the Adoption Agreement. The Privacy Officer shall be responsible for compliance with the Health FSA obligations under this Article X and HIPAA.

10.13 HIPAA Security Rule. The Employer (Plan Sponsor) shall comply with the plan document requirements of the HIPAA security regulations found at 45 CFR § 164.314(b).

- a. "Electronic Protected Health Information" shall mean individually identifiable health information that is transmitted by electronic media or maintained in electronic media by the Plan.
- b. The Employer agrees to:
 1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
 2. Ensure that the adequate separation between the Plan and the Employer as required by Privacy Rule is supported by reasonable and appropriate security measures.
 3. Ensure that any agent, including subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect such Electronic PHI.

4. Report to the Plan Administrator any security incident of which it becomes aware.

10.14 Complaints. In the event a Participant believes the Participant's HIPAA privacy rights have been violated by the Plan, the Participant may file a written complaint with the Plan's privacy officer or with the U.S. Secretary of the Department of Health and Human Services.

SUPPLEMENT

Group Medical Plan Coverage Premium Payment Benefits Under 125 Flexible Benefits Plan

1. **Purpose.** The purpose of this Supplement is to permit participants to pay the employee portion of the cost of coverage under the Group Medical Plan by making salary reduction contributions to the Plan. This Supplement constitutes the group medical premium payment plan of the Employer. The benefit provided under this Supplement is a "premium payment benefit." The specific provisions of the Group Medical Plan, as set forth in a contract(s) or policy(s) issued by a company, shall be considered a part of the Plan and incorporated herein by reference.

2. **Amount of Premium Payment Benefit.** Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to reduce his compensation and to contribute the amount of such salary reduction to the Plan as his group medical premium cost. The term "group medical premium cost," as used in the Plan, means the participant's share of the cost of group medical coverage. A participant who fails to make the election shall be deemed to have made an automatic election to reduce his or her compensation by the premium amount selected under the Group Medical Plan election, and such election shall be deemed to be made on an annual basis there after unless a different election is made by the participant.

SUPPLEMENT

Group Dental Plan Coverage Premium Payment Benefits Under 125 Flexible Benefits Plan

- 1. Purpose.** The purpose of this Supplement is to permit participants to pay the employee portion of the cost of coverage under the Group Dental Plan by making salary reduction contributions to the Plan. This Supplement constitutes the group dental premium payment plan of the Employer. The benefit provided under this Supplement is a “premiums payment benefit”. The specific provisions of the Group Dental Plan, as set forth in a contract(s) or policy(s) issued by a company, shall be considered a part of the plan and incorporated herein by reference.
- 2. Amount of Premium Payment Benefit.** Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to reduce his compensation or to forego an increase in his compensation and to contribute the amount of such salary reduction to the Plan as his group dental premium cost. The term “group dental premium cost,” as used in the Plan means the participant’s share of the cost of group dental coverage. A participant who fails to make the election shall be deemed to have made an automatic election to reduce his or her compensation by the premium amount selected under the Group Medical Plan election, and such election shall be deemed to be made on an annual basis there after unless a different election is made by the participant.

SUPPLEMENT

Group Vision Plan Coverage Premium Payment Benefits under 125 Flexible Benefits Plan

1. **Purpose.** The purpose of the Supplement is to permit participants to pay the employee portion of the cost of coverage under the Group Vision Plan by making salary reduction contributions to the Plan. This Supplement constitutes the group vision premium payment plan of the Employer. The benefit provided under this Supplement is a “premium payment benefit”. The specific provisions of the Group Vision Plan, as set forth in a contract(s) or policy(s) issued by a company, shall be considered a part of the Plan and incorporated herein by reference.

2. **Amount of premium Payment Benefit.** Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to reduce his compensation or to forego an increase in his compensation and to contribute the amount of such salary reduction to the Plan as his group vision premium cost. The term “group vision premium cost”, as used in the Plan, means the participant’s share of the cost of group vision coverage.

SUPPLEMENT

Dependent Child Care Reimbursement Plan Benefits Under 125 Flexible Benefits Plan

1. **Purpose.** The purpose of this Supplement is to provide for the reimbursement of certain child and dependent care expenses to participants. This supplement constitutes the child and dependent expense reimbursement plan of the Employer. The benefit provided under this supplement is a "reimbursement benefit" called the Dependent Care Assistance Plan (DCAP).

