

<p>Village President P. Sean Michels</p> <p>Village Clerk Cynthia Galbreath</p> <p>Village Administrator Brent M. Eichelberger</p>	 <p>10 S. Municipal Drive Sugar Grove, Illinois 60554 Phone: 630-466-4507 Fax: 630-466-4521</p>	<p>Village Trustees</p> <p>Robert Bohler Kevin Geary Mari Johnson Rick Montalto David Paluch Thomas Renk</p>
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Agenda
December 18, 2012
Regular Board Meeting
6:00 P.M.

1. Call to Order
2. Pledge of Allegiance
3. Roll Call
4. Public Hearing:
 - a. None
5. Appointments and Presentations
 - b. Oaths of Office – Part Time Police Officers
6. Public Comment on Items Scheduled for Action
7. Consent Agenda
 - a. Approval: Vouchers
 - b. Approval: Treasurer’s Report
 - c. Resolution: Accepting Easements for Water Main Looping
 - d. Resolution: Approval of Affordable Care Act Compliance HRA Plan Document
 - e. Resolution: Approval of Affordable Care Act Compliance FSA Plan Document
8. General Business
 - a. Resolution: Authorizing an Agreement for Mallard Point Rolling Oaks Area Pond/Wetland Maintenance
 - b. Ordinance: Amending Village Code to Provide Solar Panel Regulations *STAR
 - c. Resolution: Well 8 Pump Maintenance and Media Replacement
 - d. Resolution: Supporting Participation in Kane County Grant Programs
9. New Business
10. Reports
 - a. Staff Reports
 - b. Trustee Reports
 - c. Presidents Report
11. Public Comments
12. Airport Report
13. Closed Session: Land Acquisition, Personnel, Litigation
14. Adjournment

The consent agenda is made up of items that have been previously discussed, non-controversial, or routine in subject manner and are voted on as a ‘package’. However, by simple request any member of the Board may remove an item from the consent agenda to have it voted upon separately.

*Items that are marked as * STAR – indicate that the item is Subject to Attorney Review*

<p>Village President P. Sean Michels</p> <p>Village Clerk Cynthia Galbreath</p> <p>Village Administrator Brent M. Eichelberger</p>	 <p>10 S. Municipal Drive Sugar Grove, Illinois 60554 Phone: 630-466-4507 Fax: 630-466-4521</p>	<p>Village Trustees</p> <p>Robert Bohler Kevin Geary Mari Johnson Rick Montalto David Paluch Thomas Renk</p>
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Agenda
December 18, 2012
Committee of the Whole Meeting
6:30 P.M.

1. Call to Order
2. Roll Call
3. Public Comments
4. Discussion: Video Gaming Advisory Referendum
5. Closed Session: Land Acquisition, Personnel, Litigation
6. Adjournment

Members of the public wishing to address the Board shall adhere to the following rules and procedures:

1. Complete the public comment sign-in sheet prior to the start of the meeting.
2. The Village President will call members of the public to the podium at the appropriate time.
3. Upon reaching the podium, the speaker should clearly state his or her name and address.
4. Individual comment is limited to three (3) minutes. The Village President will notify the speaker when time has expired.
5. Persons addressing the Board shall refrain from commenting about the private activities, lifestyles, or beliefs of others, including Village employees and elected officials, which are unrelated to the business of the Village Board. Also, speakers should refrain from comments or conduct that is uncivil, rude, vulgar, profane, or otherwise disruptive. Any person engaging in such conduct shall be requested to leave the meeting.
6. The aforementioned rules pertaining to public comment may be waived by the Village President, or by a majority of a quorum of the Village Board.
7. Except during the time allotted for public discussion and comment, no person, other than a member of the Board, shall address that body, except with the consent of two (2) of the members present.

**VILLAGE OF SUGAR GROVE
BOARD REPORT**

TO: VILLAGE PRESIDENT & BOARD OF TRUSTEES
FROM: JUSTIN VANVOOREN, FINANCE DIRECTOR
SUBJECT: RESOLUTIONS: ADOPTION OF THE HRA & FSA PLAN DOCUMENTS
FOR AFFORDABLE CARE ACT COMPLIANCE
AGENDA: DECEMBER 18, 2012 REGULAR BOARD MEETING
DATE: DECEMBER 13, 2012

ISSUE

Shall the Village Board approve HRA and FSA Plan Documents.

DISCUSSION

Certain revisions are required of our Health Reimbursement Arrangement (HRA) and Flexible Benefit Plan (contains our Flexible Spending Account) plan documents to make them in accordance with the provisions of the Affordable Care Act. These changes are mandatory and required by the IRS, who is the enforcement arm of the above pre-tax plans. Although there are no major changes, the Village will be required to provide additional notices to its employees.

COST

There are no costs associated with approval of the HRA and FSA Plan Documents.

RECOMMENDATION

That the Village Board approve a:

- 1) Resolution: Adopting the Health Reimbursement Arrangement Plan Documents;
and
- 2) Resolution: Adopting the Flexible Benefit Plan Documents.

**VILLAGE OF SUGAR GROVE
BOARD REPORT**

TO: VILLAGE PRESIDENT & BOARD OF TRUSTEES
FROM: RICHARD YOUNG, COMMUNITY DEVELOPMENT DIRECTOR
SUBJECT: APPROVAL: GRANT APPLICATION AUTHORIZATION
AGENDA: DECEMBER 18, 2012 REGULAR BOARD MEETING
DATE: DECEMBER 14, 2012

ISSUE

Should the Village apply for 2013 Kane County Small Cities and Kane County River Boat Grant funds.

DISCUSSION

Staff has reviewed a number of different grant opportunities which are available throughout Kane County for 2013 and would like the Board's authorization to pursue these opportunities. The first step is to review the basic eligibility requirements with the appropriate grant for each project.

At this time, CD Staff would recommend that a grant application be made for the design of traffic signalization at the intersection of Park Ave. and IL Rt. 47. This application has been made in the past, but has not been funded. Staff would also recommend a second application be submitted for the development of a unified development code. We have noted this in the past as a long range goal of the department and have determined that consultant support is needed for this project. A unified development code would pull the subdivision regulations and the zoning ordinance into one code and simplify the development review and approval process. We believe the grant funds could be used to complete this work and assist with the additional costs of the consultant

COST

There are no costs associated with the consideration of these grant applications. If granted, costs associated with matching funds would need to be allocated as a part of the FY 2013-2014 Budget process.

RECOMMENDATION

That the Board review the idea of these grant applications and authorize the execution of documents necessary to complete these projects.

PROPOSAL NO. 12-1119D-1
Revised 12.11.12

December 11, 2012

Village of Sugar Grove
10 S. Municipal Drive
Sugar Grove, IL 60554

Re: Mallard Point 3 Year Wetland Restoration & Management Work, Sugar Grove, IL

TASK	DESCRIPTION	UNIT	NO. OF UNITS	UNIT COST	EXTENDED COST
1	Excavation of channels to connect open water pockets within existing stormwater detention basin	Lump Sum	1	\$6,315.00	\$6,315.00
2	Ground Preparation, Seeding, and Plugging of Exposed Shoreline Areas	Acre	1	\$5,500.00	\$5,500.00
3	Herbicide applications to 0.5 acre buffer planting area	Lump Sum	1	\$2,175.00	\$2,175.00
4	Cut and remove (off-site) dead vegetation from the 0.5 acre planting area	Lump Sum	1	\$2,445.00	\$2,445.00
5	Plant treated 0.5 acre buffer area with low profile prairie seed	Lump Sum	1	\$2,400.00	\$2,400.00
6	Installation of No Mowing/Dumping Signs	Each	5	\$125.00	\$625.00
7	Management of 0.5 acre buffer	Year	3	\$4,375.00	\$13,125.00
8	Herbicide and Prescribed burn of on-site natural areas (20+ acres)	Year	3	\$14,250.00	\$42,750.00
9	Cutting of woody tree and shrub species, herbicide application to stumps, and burning of debris.	Acre	25	\$2,100.00	\$52,500.00
TOTAL COST:					\$127,835.00
Alternate for Rip Rap at Inlets					
A1	Installation of Rip Rap 3 at 3 Inlets	TON	47	\$50.25	\$2,361.75
A2	Installation of Rip Rap 4 at 2 Inlets	TON	173	\$58.75	\$10,163.75
A3	Installation of Rip Rap 5 at 1 Inlet	TON	186	\$75.85	\$14,108.10
ALTERNATE COST:					\$26,633.60

In addition to the above costs, semi annual inspections and clearing of debris from storm sewer structures should be performed by a qualified firm.