2. **Amount of Benefit.** Subject to the conditions and limitations of the Plan (\$5,000) maximum reimbursement per year if you are married and filing a joint return; if you are married but furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursement under the DCAP, maintain a separate residence from your spouse and filing a separate return; or if you are single or are the head of the household for tax purposes, or, if the participant is married and files a separate tax return (\$2,500), each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to be reimbursed from the Employer for child and dependent care costs (as defined in paragraph 3) incurred, which means that the services must actually be rendered, during that year by him to the extent that such costs do not exceed an amount equal to the lesser of:

- (a) The total child and dependent care costs paid by the participant and attributable to child and dependent care services rendered during that plan year and regardless of whether such costs are paid by the participant during such plan year; or
- (b) The amount allocated by the participant to this benefit.

3. **Costs.** The term "child and dependent care costs," as used in the Plan, means amounts paid by a participant for child and dependent care for in house or on site day care or for at home day care provided by third parties meeting applicable state law requirements and the qualifications set forth in Section 44A of the Code. In no event shall child and dependent care costs include costs for any person not included within the meaning of "qualifying individual" as defined in Section 44A(c) (1) of the Code.

4. **Manner of Making Payments.** The employer shall reimburse each participant for the portion of the child and dependent care costs that is payable to him under paragraph 2, provided that the Plan Administrator receives evidence acceptable to it that such child and dependent care costs have been incurred, which means that the services must actually be rendered, by the participant, and the Plan Administrator receives a signed statement from the participant that he has not, and will not in the future, deduct such costs as expenses on his individual Federal or State Income Tax Returns, and further provided the participant provides the Tax ID number of the dependent child care provider.

The amount of coverage that is available for reimbursement of Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to the

DCAP Account at the time the claim is paid, reduced by the amount of any prior reimbursements paid during the Plan Year. Services must be incurred during the Plan Year. A Dependent care expense is incurred when the service gives rise to the expense is provided; when the expense is paid is irrelevant. Participants cannot request reimbursement for dates of care not yet rendered as in paying the month ahead. The total dependent care costs paid by the participant and attributable to dependent care rendered during the plan year or if elected by the Employer the grace period must not extend beyond the fifteenth day of the third month following close of plan year and regardless of whether such costs are paid by the participant during such plan year.

5. Non-duplication of Benefits. A participant shall not be reimbursed for child and dependent care costs under this Plan to the extent that such costs are paid to, or for the benefit of, the participant, or to, or for the benefit of, any individual included in his family unit, under the provisions of any other Plan. Also, a participant must reduce on a dollar for dollar basis, any expenses excludable from gross income under this dependent child care option to the extent that those same dollars might be claimed under the Dependent Care tax credit (i.e. the same dollars cannot be claimed on both the taxpayer tax return and under this account.).

6. Dependent Care Expenses. The expense must be for a qualifying individual, one who is under 13 years of age and you are entitled to claim a dependency exemption on your federal tax return, or you have custody of the child; or a spouse or person who is your dependent under federal tax law defined in Code § 152 (even if you cannot claim the dependency exemption), but only if he or she is physically or mentally incapable of self-care and resides in your home at least 8 hours a day. The expenses must be incurred to enable you (and your spouse if married) to be gainfully employed, which means working or looking for work under Code § 21(b)(2). If your Spouse is not working or looking for work, he must be a full-time student or physically or mentally incapable of self-care. The expense may be provided by a dependent care center, or a person who was *not* your Spouse or for whom you are entitled to a personal exemption under IRS Code 151.

7. Dependent Care Annual Amount. The participant will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Dependent Care Expenses they have incurred and the annual coverage level that was elected and paid for. The difference will be forfeited. The participant will forfeit any amount allocated to the Dependent Care Assistance Plan if that amount has not been applied to the Dependent Care Account for any Plan Year by the end of the 90 day run out period or grace period if applicable, following the end of the plan year for which the election was made. Former employees may make claims for reimbursement for qualifying expenses after the employee's termination for remainder of the plan year if such former employee has a remaining account balance.

SUPPLEMENT

General Purpose Flexible Un-Reimbursed Medical Expense Plan Benefits under 125 Flexible Benefits Plan

1. **Purpose.** The purpose of this Supplement is to provide for the reimbursement of certain health expenses to participants. This Supplement constitutes the health expense reimbursement plan of the Employer. The benefit provided under this supplement is a "reimbursement benefit" called a Health Flexible Spending Account.

2. **Amount of Benefit.** Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to be reimbursed from the Employer for health care costs (as defined in paragraph 3) incurred, when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care, during that year with respect to him and to his family unit (as defined in paragraph 4) to the extent that such costs do not exceed an amount equal to the lesser of:
 - (a) The total health care costs paid by the participant and attributable to health services rendered during the plan year or, if elected by the Employer the grace period, must not extend beyond the fifteenth day of the third month following the close of the plan year and regardless of whether such costs are paid by the participant during such plan year; or

 - (b) The amount that the participant has elected to have withheld for the benefit for the Plan Year (limited by the **maximum reimbursement amount of \$2,500.00**).