Page 2
Village of Sugar Grove
Mallard Point 3 Year Wetland Restoration and Management

The above costs address the initial three years typically associated with prairie establishment. Assuming the clearing would take place incrementally over 3 years, the initial three year budget would be broken out as follows: Year 1 - \$55,585.00; Year 2 - \$36,125.00; Year 3 - \$36,125.00. Long term maintenance after the initial three year period would consist of vegetation monitoring and management and debris clearing. Long term management is estimated to cost approximately \$12,250.00 per year.

Payment Agreement

The Village of Sugar Grove, (hereinafter "Client") shall be solely liable for the timely payment of all amounts invoiced under this proposal. Invoices will be tendered by ENCAP, Inc. ("ENCAP") from time to time, but no more frequently than every two weeks, and shall be due and payable upon receipt. If Client objects to all or any portion of an invoice, Client shall nevertheless timely pay the undisputed amount of such invoice and promptly advise ENCAP in writing of the reasons for disputing any amount.

Client shall pay an additional charge of two (2) percent (or the maximum percentage allowed by law, whichever is lower) of the invoiced amount per month for any payment received by ENCAP more than thirty (30) calendar days from the date of the invoice, excepting any portion of the invoiced amount in dispute and resolved in favor of Client. Payments shall first be applied to accrued interest and then to the unpaid principal amount.

If Client fails to pay invoiced amounts within thirty (30) calendar days of the date of the invoice, ENCAP may at any time, without waiving any other claim against Client and without incurring any liability to Client, suspend or terminate performance under this Agreement as long as any hazardous conditions created by ENCAP'S previously performed services are rendered non-hazardous to Clients employee's, agents and subcontractors, the general public, and the environment. Termination shall not relieve Client of its obligation to pay amounts incurred up to termination. ENCAP shall be entitled to recover any and all costs of collection associated with recovery of amounts due under this Payment Agreement, including but not limited to reasonable attorney's fees.

Client will indemnify and hold harmless ENCAP and its representatives, agents, employees, and successors and assigns from and against any and all claims, suits, actions, losses, penalties, fines, and damages of any nature whatsoever, and shall pay any reasonable attorney's fees, expert witnesses fees, and ENCAP fees, and court costs arising or resulting from (1) Client's breach of this Agreement; or (2) Client's negligence or intentional misconduct.

** All Legal Proceedings to be conducted in DeKalb County **

Client shall accept full responsibility for payment notwithstanding any other agreement with owner or other party, and in no event will any provision in a contract, agreement, or understanding which conditions Client's payment to ENCAP upon receipt of the payment from any other party relieve Client from responsibility for payment to ENCAP.

By: ENCAP, Inc.

By: Village of Sugar Grove

Jonathan Koepke

Date

Authorized Rep.

Date

**VILLAGE OF SUGAR GROVE
BOARD REPORT**

TO: VILLAGE PRESIDENT & BOARD OF TRUSTEES
FROM: ANTHONY SPECIALE, DIRECTOR OF PUBLIC WORKS
GEOFF PAYTON, STREETS & PROPERTIES SUPERVISOR
SUBJECT: RESOLUTION: MALLARD POINT WETLAND RESTORATION
AGENDA: DECEMBER 18, 2012 REGULAR BOARD MEETING
DATE: DECEMBER 12, 2012

ISSUE

Should the Village Board approve a resolution for the Mallard Point wetland restoration.

DISCUSSION

As discussed at the December 4, 2012 Board meeting, The Mallard Point Drainage Project includes restoration of the wetlands and pond area. EnCap, Inc. has provided a proposal for the project, which includes the restoration, riprap installation and a maintenance agreement.

The estimated cost for the 3-year restoration is \$127,835.00 for the work described in the proposal. An additional \$26,633.60 for installation of riprap at the existing inlets has been included in the revised proposal. It has been confirmed that riprap is not present in the field and it is recommended to be installed to prevent erosion. It is anticipated to take 3 years to complete the full restoration; however, maintenance will begin in year 2 that would trigger the maintenance SSA.

The total cost for the project would be \$154,468.60. The restoration costs were included in the original budget for the project. In addition, an extended maintenance program is recommended for a three-year period following restoration. The estimated cost for maintenance is \$12,250.00 annually and would consist of vegetation monitoring, debris clearing and dredging of open water pockets.

COST

The estimated costs for the restoration are \$154,468.60 over a three year period and would be broken down as follows: year 1 - \$55,585.00, year 2 - \$36,125.00 and year 3 - \$36,125.00. An additional \$26,633.60 for installation of riprap at the existing inlets has been included in the revised proposal. The ongoing maintenance costs are anticipated to be \$12,250.00 per year. Account 30-53-7008: Capital Improvements has \$1,623,765.00 allocated for this project in FY 2012-13.

RECOMMENDATION

The Village Board approves Resolution **20121218PW1** with EnCap, Inc, 1709 Afton Road, Sycamore Illinois 60178 for the Mallard Point Wetland restoration project, riprap installation at the inlets and subsequent maintenance recommendations.



RESOLUTION NO. 20121218PW1

VILLAGE OF SUGAR GROVE, KANE COUNTY, ILLINOIS

RESOLUTION AUTHORIZING EXECUTION OF AN AGREEMENT WITH ENCAP, INC. FOR THE MALLARDPOINT WETLAND RESTORATION AND LONG TERM MAINTENANCE

WHEREAS, the Village of Sugar Grove Board of Trustees find that it is in the best interest of the Village to engage the services of EnCap, Inc. to provide the Mallard Point wetland restoration and long term maintenance, and to execute the attached agreement;

NOW, THEREFORE, BE IT RESOLVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, as follows:

That attached hereto and incorporated herein by reference as Exhibit A is an agreement between EnCap, Inc. and the Village of Sugar Grove to provide Mallard Point wetland restoration and long term maintenance. The President and Clerk are hereby authorized to execute said agreement on behalf of the Village and to take such further actions as are necessary to fulfill the terms of said agreement.

Passed by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, at a regular meeting thereof held on the 18th day of December, 2012.

 P. Sean Michels, President of the Board
 of Trustees of the Village of Sugar Grove,
 Kane County, Illinois

ATTEST: _____
 Cynthia Galbreath, Village Clerk,
 Village of Sugar Grove

	Aye	Nay	Absent	Abstain
Trustee Robert E. Bohler	_____	_____	_____	_____
Trustee Kevin M. Geary	_____	_____	_____	_____
Trustee Mari Johnson	_____	_____	_____	_____
Trustee Rick Montalto	_____	_____	_____	_____
Trustee David Paluch	_____	_____	_____	_____
Trustee Thomas Renk	_____	_____	_____	_____



RESOLUTION NO. 20121218F1

**A RESOLUTION ADOPTING THE FLEXIBLE BENEFIT PLAN DOCUMENTS FOR
THE VILLAGE OF SUGAR GROVE**

BE IT RESOLVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, as follows;

WHEREAS, the Village of Sugar Grove is not a home rule municipality within Article VII, Section 6A of the Illinois Constitution and, pursuant to the powers granted to it under 65 ILCS 5/1-1 et seq.; and,

WHEREAS, the Village of Sugar Grove offers certain benefits to its full-time employees; and,

WHEREAS, the Village of Sugar Grove is required to make certain changes to the Flexible Benefits Plan to be in accordance with the Affordable Care Act;

NOW THEREFORE BE IT RESOLVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, as follows:

SECTION ONE: PLAN APPROVAL

1. The recitals set forth above are adopted and incorporated herein as the material and significant findings of the President and the Board of Trustees as if fully stated herein.
2. The Flexible Benefits Plan and Summary Plan Description are attached hereto as Exhibits A and B, respectively, and by this reference incorporated herein and made a part hereof.
3. The form of Flexible Benefits Plan including any applicable Dependent Care Assistance Program, Healthcare Flexible Spending Account Plan, and Individual Insurance Account, effective 1/1/2013, presented to this meeting is hereby approved and adopted and that the Village Treasurer and/or Village

Administrator are hereby authorized and directed to execute and deliver to the Administrator of the Plan the necessary documents to make the plan effective.

4. That the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

SECTION TWO: GENERAL PROVISIONS

SEVERABILITY: Should any provision of this resolution be declared invalid by a court of competent jurisdiction, the remaining provisions will remain in full force and effect the same as if the invalid provision had not been a part of this resolution.

REPEALER: That all resolutions, or parts thereof, in conflict with the provisions of this Resolution are hereby repealed.

EFFECTIVE DATE: This resolution shall be in full force and effect on and after its approval and passage.

PASSED AND APPROVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois on this 18th day of December, 2012.

P. Sean Michels, President of the Board
of Trustees of the Village of Sugar Grove,
Kane County, Illinois

ATTEST: _____
Cynthia Galbreath, Village Clerk,
Village of Sugar Grove

	Aye	Nay	Absent	Abstain
Trustee Robert Bohler	_____	_____	_____	_____
Trustee Kevin Geary	_____	_____	_____	_____
Trustee Rick Montalto	_____	_____	_____	_____
Trustee Mari Johnson	_____	_____	_____	_____
Trustee Thomas Renk	_____	_____	_____	_____
Trustee David Paluch	_____	_____	_____	_____



RESOLUTION NO. 20121218F2

**A RESOLUTION ADOPTING THE HEALTH REIMBURSEMENT ARRANGEMENT
PLAN DOCUMENTS FOR THE VILLAGE OF SUGAR GROVE**

BE IT RESOLVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, as follows;

WHEREAS, the Village of Sugar Grove is not a home rule municipality within Article VII, Section 6A of the Illinois Constitution and, pursuant to the powers granted to it under 65 ILCS 5/1-1 et seq.; and,

WHEREAS, the Village of Sugar Grove offers certain benefits to its full-time employees; and,

WHEREAS, the Village of Sugar Grove is required to make certain changes to the Health Reimbursement Arrangement to be in accordance with the Affordable Care Act;

NOW THEREFORE BE IT RESOLVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, as follows:

SECTION ONE: PLAN APPROVAL

1. The recitals set forth above are adopted and incorporated herein as the material and significant findings of the President and the Board of Trustees as if fully stated herein.
2. The Health Reimbursement Arrangement Plan and Summary Plan Description are attached hereto as Exhibits A and B, respectively, and by this reference incorporated herein and made a part hereof.
3. The form of Health Reimbursement Arrangement Plan effective 1/1/2013, presented to this meeting is hereby approved and adopted and that the Village Treasurer and/or Village Administrator are hereby authorized and directed to

execute and deliver to the Administrator of the Plan the necessary documents to make the plan effective.

4. That the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

SECTION TWO: GENERAL PROVISIONS

SEVERABILITY: Should any provision of this resolution be declared invalid by a court of competent jurisdiction, the remaining provisions will remain in full force and effect the same as if the invalid provision had not been a part of this resolution.

REPEALER: That all resolutions, or parts thereof, in conflict with the provisions of this Resolution are hereby repealed.

EFFECTIVE DATE: This resolution shall be in full force and effect on and after its approval and passage.

PASSED AND APPROVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois on this 18th day of December, 2012.

P. Sean Michels, President of the Board
of Trustees of the Village of Sugar Grove,
Kane County, Illinois

ATTEST: _____
Cynthia Galbreath, Village Clerk,
Village of Sugar Grove

	Aye	Nay	Absent	Abstain
Trustee Robert Bohler	_____	_____	_____	_____
Trustee Kevin Geary	_____	_____	_____	_____
Trustee Rick Montalto	_____	_____	_____	_____
Trustee Mari Johnson	_____	_____	_____	_____
Trustee Thomas Renk	_____	_____	_____	_____
Trustee David Paluch	_____	_____	_____	_____

**STAFF REPORT TO THE SUGAR GROVE PLANNING COMMISSION
FROM MIKE FERENCAK, PLANNER**

GENERAL CASEFILE INFORMATION

Commission Meeting Date: **December 12, 2012**

Petition Number: 12-013

Project Name: Solar Energy Systems

Petitioner: Village of Sugar Grove

Request: 1. Zoning Ordinance Text Amendment to create Section 11-4-21 Solar Energy Systems and, as necessary, modify section 11-4-7 (Accessory Uses, Structures, and Buildings) of the Sugar Grove Zoning Ordinance.

Location: Village-wide

Exhibits: **Revised Draft Solar Energy Systems Ordinance (dated December 12, 2012)**

DEVELOPMENT PROPOSAL

The Planning Commission will consider the following request:

1. Zoning Ordinance Text Amendment to create Section 11-4-21 Solar Energy Systems and, as necessary, modify section 11-4-7 (Accessory Uses, Structures, and Buildings) of the Sugar Grove Zoning Ordinance.

HISTORY

The Wind Energy Systems Ordinance was adopted on June 1, 2010. At that time, staff contemplated also creating a similar ordinance for solar technology. In the last year, staff has had inquiries from at least two residents about installing a solar energy system at their residence. In the last month staff has been working on preparing a draft Solar Energy Systems Ordinance. **A draft was developed and presented to the Plan Commission at the November 14, 2012 meeting. Since that time additional staff review has taken place. The draft text amendment has not been presented to the Committee of the Whole, but an overview of the layout of the draft with a focus on aesthetic issues was discussed at the December 4, 2012 meeting.**

The content of the proposed Ordinance has been mostly developed from the existing Wind Energy Systems Ordinance (for format consistency) and review of other Illinois community's solar energy system ordinances.

ZONING ORDINANCE

This amendment would create Section 11-4-21 Solar Energy Systems of the Sugar Grove Zoning Ordinance. This would be a section in the General Provisions Chapter of the Zoning Ordinance and applicable in all zoning districts. Small solar energy systems are a type of accessory structure, so there are some modifications proposed to the Accessory Uses, Structures, and Buildings section (11-4-7) of the General Provisions Chapter as well.

EVALUATION

The following is a summary of comments and questions that have been generated during and since the last Plan Commission meeting:

November 14, 2012 Plan Commission meeting:

- **Is the kilowatt figure representative of a day or year? How many kilowatts does a home use? *The figure is representative of a day. Typical home installations of solar energy systems range from 3 to 7 kilowatts. For example, someone with a monthly 700 kilowatt hour usage and 4.5 average sun hours per day would need a 6.3 kilowatt system to cover 100% of his/her daily usage. More detail is provided below.***

Estimating Solar Electric (PV) System Size: Area of Solar Panels

On average (as a general "rule of thumb") modern photovoltaics (PV) solar panels will produce 8 - 10 watts per square foot of solar panel area. For example, a roof area of 20 feet by 10 feet is 200 square-feet (20 ft x 10 ft). This would produce, roughly, 9 watts per sq-foot, or $200 \text{ sq-ft} \times 9 \text{ watts/sq-ft} = 1,800 \text{ watts (1.8 kW)}$ of electric power.

Converting Power (watts or kW) to Energy (kWh)

One kilowatt-hour (1 kWh) means an energy source supplies 1,000 watts (1 kW) of energy for one hour. Generally, a solar energy system will provide output for about 5 hours per day. So, if you have a 1.8 kW system size and it produces for 5 hours a day, 365 days a year: This solar energy system will produce $3,285 \text{ kWh}$ in a year ($1.8 \text{ kW} \times 5 \text{ hours} \times 365 \text{ days}$).

If the PV panels are shaded for part of the day, the output would be reduced in accordance to the shading percentage. For example, if the PV panels receive 4 hours of direct sun shine a day (versus the standard 5 hours), the panels are shaded $1 \text{ divided by } 5 = 20\%$ of the time (80% of assumed direct sun shine hours received). In this case, the output of a 200 square-foot PV panel system would be $3,285 \text{ kWh per year} \times 80\% = 2,628 \text{ kWh per year}$.