3. **Health Care Costs.** The term "health care costs," as used in the Plan, means amounts paid by a participant because of deductible amounts, co-insurance provisions, exclusions from coverage or as a result of any other provision of the Employer's health care plan to the extent that such amount, if paid or reimbursed under such plans, would be excluded from the participant's taxable income. In no event shall health care costs include any item, which is not included within the meaning of "medical care" as defined in Section 213(d) of the Code of the participant and his family unit.

4. **Family Unit.** The term "family unit," as applied to any participant, means the participant, his spouse, and such of his eligible children as are dependents as defined by the IRS Code.

5. **Manner of Making Payments.** The Employer shall reimburse each participant for the portion of his family unit's health care costs that is payable to him under paragraph 2, provided that the plan administrator receives evidence acceptable to it that such health care costs have been incurred, (as defined in #2), by the participant or any other member of the family unit and the Plan Administrator receives a signed statement from the participant that he has not, and will not in the future, deduct such costs as expenses on his

individual Federal or State Income Tax Returns, and further provided that such expenses are documented by statements from an independent third party showing the date the medical expense was incurred, provider of said expense, patient, fee charged and amount due after insurance has paid, if any. If the employer elects to include a grace period in the Plan, a participant who has unused benefits or contributions relating to a particular qualified benefit from the immediately preceding plan year, and who incurs expenses for that same qualified benefit during the grace period, may be paid or reimbursed for those expenses from the unused benefits or contributions as if the expenses had been incurred in the immediately preceding plan year. To the extent any unused benefits or contributions from the immediately preceding plan year exceed the expenses for the qualified benefit incurred during the grace period, those remaining unused benefits or contributions may not be carried forward to any subsequent period (including any subsequent plan year) and are “forfeited” under the “Use-It-Or-Lose-It” rule.

6. Non-duplication of Benefits. A participant shall not be reimbursed for health care costs under this Plan to the extent that such costs are paid to, or for the benefit of, the participant, or to, or for the benefit of, any individual included in his family unit, under the provisions of any other plan.

7. Medical Care Expenses. Medical, Dental, Vision and/or Prescription expenses that are medically necessary and have been processed through insurance coverage (if applicable) and are not reimbursable from any other source qualify for reimbursement.

As of January 1, 2011 a prescription from your doctor for any OTC drugs and medicines will be required for reimbursement. OTC medicines or drugs are not reimbursable through a Flexible Spending Account unless the medicine or drug requires a prescription, is available without a prescription and the individual obtains a prescription, or is insulin. For purposes of the new restrictions, a prescription for a medicine or drug must be a written or electronic order that satisfies the legal requirements for a prescription in that state (including that it is issued by someone authorized to issue prescriptions in that state). To show that an OTC drug has been prescribed, employees must submit the prescription or other documentation, along with the other independent third-party substantiation required under IRS rules. A receipt identifying the purchaser (or the patient), the date and amount of the purchase, and an RX number would meet these requirements. A receipt without an RX number along with a copy of the prescription is also acceptable.

Debit Card participants: After January 15, 2011, health FSA debit cards may continue to be used to purchase over-the-counter medicines or drugs at drug stores and pharmacies, at non-health care merchants that have pharmacies and at mail order and web-based vendors that sell prescription drugs; if :

- (1) prior to purchase,
 - (i) The prescription for the over-the-counter medicine or drug is presented to the pharmacist;
 - (ii) The over-the-counter medicine or drug is dispensed by the pharmacist in accordance with applicable law and regulations pertaining to the practice of pharmacy; and

- (iii) An Rx number is assigned;
- (2) The pharmacy or other vendor retains a record of the Rx number, the name of the purchaser (or the name of the person for who the prescription applies), and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements;
- (3) All of these records are available to the employer or its agent upon request;
- (4) The debit card system will not accept a charge for an over-the-counter medicine or drug unless an RX number has been assigned; and
- (5) The IRS Debit Card use requirements are met,

The debit card transaction will be considered fully substantiated at the time and point-of-sale.

For vendors other than drug stores and pharmacies, non-health care merchants that have pharmacies and mail order and web-based vendors that sell prescription drugs: Health FSA debit cards can be used after January 15, 2011 to purchase OTC drugs from vendors with health care-related merchant category codes (MCCs) if the following requirements are met:

- (1) The pharmacy or other vendor retains a record of the name of the purchaser or patient and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements for card programs;
- (2) The records are available to the employer or its agent upon request; and
- (3) The requirements of other IRS guidance regarding card programs are satisfied.