- **Provide examples of decibel levels. *See below.***

Painful Acoustic Trauma	140	Shotgun blast
	130	Jet engine 100 feet away
	120	Rock concert
Extremely Loud	110	Car horn, snowblower
	100	Blow dryer, subway, helicopter, chainsaw
	90	Motorcycle, lawn mower, convertible ride on highway
Very Loud	80	Factory, noisy restaurant, vacuum, screaming child
Loud	70	Car, alarm clock, city traffic
	60	Conversation, dishwasher
Moderate	50	Moderate rainfall
Faint	40	Refrigerator
	30	Whisper, library
	20	Watch ticking
	dB levels	

- On letter C, number 10 change the word “preferred” to something more definitive. *Change made.*

November 29, 2012 staff meeting:

- For flush mounted systems, add to the definition “parallel to the roof”. *Change made.*
- Change all usages of the word “preferred” to something more definitive throughout the amendment. *Changes made.*
- Small solar energy systems are to be either ground mounted or building mounted, but the building mounted ones are by definition only allowed on roofs. *Changes made to definitions and throughout amendment.*
- Added “Solar Rating and Certification Corporation to letter C, number 1. *Complete.*
- Improved text in letter C, number 4. *Complete.*
- Improved title of letter C, number 5. *Complete.*
- Still need to insert distances for Arterial and Collector overlay in letter C, number 11. *Need direction from Plan Commission.*
- Changed letter D, number 1 to 10 kW (from 100 kW). *Complete.*
- Improved title of letter E, number 2. *Complete.*
- All references to “collectors” or “solar collectors” changed to “solar collector panels” throughout document. *Complete.*
- All references to “roof section” changed to “roof plane” throughout document. *Complete.*
- Changed setbacks in letter E, number 3 to be applicable to all edges of roof plane. *Complete.*
- Improved text in letter E, number 4. *Complete.*

December 4, 2012 Committee of the Whole meeting:

- Allow flush roof mounted systems on roof planes adjacent to front and corner side yards, but only one plane and only on the highest plane. *Change made to letter E, number 6.*
- Lower the percentage of the roof plane that may be covered. *Lowered from 80% to 60%.*
- How would this ordinance apply for condos? *The only solar energy systems that would be permitted through this ordinance are small systems. Since the small systems are limited to 10 kW, they really only produce enough energy for one household or business. If a condo owner wanted to install one they would need to get the permission of their condo association. If a condo association wanted to install them for all residents, they would not be able to install a system large enough to be viable under this ordinance.*
- What have other nearby municipalities done for these types of ordinances? *The City of Aurora's requirements may be viewed on page 64 of this document: http://www.aurora-il.org/documents/planning/ordinance/appendix_a_zoning.pdf The Village of Montgomery's requirements may be viewed on page 51 of this document: <https://ci.montgomery.il.us/DocumentCenter/Home/View/122>*

PUBLIC RESPONSE

A public notice was published in a local newspaper. Staff has not had any inquiries from the public about the proposal at this time, **other than the homeowner who plans to install a system by the end of the year.**

STAFF RECOMMENDATION

Review and discuss the draft Solar Energy Systems Ordinance. If appropriate, close the public hearing. **Recommend approval of the Solar Energy Systems Ordinance.**



**VILLAGE OF SUGAR GROVE
KANE COUNTY, ILLINOIS**

ORDINANCE NO. 2012-1218

**An Ordinance Amending Title 11, of the Village Code
Concerning the Zoning Laws of the
Village of Sugar Grove, Kane County, Illinois
(Solar Energy Systems)**

Adopted by the
Board of Trustees and President
of the Village of Sugar Grove
this 18th day of December, 2012.

Published in Pamphlet Form
by authority of the Board of Trustees
of the Village of Sugar Grove, Kane County,
Illinois, this 18th day of December, 2012.

ORDINANCE NO. 2012-1218
An Ordinance Amending Title 11, of the Village Code
Concerning the Zoning Laws of the
Village of Sugar Grove, Kane County, Illinois
(Solar Energy Systems)

BE IT ORDAINED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, as follows;

WHEREAS, the Village of Sugar Grove is not a home rule municipality within Article VII, Section 6A of the Illinois Constitution and, pursuant to the powers granted to it under 65 ILCS 5/1-1 *et seq.*; and,

WHEREAS, the Village of Sugar Grove currently maintains zoning restrictions on the use of land within the Village; and,

WHEREAS, the Village finds that such restrictions provide for the safety and well-being of Village inhabitants and benefit the public welfare, safety and morals; and,

WHEREAS, the Village seeks to establish standards and quantifiable procedures to direct the aesthetics, engineering, site design, installation, maintenance, relocation and abandonment of Solar Energy Systems; and,

WHEREAS, the Village seeks to amend the Village Code to more fully protect and preserve the safety, quality of life and economic stability of adjoining property and overall community;

NOW, THEREFORE, BE IT ORDAINED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, as follows:

SECTION ONE: Ordinance Sections Created/Amended

That the following Sub-section(s) of Title 11 of the Village Code of Ordinances are hereby created and/or amended as follows:

Section 11-4-21 is hereby created to read as follows:

A. Definitions:

1. Solar Energy System: Equipment, whether permanent or temporary, that converts and stores or transfers energy collected from the sun into usable forms of energy such as thermal, electrical, and mechanical, and includes any solar collector panel, support structure, pole, base or foundation, control, wire,

battery, energy storage device, inverter, transformer, generator, heat pump, heat exchanger, or other component used in the system.

2. **Large Solar Energy System:** A solar energy conversion system consisting of multiple solar collector panels, support structures, and associated controls or conversion electronics that are mounted on the ground as a principal use and with a nameplate capacity of 100 kilowatts or more.
3. **Small Solar Energy System:** A solar energy conversion system consisting of one or more solar collector panels, support structure/s and associated controls or conversion electronics that are mounted on a principal building, garage, shed, or on the ground as an accessory structure/s and with a nameplate capacity of less than 100 kilowatts.
4. **Small Solar Energy System, Building-Mounted:** A type of small solar energy system that is mounted on the roof of a principal building, garage, or shed. A building-mounted solar energy system includes:
 - a. **Integrated:** A building-mounted solar energy system that is an integral part of a building, rather than a separate mechanical device, replacing or substituting for an architectural or structural part of the building. Integrated systems include, but are not limited to photovoltaic or thermal systems that are contained within roofing materials, skylights, shading devices and similar architectural components.
 - b. **Flush Roof Mounted:** A building-mounted solar energy system that is mounted to a finished roof surface where the solar collector panels, once installed, project no further than six (6) inches in height beyond the roof surface and is parallel to the roof surface.
 - c. **Non Flush Roof Mounted:** A building-mounted solar energy system that is mounted to a finished roof surface where the solar collector panels, once installed, projects more than six (6) inches in height beyond the roof surface.
5. **Small Solar Energy System, Ground-mounted:** A type of small solar energy system that is mounted to the ground.
6. **Self-contained Solar Energy System:** A professionally manufactured system that utilizes solar collectors to produce small amounts of power that are generated exclusively for a single device. A self-contained solar energy system is typically located in areas that are not in close proximity to a utility power source.
7. **Total Height:** The vertical distance from grade to the highest point of the solar energy system.

B. Large Solar Energy System Provisions

Large solar energy systems shall be prohibited within all zoning districts of the Village and within the one and one-half (1 ½) mile radius surrounding the Village limits.

C. Small Solar Energy Systems General Provisions

Small solar energy systems shall be a permitted use in all zoning districts subject to the following provisions:

1. **Building Permit.** All small solar energy systems require an approved building permit:
 - a. In order to receive permit, small solar energy systems must be approved by a small solar certification program recognized by the Solar Rating Certification Corporation or other recognized industry association and be installed by an experienced installer.
 - b. Prior to permit issuance, the owner shall sign an acknowledgement that said owner will be responsible for any and all enforcement costs and remediation costs resulting from any violations of this Ordinance. These costs could include, but are not limited to, removal of system, property restoration necessary upon removal of the system, village legal expenses and hearing costs associated with violations of this Ordinance.
2. **Building Code / Safety Standards.** Any owner or operator of a small solar energy system shall maintain said system in compliance with the standards contained in the current and applicable state or local building codes and any applicable standards for solar energy systems that are published by the International Building Code and National Electrical Code as amended from time to time.
3. **Compliance.** If, upon inspection, the Community Development Director or his / her designee, concludes that a solar energy system fails to comply with such codes and standards or constitutes a danger to persons or property, the Community Development Director or his / her designee, shall require immediate repair or removal of the system at the owner's expense.
4. **Color.** All support structure for small solar energy systems shall be a monochromatic, neutral, and non-reflective color and shall match the color of the material it is being mounted to or the color of structures located on the lot. Multiple solar collector panels shall match each other.
5. **Style.** When more than one solar collector panel is located on a lot, the multiple solar collector panels shall be uniform in style.
6. **Electric.** All electrical wires associated with a small solar energy system, other than wires necessary to connect the solar collector panels to the pole wiring, the pole wiring to the disconnect junction box, and the grounding wires, must be hidden or enclosed.

7. Signs. No sign, other than a warning sign or installer, owner, or manufacturer identification sign as permitted by Section 11-14, may be placed on any component of a small solar energy system.
8. Lighting. A small solar energy system shall not be artificially illuminated.
9. Positioning. Concentrated sunlight or glare from solar collector panel surfaces shall be oriented away from neighboring windows.
10. Quantity. One small solar energy system is permitted per lot, but the system may include one or more solar collector panels. A ground-mounted system and a building-mounted system shall not both be installed on a single lot.
11. Utility Notification and Interconnection. The utility company shall be informed of the customer's intent to install an interconnected customer-owned generator. No small solar energy system shall be installed until proof of acceptance from the utility company has been provided to the Village. Off-grid systems (independent systems or systems not connected to the utility electrical system) shall be exempt from this requirement.
12. Batteries. All batteries and energy storage systems shall be installed within buildings and not outside.

D. Small Solar Energy Systems Ground-Mounted Standards

1. Permitted Use. Ground-mounted small solar energy systems shall only be permitted as an accessory structure to an existing principal building / principal use, must be mounted on the ground and must have a nameplate capacity of less than one hundred kilowatts (100kw).
2. Setbacks. A ground-mounted small solar energy system with monopole support structure must be setback:
 - a. at least 1.1 times its total height from any property line of the lot on which it is located;
 - b. at least 1.1 times its total height from any public road right-of-way.
 - c. at least 1.1 times its total height and no less than 10 feet from any overhead utility lines.

A ground-mounted small solar energy system with non-monopole support structure shall be setback at least five (5) feet from the property line.

No ground-mounted small solar energy system shall be located in an easement.

3. Allowed Yards. No ground-mounted small solar energy components shall be located in the front or corner side yard of any zoning lot.

4. Total Height. Ground-mounted small solar energy systems shall be limited to a maximum of fifteen feet (15') in total height.
5. Soil Conditions. A soil analysis may be required as part of the building permit application and inspection process to confirm that the soils meet the minimum bearing capacity assumed by the structural design of the pole/s, support structure, and foundation.

E. Small Solar Energy Systems Building-Mounted Standards

1. Permitted Use. Building-mounted small solar energy systems shall only be permitted as accessory structures, must be mounted to the roof of a principal building, a garage, or a shed and must have a nameplate capacity of less than one hundred kilowatts (100kw).
2. Roof Type. Integrated and flush roof mounted systems are allowed on sloped or flat roofs. Non flush roof mounted systems are allowed only on flat roofs if the solar collector panels are completely screened from view to an observer's eye six (6) feet above the ground at any point along an abutting property line.
3. Setbacks. Building-mounted small solar energy systems must meet all building setback requirements, or accessory building setback requirements in the case of garages and sheds, and are not allowed to encroach into required yards. Additionally, they must be setback a minimum of one (1) foot from all edges of the individual roof plane on which they are mounted.
4. Height. Non flush roof mounted systems shall not extend above the highest point of the roof plane on which they are mounted.
5. Area. The solar collector panel surface area shall not exceed sixty percent (60%) of the roof plane upon which the solar collector panels are mounted. If more than one roof area is to contain solar collector panels, the Fire District shall review and comment on the installation of the solar collector panels to verify that adequate roof access is provided to emergency personnel in the event of an emergency.
6. Mounting Location. Non flush roof mounted systems are prohibited on roof planes adjacent to front and corner side yards. Integrated and flush roof mounted systems are permitted on any roof plane, however if installed on roof planes adjacent to front and/or corner side yards they may only be installed on one plane with that plane being the highest plane.
7. Weight and Wind Resistance. Building-mounted small energy systems shall meet all weight and wind resistance requirements of applicable building codes.

F. Self-contained Solar Energy System Standards

1. Permitted / Allowed Use. Self-contained solar energy systems are a permitted use. Any low voltage self-contained solar energy systems shall be an allowed use.
2. Setbacks. A self-contained solar energy system shall be setback at least five (5) feet from the property line.
3. Allowed Yards. No self-contained solar energy system components shall be located in the front or corner side yard of any zoning lot, except for parking lot light poles.
4. Area. Self-contained solar energy systems shall be limited to a maximum aggregate solar collector panel surface area of six (6) square feet.

G. Abandonment, Violations and Enforcement

1. Abandonment. All abandoned or unused solar energy systems shall be deemed a nuisance after two (2) months of the cessation of operations unless an extension is approved by the Village Board. The Village may act to abate such nuisance and require removal at the property owner's expense. After the solar energy system is removed, the owner of the property shall restore the site to its original condition, or to an approved improved condition with thirty (30) days of removal.
2. Violation. It is unlawful for any person to construct, install or operate a small solar energy system that is not in compliance with this Ordinance. It is unlawful for a person to disobey; fail, neglect, or refuse to comply with; or otherwise resist an order issued pursuant to this Ordinance. A separate offense is deemed committed on each day that a violation occurs or continues.
3. Enforcement. The Community Development Director, or his / her designee, may enter any property for which a building permit has been issued under this Ordinance to conduct an inspection to determine whether there is any violation of this Ordinance or whether the conditions stated in the permit have been met. The Community Development Director, or his / her designee, may issue a citation for any violation of this Ordinance. Nothing in this section may be construed to prevent the Village of Sugar Grove from using any other lawful means to enforce this Ordinance.

Section 11-4-7-E, 11-4-7-F, and 11-4-7-G are hereby modified to read as follows:

- E. Yards: No accessory use, accessory structure, or accessory building shall encroach upon a required: front yard of any lot, corner side yard of a lot abutting a street; or the rear yard of a through lot (double frontage lot), with the following exceptions:

All yards: awnings and canopies, steps (4 feet or less above grade which are necessary for access to a permitted building or for access to a zoning lot from a street or alley), chimneys (which project 3 feet or less into the required minimum yard), bay windows (one-story,

which project 3 feet or less into the minimum required yard), arbors and trellises, overhanging eaves and gutters (which project 3 feet or less into the minimum required yard), nonresidential off street parking lots and drive aisles and driveways, residential off street parking areas and driveways, parking lot light poles, commercial outdoor dining, commercial outdoor display, commercial outdoor sales, patios and sidewalks, cart corrals, mailboxes, dispensing cabinets, phone booths, gardens, and ponds.

Front and corner side yards: open patios and decks (not over 3 feet above the average level of the adjoining ground, provided they do not extend more than 5 feet into the minimum required yard).

Rear yards of through lots: balconies, open patios or decks (provided they are not over 3 feet above the average level of the adjoining ground and located at least 5 feet from any property line), recreational equipment, clotheslines for laundry, mechanical equipment (including ground supported air conditioning units which extend not more than 4 feet into the minimum required yard).

Allowable yards for fences and walls, signs, flags, and flagpoles, small solar energy systems, and small wind energy systems shall be regulated by their respective chapters of this zoning ordinance.

In cases where the principal building is set back farther from the front/corner side property line than the required setback, the actual setback shall serve as boundary between the front/corner side yard for accessory use, accessory structure, and accessory building purposes.

In the residential districts, accessory uses and accessory buildings may only be located in the rear yard, except for garages and sheds which may be located in both side and rear yards.

Residential mechanical equipment (including ground supported air conditioning units) shall not extend more than four feet (4') into any required yard.

F. Height: No accessory use, accessory structure, or accessory building shall exceed the height of one story or fifteen feet (15'), with the following exceptions:

1. Private stables shall not exceed the height of twenty five feet (25').
2. Uses and buildings accessory to farm operations shall not exceed the height of twenty five feet (25').
3. Sign and flagpole height shall be regulated by chapter 14 of this title.
4. Fence, wall, and trash enclosure height shall be regulated by section 11-4-13 of this chapter. Trash enclosures must be a minimum of six feet (6') in height.
5. Small wind energy system height shall be regulated by section 11-4-20 of this chapter.

6. Small solar energy system height shall be regulated by section 11-4-21 of this chapter.
7. Parking lot light pole height shall be regulated by subsection 11-12-3H3 of this title.
8. Chimneys, ornamental towers, scenery lofts, monuments, domes, spires, steeples, water towers, mechanical equipment, and residential communications antennas may be erected to their customary height, regardless of the height limitations of the zoning district in which they are located.
9. Commercial communications antennas height shall be regulated by the special accessory structure review.

G. Setbacks: Accessory buildings and the following accessory structures: commercial mechanical equipment, carports, tree houses, pergolas, arbors, trellises, gazebos, and decks shall be located at least five feet (5') from any property line and if not structurally attached to the principal building shall be located at least ten feet (10') from the principal building and any other such accessory building or structure.

Accessory buildings in the E-1 district shall be located at least ten feet (10') from a side or rear property line.

Accessory uses, accessory structures, and accessory buildings shall be allowed in easements as follows:

1. The easement is a minor drainageway (only draining the immediate adjacent lots);
2. The easement contains no public utilities such as storm sewer, sanitary sewer, or water main; and
3. There shall be no construction within five feet (5') of the property line to accommodate drainage along the common lot line and allow for any future construction of minor utilities such as cable and street lighting.