Transactions meeting these requirements are considered to be fully substantiated at the time and point-of-sale.

Cards may not be used to purchase OTC drugs at providers or merchants not listed above after January 15, 2011.

The prescription restriction does not apply to OTC items other than medicines or drugs (e.g. equipment, supplies, and medical devices). The rules for reimbursing these items remain unchanged. Items such as crutches, bandages, blood sugar test kits, and eyeglasses are not subject to the new restrictions, and debit cards may continue to be used for these items. Receipt substantiation may be required. It is the participant's responsibility to comply with IRC requiring taxpayers to maintain receipts and or payment verification for pre-tax reimbursements.

8. Flexible Spending Account Annual Amount. The participant will not be entitled to receive any direct or indirect payment of any amount that represents the difference between

the actual Flexible Spending Account Expenses that they have incurred and the annual coverage level that was elected and paid for. The difference will be forfeited. The participant will forfeit any amount allocated to the Flexible Spending Account if that amount has not been applied to the Flexible Spending Account for any Plan Year by the end of the 90 day run out period, or grace period if applicable, following the end of the plan year for which the election was made.

SUPPLEMENT

Limited Purpose Flexible Unreimbursed Medical Expense Plan Benefits Under 125 Flexible Benefits Plan

1. **Purpose.** The purpose of this Supplement is to provide for the reimbursement of certain health expenses to participants who also receive benefits under a health savings account ("HSA"). This Supplement constitutes a limited purpose health expense reimbursement plan of the Employer. The benefit provided under this supplement is a "reimbursement benefit" called a Health Flexible Spending Account, for the limited purpose of providing reimbursement for vision and dental expenses and preventative care benefits, as permitted under Revenue Ruling 2004-45 and Notice 2004-23, as may be amended, modified or superceded from time-to-time.

2. **Amount of Benefit.** Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to be reimbursed from the Employer for health care costs (as defined in paragraph 3) incurred, when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care, during that year with respect to him and to his family unit (as defined in paragraph 4) to the extent that such costs do not exceed an amount equal to the lesser of:

 - (a) The total health care costs paid by the participant and attributable to health services rendered during the plan year or, if elected by the Employer the grace period must not extend beyond the fifteenth day of the third month following the close of the plan year and regardless of whether such costs are paid by the participant during such plan year; or
 - (b) The amount that the participant has elected to have withheld for the benefit for the Plan Year (limited by the **maximum reimbursement amount of \$2,500.00**).

3. **Health Care Costs.** The term "health care costs," as used in the Plan, means amounts paid by a participant because of vision or dental expenses or preventative care expenses. In no event shall health care costs include any item, which is not included within the meaning of "medical care" as defined in Section 213(d) of the Code of the participant and his family unit.

4. **Family Unit.** The term "family unit," as applied to any participant, means the participant, his spouse, and such of his eligible children, as are dependents as defined by the IRS Code.

5. **Manner of Making Payments.** The Employer shall reimburse each participant for the portion of his family unit's health care costs that is payable to him under paragraph 2, provided that the plan administrator receives evidence acceptable to it that such health care costs have been incurred, (as defined in #2), by the participant or any other member

of the family unit and the Plan Administrator receives a signed statement from the participant that he has not, and will not in the future, deduct such costs as expenses on his individual Federal or State Income Tax Returns, and further provided that such expenses are documented by statements from an independent third party showing the date the medical expense was incurred, provider of said expense, patient, fee charged and amount due after insurance has paid, if any. If the employer elects to include a grace period in the Plan, a participant who has unused benefits or contributions relating to a particular qualified benefit from the immediately preceding plan year, and who incurs expenses for that same qualified benefit during the grace period, may be paid or reimbursed for those expenses from the unused benefits or contributions as if the expenses had been incurred in the immediately preceding plan year. To the extent any unused benefits or contributions from the immediately preceding plan year exceed the expenses for the qualified benefit incurred during the grace period, those remaining unused benefits or contributions may not be carried forward to any subsequent period (including any subsequent plan year) and are "forfeited" under the "Use-It-Or-Lose-It" rule.

6. Nonduplication of Benefits. A participant shall not be reimbursed for health care costs under this Plan to the extent that such costs are paid to, or for the benefit of, the participant, or to, or for the benefit of, any individual included in his family unit, under the provisions of any other plan.

7. Flexible Spending Account Annual Amount. The participant must submit all claims for reimbursement by the end of the claims payment period immediately following the end of the plan year for which the election was made. The participant will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Flexible Spending Account Expenses that they have incurred and the annual coverage level that was elected and paid for. The difference will be forfeited.