Small wind energy system and small solar energy system setback requirements shall be regulated by their respective chapters of this zoning ordinance.

SECTION TWO: GENERAL PROVISIONS

REPEALER: All ordinances or portions thereof in conflict with this ordinance are hereby repealed.

SEVERABILITY: Should any provision of this Ordinance be declared invalid by a court of competent jurisdiction, the remaining provisions will remain in full force and effect the same as if the invalid provision had not been a part of this Ordinance.

EFFECTIVE DATE: This Ordinance shall be in full force and effect on and after its approval, passage and publication in pamphlet form as provided by law.

PASSED AND APPROVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, this 18th day of December, 2012.

P. Sean Michels,
President of the Board of Trustees
of the Village of Sugar Grove, Kane
County, Illinois

ATTEST: _____
Cynthia L. Galbreath,
Clerk, Village of Sugar Grove

	Aye	Nay	Absent	Abstain
Trustee Mari Johnson	___	___	___	___
Trustee Thomas Renk	___	___	___	___
Trustee Rick Montalto	___	___	___	___
Trustee Robert E. Bohler	___	___	___	___
Trustee David Paluch	___	___	___	___
Trustee Kevin M. Geary	___	___	___	___

**VILLAGE OF SUGAR GROVE
BOARD REPORT**

TO: VILLAGE PRESIDENT & BOARD OF TRUSTEES
FROM: RICH YOUNG, COMMUNITY DEVELOPMENT DIRECTOR
MIKE FERENCAK, VILLAGE PLANNER
SUBJECT: ORDINANCE: ZONING ORDINANCE TEXT AMENDMENT TO
CREATE SECTION 11-4-21 SOLAR ENERGY SYSTEMS
AGENDA: DECEMBER 4, 2012 COMMITTEE OF THE WHOLE MEETING
DATE: DECEMBER 14, 2012

ISSUE

Should the Village Board amend the zoning ordinance to add regulations for solar energy systems.

DISCUSSION

A full background is not included in this report. Previous attachments are not included in this report. Prior report(s) and attachments are available upon request.

The Committee discussed the proposed solar energy systems ordinance at the December 4, 2012 meeting. The discussion focused primarily on the aesthetic controls. The proposed text amendment has been on an expedited schedule to help accommodate a resident that is trying to take advantage of a federal tax credit which expires on December 31, 2012. With this in mind, the request is to approve the text amendment at tonight's meeting.

The comments from the December 4, 2012 Committee meeting were incorporated into the draft text amendment that was then reviewed by the Plan Commission at the December 12, 2012 special meeting. The Commission provided further comment which also has been incorporated into the final proposed text amendment attached to this report.

Per Committee direction the following have been incorporated into or remain as is in the text amendment:

- The text amendment continues to allow only flush (or integrated) systems on all roof planes. Non flush systems are not allowed on planes adjacent to front and corner side yards. However, for integrated and flush roof mounted systems, when they are installed on roof planes adjacent to front and corner side yards they are only allowed on one roof plane and that roof plane must be the highest plane.
- Lowered the allowed solar collector panel surface area from 80% per roof plane to 60% per roof plane.

- The text amendment continues to require that support structure for solar energy systems shall be a monochromatic, neutral, and non-reflective color and match the color of the material it is being mounted to or the color of structures located on the lot. This does not mean the solar collector panels themselves must match the roof or background material, again only the support structure.
- Please see the attached Plan Commission staff report for information regarding how the regulations would apply to condos and how other nearby cities have addressed solar energy systems.

Items from staff or the Plan Commission that have been incorporated into the text amendment:

- Edited definition of the Solar Energy System to cover both permanent and temporary systems.
- Edited definition of Integrated systems to change “hot water” to “thermal”.
- Edited definition of Self-contained Solar Energy System to note “a single” device.
- Edited Building Permit requirements for Small Solar Energy Systems to state that they must be “installed by an experienced installer”.
- Eliminated Noise requirements.
- Eliminated Arterial and Collector Right-of-Way setbacks that were in addition to normal setbacks for Small Solar Energy Systems.
- Clarified that a single lot can include a building-mounted system or a ground-mounted systems, but not both in the Quantity section.
- Corrected both the ground-mounted and building-mounted standards so that either can be allowed up to a 100 kW system, consistent with the 100 kW cutoff listed in the definitions for Small and Large systems.
- Added to ground-mounted setback requirements that a minimum of 10 feet must be maintained between any system and any overhead utility lines. Other setback requirements remain.
- Other minor changes throughout for improved reading.

The following items are attached for your information:

1. Text Amendment Ordinance
2. Staff Report for the December 12, 2012 Plan Commission meeting

COST

The public notice was published in a local newspaper and cost under \$150.

RECOMMENDATION

That the Board adopts Ordinance 2012-1218, An Ordinance Amending Title 11 of the Village Code Concerning Zoning Laws for Solar Energy Systems.

**VILLAGE OF SUGAR GROVE
BOARD REPORT**

TO: VILLAGE PRESIDENT & BOARD OF TRUSTEES
FROM: RICHARD YOUNG COMMUNITY DEVELOPMENT DIRECTOR
SUBJECT: RESOLUTION: EASEMENTS FOR WATER MAIN LOOPING
AGENDA: DECEMBER 18, 2012
DATE: DECEMBER 14, 2012

ISSUE

Should the Village Board authorize execution of Grant of Easements for the proposed Settlers Ridge Subdivision to Mallard Point Subdivision water main looping improvement.

DISCUSSION

The Village of Sugar Grove Water Works System Needs Assessment Plan identified the need for a second water main connection to the Mallard Point Subdivision. The addition of a second water main would provide better water service to the Mallard Point Subdivision and ensure adequate fire flow in case of emergency.

As a part of this proposed improvement, the Village needed to acquire both temporary construction and permanent water main easements in order to construct and maintain the public water main.

COSTS

The costs associated with the acquisition for these easements have been budgeted and are part of the village wide capital improvement fund.

RECOMMENDATION

That the Board approve Resolution 20121220A authorizing the execution of and acceptance of Grants of Easements for the Settlers Ridge to Mallard Point water main looping improvements, subject to Village Attorney review.



Resolution 20121220A

RESOLUTION AUTHORIZING ACCEPTANCE OF EASEMENT AGREEMENTS FOR THE SETTLERS RIDGE TO MALLARD POINT WATERMAIN LOOP IMPROVEMENT SUGAR GROVE TOWNSHIP, KANE COUNTY, ILLINOIS

WHEREAS, the Village is not a home rule municipality within Article VII, Section 6A of the Illinois Constitution; and

WHEREAS, the Village has been presented with easement agreements for a water main which will connect the Settlers Ridge Subdivision to the Mallard Point Subdivision within Sugar Grove Township; and

WHEREAS, it is in the Village’s best interest to obtain these easements for the proposed water main connection on public and private property; and

WHEREAS, the proposed water main loop from the Settlers Ridge Subdivision to the Mallard Point Subdivision is identified in the Village of Sugar Grove Water Works System Needs Assessment.

NOW, THEREFORE, BE IT RESOLVED by the President and Board of Trustees that the Village Board hereby accepts said Grant of Easements, hereby attached, and that the Village President and Village Clerk are hereby authorized to execute said Agreements on behalf of the Village.

PASSED AND APPROVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, at a regular meeting thereof held on the 20th day of December, 2012.

P. Sean Michels, President of the Board of Trustees
of the Village of Sugar Grove, Kane County, Illinois

ATTEST: _____
Cynthia Galbreath, Clerk, Village of Sugar Grove

	Aye	Nay	Absent	Abstain
Trustee Robert E. Bohler	_____	_____	_____	_____
Trustee Kevin M. Geary	_____	_____	_____	_____
Trustee Rick Montalto	_____	_____	_____	_____
Trustee Marie Johnson	_____	_____	_____	_____
Trustee Thomas Renk	_____	_____	_____	_____
Trustee David Paluch	_____	_____	_____	_____

**VILLAGE OF SUGAR GROVE
BOARD REPORT**

TO: VILLAGE PRESIDENT & BOARD OF TRUSTEES
FROM: JUSTIN VANVOOREN, FINANCE DIRECTOR
SUBJECT: MONTHLY TREASURER'S REPORT
AGENDA: DECEMBER 18, 2012 REGULAR BOARD MEETING
DATE: DECEMBER 10, 2012

ISSUE

Should the Village Board approve the November 2012 monthly Treasurer's report.