SUPPLEMENT

AFLAC Insurance Coverage **Premium Payment Benefits under 125 Flexible Benefits Plan**

- Purpose.** The purpose of this Supplement is to permit participants to pay the employee portion of the cost of coverage under the AFLAC Insurance Benefit by making salary deduction contributions to the Plan. This Supplement constitutes the AFLAC Insurance Benefit plan of the Employer. The benefit provided under this supplement is a “premium payment benefit”. The specific provision of the AFLAC Insurance Benefit, as set forth in a contract(s) or policy(s) issued by a company, shall be considered a part of the Plan and incorporated herein by reference.
- Amount of Premium Payment Benefit.** Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan and on or before the first day of any plan year thereafter, to authorize a payroll deduction and to contribute the amount of such salary deduction to the Plan as his/her AFLAC Insurance Benefit premium cost. The term “AFLAC Insurance Benefit premium cost”, as used in the Plan, means the participant’s share of the cost of any AFLAC benefit coverage.

ADOPTION AGREEMENT
Flexible Benefits Plan
Sponsored by
Hope Haven Area Development Center Corporation

Name and address of Employer(s):

Hope Haven Area Development Center Corporation
1307 Broadway
West Burlington, IA 52655

Name and address of Plan Administrator(s): Same as above

1.1 Employer Name: **Hope Haven Area Development Center Corporation**

1.2 Original Effective Date: **November 1, 2006**
Amended Date: **November 1, 2010**

1.3 Plan Year: **November 1 to October 31**

1.4 Benefit Programs Offered:

Medical Plan Premiums*

Dental Plan Premiums*

Vision Plan Premiums*

Group Term Life Plan Premiums*

Disability Income Plan Premiums*

Cancer Insurance Premiums*

Dependent Child Care Reimbursement Plan

General Purpose Flexible Un-Reimbursed Medical Expense Plan
 Debit Card option

Limited Purpose Flexible Un-Reimbursed Medical Expense Plan
 Debit Card Option

Voluntary AD&D Plan*

HSA Contributions

AFLAC Insurance Premiums*

*It is the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

1.5 FSA Grace Period Election: Apply 2½ month grace period
 Do not apply 2½ month grace period

2.1 Eligibility Requirements:

Employees eligible to participate in the Plan:

- All Full-time Employees
- Former Employees
- Retired Employees
- Leased employees under IRC Section 414(n)

Age and Service requirements:

Age: 18

Service: You are eligible to participate under the Plan on the first day of the month following 30 days of service.

3.6 FSA to HSA rollover: Apply the rollover option
 Do not apply the rollover option

4.6 Debit Card Option Use debit card option for FSA/DCA
 Do not use debit card option for FSA/DCA

9.2 ERISA General Information:

Plan Name: **Hope Haven Area Development Center Corporation**
Plan Sponsor: **Hope Haven Area Development Center Corporation**
Plan Administrator: **Hope Haven Area Development Center Corporation**
Address: **1307 Broadway, West Burlington, Iowa 52655**

Plan Administrator EIN: **42-1000580**
Plan Funding: **Employee Funded**
Claims Administrator: Employee Benefit Systems (EBS)
Address: 214 N. Main Street
Burlington, IA 52601

10.10 Plan Sponsor HIPAA Employee Classifications for PHI Disclosures:

Hope Haven Area Development Center Corporation

- Plan Sponsor may disclose PHI to its accountants, the third party administrator of the Plan, Insurance brokers or other entities providing quotes for future services to the Plan, other health plans that provide health benefits to a Participant for purposes of subrogation and coordination of benefits and all business associates of the Plan.

- The Plan Sponsor may provide PHI to the above names, individuals and entities to permit treatment, payment or health care operations under the Plan.

10.12 HIPAA Privacy Officer: Roberta Barngrover
Title: Human Resource Specialist
Address: 1307 Broadway
West Burlington, Iowa 52655

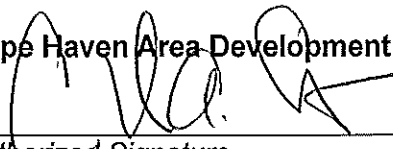
Acknowledgement

The Plan shall be construed according to the laws of the State of Iowa.

It is understood that: (1) full responsibility is assumed by the undersigned organization establishing the plan, which organization acknowledges having counseled with its legal and tax advisors with respect to the adoption of the Plan and the selection of options.

IN WITNESS WHEREOF, the undersigned affixed their signature this 21 day of January, 2011.

Hope Haven Area Development Center Corporation



Authorized Signature

Director of Fiscal Director

Title