DISCUSSION

The Summarized Revenue & Expense Reports are attached (pages 1 – 8). At November 30, 2012 we are through 7 months of the year (58.3%).

The General Fund revenues and expenditures are at 78.6% and 53.4%, respectively. The main reason revenues are higher than budgeted is due to the timing of receipt of property taxes. In addition, state income tax is expected to be higher than budgeted by \$65,00 while the telecommunications tax is expected to be lower than budgeted by \$17,000. The main reason for the expenditures being lower than budgeted is many expenditures are attributable to the prior fiscal year, for which journal entries have already been made. The following expenditures have budget or actual amounts over \$5,000 and are higher than budget by 10% or more:

		<u>Budget</u>	<u>Actual</u>	<u>% Spent</u>	
01-51-6102	Overtime	58,927	54,383	92.3%	A
01-51-6104	Salaries- Part-time	54,983	38,173	69.5%	B
01-51-6209	Uniform Allowance	14,000	12,953	92.6%	C
01-51-6301	Legal services	54,800	46,791	85.4%	D
01-51-6309	Other professional svc	9,750	44,003	451.3%	E
01-53-6405	Repair, Maint, Svc.-ROW	30,524	25,558	83.8%	F
01-53-6603	Specialized Supplies	5,500	4,225	76.9%	G
01-53-6609	Roadway Maint sup	11,000	8,988	81.8%	H
01-53-6617	Vehicle Maint. Supplies	10,000	8,127	81.3%	I
01-54-6406	Repair, Maint Svc- bldg	14,000	15,984	114.1%	J
01-55-6301	Legal Services	52,000	35,421	68.2%	K
01-55-6309	Other professional svc	17,800	22,003	123.6%	M

01-56-6302	Audit Services	10,600	9,117	86.1%	N
01-56-6307	I.S. services	5,182	5,137	99.2%	O

- A Pol – This is due to officers out on disability, as well as training for staff. This cost is expected to level off as the Village has added 4 part-time officers to the Police Department.
- B Pol – This is due the 4 part-time officers added to the Police Department. It is expected for this item to be over budget.
- C Pol – This is due the timing of uniform allowances and the purchase of bullet proof vests. These were budgeted expenditures and this account is not expected to be over budget.
- D Pol – This is due to the timing of negotiations that took place with the Sergeants. This account is expected to be over budget.
- E Pol – This is related to contractual costs of temporary personnel.
- F Str – This is due to 2 street light replacements which were damaged by vehicles.
- G Str – This is due to the seasonal purchase of mosquito control chemicals which was a budgeted item.
- H Str – This is due to the timing of roadway maintenance throughout the year. This account is not expected to be over budget.
- I Str – This is due to hydraulic repairs of the Village’s bucket truck. This account will continue to be monitored.
- J BM – This is related to carpet replacement costs. This expenditure was anticipated to take place last fiscal year, but was delayed until after April 30. Therefore, this account is expected to be over budget since it was not budgeted for in fiscal year 2012 – 2013.
- K CD – This is due to legal costs associated with development some of which will be reimbursed. This account will continue to be monitored.
- M CD – This is due to payment for the special event traffic study. The Village is the recipient of a Kane County Grant to help offset the cost associated with the traffic study.
- N Fin – This is due to the timing of payments which coincide with the filing of the audit. There is no anticipation for this account to be over budget.
- O Fin – This is due the timing of payment for the Village’s financial software maintenance agreement.

Please note engineering invoices are paid approximately 2 months after services are provided. Thus, engineering services accounts in the General Fund, Infrastructure Capital Projects Fund, and Waterworks and Sewerage Fund will reflect a 2 month lag.

The General Capital Projects Fund revenues are at 99.3% and expenditures are at 75.6%. The revenues are high due to the receipt of funds associated with the Mallard Point and Rolling Oaks drainage project. The expenditures are low due to projects not being billed or not starting yet this fiscal year.

The Industrial TIF #1 Fund expenditures are at 100.0%. There are minor expenditures that were not been budgeted for this fiscal year.

The Industrial TIF #2 Fund expenditures are at 48.9%.

The Infrastructure Capital Projects Fund revenues are at 18.5% and expenditures are 20.2%. The revenues are low due to the timing of receipt of reimbursements for the various projects scheduled. The expenditures are low due to projects not being billed or not starting yet this fiscal year.

The Debt Service Fund revenues are at 51.3% and the expenditures are at 17.0%. The expenditures are low due to the timing of debt payments throughout the year.

The Waterworks and Sewerage Fund operating revenues and operating expenses are at 67.2% and 50.5%, respectively. The capital revenues and expenses are at 61.7% and 49.1%, respectively. The operating revenue is high due to the higher usage during the drought this summer. The capital expenses are low due to projects not starting yet this fiscal year. The following expenses have budget or actual amounts over \$5,000 and are higher than budget by 10% or more:

		<u>Budget</u>	<u>Actual</u>	<u>% Spent</u>	
50-50-6302	Audit Services	10,600	9,117	86.1%	P
50-50-6307	I.S. Services	7,370	6,082	82.6%	Q
50-50-8003	Debt – Interest	203,929	159,675	78.3%	R
50-59-6313	Scada Services	8,000	9,395	117.4%	S
50-59-6407	Repair, Maint Svc.-Veh	6,000	8,905	148.4%	T
50-72-8002	Debt – Principal	237,250	166,075	70.0%	U

P W&S Adm – This is due to the timing of payments which coincide with the filing of the audit. There is no anticipation for this account to be over budget.

Q W&S Adm – This is due to the installation and monthly hosting of iConnect (for online utility billing). This was not a budgeted item, but was discussed with the Board prior to installation. The account will be over budget for the year.

R W&S Adm – This is due to the timing of payments for debt. Payments are budgeted; this account is not expected to be over budget.

S PW – This is due to equipment replacement at Well 8, this was not a budgeted item and this account will continue to incur expenses associated with Scada Services.

T PW – This is due to multiple unforeseen repairs of the Villages' fleet. This account will continue to be monitored.

U Sewer Cap – This is due to the timing of payments to Fox Metro. Payments are budgeted; this account is not expected to be over budget.

The Refuse Fund revenues and expenses are at 58.2% and 50.3%, respectively. The expenses are below expectations due to the timing of payments being made to Waste Management.

Staff projected and included 0 residential and 6 commercial, and 325 miscellaneous permits in the fiscal year 2012 – 2013 budget approved by the Village Board, which we will track throughout the fiscal year and report on. As of December 12, 2012, 3 of the residential, 3 of the commercial, and 198 of the miscellaneous permits have been issued. The following accounts will be included in each Treasurer’s Report to reflect the revenues from building activity:

	<u>Budget</u>	<u>Actual</u>	<u>% Earned</u>
01-00-3310 Building Permits	38,100	25,813	67.8%
01-00-3320 Cert of Occupancy Fees	600	700	116.6%
01-00-3330 Plan Review Fees	1,920	1,004	52.3%
01-00-3340 Reinspection Fees	1,215	800	65.9%
01-00-3350 Transition Fees	0	0	0.0%
01-00-3740 Zoning and Filing Fees	5,500	4,850	88.2%
01-00-3760 Review and Dev. Fees	106,600	63,731	59.8%
30-00-3850 Improvement Donations	0	0	0.0%
30-00-3851 Emerg Warn Device Fee	0	0	0.0%
30-00-3852 Life Safety-Police	0	863	100.0%
30-00-3853 Life Safety-Streets	0	863	100.0%
30-00-3856 Commercial Fee	0	0	0.0%
35-00-3854 Traffic Pre-emption Donate	0	0	0.0%
35-00-3855 Road Impact Fee	0	13,980	100.0%
50-00-3310 Meter Reinspections	960	160	16.7%
50-00-3670 Meter Sales	8,850	5,340	60.4%
50-01-3651 Water Tap-On Fees	17,403	16,852	96.9%
50-01-3652 Sewer Tap-On Fees	0	3,540	100.0%
50-01-3791 Fire Suppr Tap-On Fee	17,403	5,801	33.4%

COST

There are no direct costs associated with the monthly Treasurer’s report.

RECOMMENDATION

That the Board approve the November 2012 monthly Treasurer’s reports

**VILLAGE OF SUGAR GROVE
BOARD REPORT**

TO: VILLAGE PRESIDENT & BOARD OF TRUSTEES
FROM: CYNTHIA L. GALBREATH, VILLAGE CLERK
SUBJECT: DISCUSSION: VIDEO GAMING REFERENDUM
AGENDA: DECEMBER 18, 2012 COMMITTEE OF THE WHOLE
DATE: DECEMBER 13, 2012

ISSUE

Should the Village/Board consider placing a non-binding question regarding Video Gaming on the ballot at the April 9, 2013 Consolidation Election.

DISCUSSION

This item was last discussed at the September 18, 2012 Board meeting. At that meeting the Board directed staff to research the process to place a referendum on the April 9, 2013 ballot on whether Video Gaming should be allowed. The Video Gaming Act states that a binding question for Video Gaming must be placed on the ballot by the public, however, the Board can place a non-binding referendum on the Ballot. It should be noted that in no way is any Board from now, in to perpetuity, bound by a non-binding referendum or the actions of a prior Board in response to a non-binding referendum. Should a binding question pass it cannot be overridden by this Board or future Board's. At this time it is unknown if a petition for a binding resolution will be submitted.

The following outlines the deadlines for ballot placement of a referendum:

Petition Submittal

January 7, 2013 is the last day for the public to file a petition requesting placement of a referendum for submission of a public question. Referendum petitions are filed with the Local Election Official (the Village Clerk). After receipt of proper petitions an ordinance or resolution would be prepared for the Village Board to adopt.

Ordinance / Resolution Adoption

January 22, 2013 is the last date for adoption of the resolution/ordinance for either a non-binding or binding referendum.

Ballot Certification

January 31, 2013 is the last date an ordinance/ resolution must then be certified by the Clerk and submitted to the County Clerk.

The Board will not know for sure if there will be a binding referendum until proper petitions are filed, or the deadline passes without a petition. If there is a public filed petition for a binding referendum, a Village initiated advisory referendum becomes moot.

As previously stated the last date for the public to submit a petition for referendum being January 7 and the last day to adopt ordinance/resolutions January 22nd, these dates allow for sufficient time to submit a referendum to the county.

Public safety was one of the concerns raised during the prior discussion of Video Gaming. Since that discussion, Video Gaming has become operational in several area establishments. The Sugar Grove Police Department contacted the Kane County Sheriff's office who stated establishments current operational include:

- Blackberry Inn
- Bookers bar and Grill (South Elgin)
- Road Ranger (Hampshire)
- Parkside Lanes

The Kane County Sheriff's office reported no Public Safety problems.

COST

There is no cost for discussion. If a referendum was to be placed on the ballot there will be a cost. All questions submitted must be translated into Spanish by a certified translation company, the cost of which must be borne by the submitting municipality. This cost is approximately \$35.00.

RECOMMENDATION

That the Board discuss the possibility of placing a referendum on the April 9, 2013 Consolidation Election Ballot regarding Video Gaming and direct staff as to whether or not further discussion is desired at the January 8, 2013 COTW Meeting should a binding petition driven referendum not be filed.



WATER • MINERAL • ENERGY

December 13, 2012

Mr. Anthony Speciale
Director of Public Works
Village of Sugar Grove
601 Heartland Drive
Sugar Grove, Illinois 60554

SUBJECT: Village of Sugar Grove, IL - Softening System Media Removal and Replacement

Dear Mr. Speciale:

Layne is pleased to provide this proposal to perform a media exchange to replace the ion exchange softening media with Purolite C100 NSF-61 approved media. The media being removed will be tested for properties as required by Waste Management to document the disposal criteria as needed. The standard contract for Waste Management through the Village of Sugar Grove will be used to make the disposal as economical as possible. In addition, the Village will supply the vacuum truck with operator for two days for assisting with the media removal. Layne will provide a two man crew with truck per our service agreement for vaccing the media out, transferring to dumpsters for hauling to disposal, for reloading the vessels and to assist with initial media regeneration.

The following is our proposal to perform this media removal and replacement:

	Description	Cost/Day	Total Cost
1	Supply sample to lab for testing as required by Waste Management	TBA	
2	Removal of waste softening resin and gravel base by vac truck with Layne's two (2) man crew supervising the process	\$2,900.00	\$5,800.00
3	Supply sub gravel for covering nozzles and below the IX resin	\$1,402.00	\$1,402.00
4	Provide new Purolite C100 media, 339 ft ³ total.	\$22,426.00	\$22,426.00
5	Shipping for Purolite media	\$3960.00	\$3,900.00
6	Installation of new gravel and softening resin	\$2,900.00	\$5,800.00
7	Fork truck and scissors lift and accessories	\$652.00	\$652.00
8	Assist with initial procedure for acquiring safe Bac-T tests	Included	Included
	Final project estimated total.		\$39,980.00

Layne feels we are uniquely qualified to perform this work as we have a Water Treatment Specialist to supervise the work, have volume buying power, have a field water treatment service technician who will be part of the two man crew, and have the knowledge of working with dozens of treatment plants in the past. This pricing does not include repairs to softening internals. After removal of media, Layne will report if any maintenance is required and wait for approval to proceed on any repairs from the Village of Sugar Grove.

WATER RESOURCES



We have estimated two days each for removing the media and for reinstalling the media. If the time is less than that, we will pass the savings on to the Village of Sugar Grove.

Thank you for the opportunity to provide these services to your community and we look forward to working with you on improving the water quality provided to your residents.

If you have any questions regarding this proposal, please contact us at your earliest convenience.

Respectfully,

LAYNE CHRISTENSEN COMPANY

A handwritten signature in black ink that reads "Jim Groose" followed by a stylized monogram "JNB".

Jim Groose
Business Development Manager - Water Treatment

Attachments: Purolite C100 Brochure

cc. William Balluff, Layne Christensen Company

WATER RESOURCES



December 10, 2012

Village of Sugar Grove, IL
Attn: Mr. Anthony Speciale, Director of Public Works
Public Works Department
601 Heartland Drive
Sugar Grove, IL 60554

**RE: WELL 8
200 HP 12H 10MQH Byron Jackson Pumping Assembly
Byron Jackson s/n 12-6131-4-1**

Mr. Speciale:

A Preventative Maintenance (PM) Test was conducted on the Village's Well #8 on November 8, 2012. Test data indicates:

- Static water level has remained stable since the permanent pump was installed in 2003.
- The well's specific capacity has declined to 4.9 GPM/foot of drawdown from the 2003 recorded specific of 12.8.
- The pumping equipment has not been pulled for inspection/repair since its original installation in 2003.
- The pump's capacity production has declined over 20% since its 2003 installation.
- The submersible motor is operating within motor service factor with balanced current draw. Motor insulation appears to be in good condition with resistance readings, from the starter cabinet, at 2420 megohms.

As the pump has operated for nine years without maintenance service, the pump exhibits a significant decline in production, and the well exhibits a significant decline in specific capacity, we recommend pump removal, a complete inspection of the pump components, and an investigative television survey of the well.

This pumping assembly was originally installed by Layne in 2003. The pumping assembly consists of a Byron Jackson / Flowserve 200 HP 12H 460V 3 phase 60 Hz 4 pole submersible motor, a Byron Jackson 22 stage 10MQH 15 stage bowl assembly, 701' of 6" threaded and coupled column pipe, 500MCM three conductor with ground power cable, Byron Jackson flat cable with molded bronze terminal clamp, and a Baker Pitless Adapter.

The Byron Jackson Type H submersible motor, as is currently installed in Well #8, is considered the preeminent motor in northern Illinois for reliability and dependability in high capacity, deep sandstone well applications such as Well #8. Per recent Illinois legislation, the Type H motor can no longer be sold or distributed in Illinois. Type H motors that are in operation can, however, receive a standard service by a certified Byron Jackson technician and returned to effective service function.

The estimated costs associated with this project are as follows:

Phase I – Pump Removal, video survey, and component inspection				
	Item	Quantity	Unit Cost	Extension
1	Load and mobilize to the project site, set up pipe inspection racks, pump service rig, and support equipment, tag disconnect the power leads, lockout/tagout the power, remove pitless adapter cap, and spool, and set up cable spool. <ul style="list-style-type: none"> • Large Pump Service Rig and operator • Serviceman with large service crane • Helper 	8 hrs.	\$246.05/hr.	\$1,968.40
		8 hrs.	\$246.05/hr.	\$1,968.40
		8 hrs.	\$116.85/hr.	\$934.80
2	Remove the complete pumping assembly. <ul style="list-style-type: none"> • Large Pump Service Rig, support equipment, and operator • Two Helpers 	24 hrs.	\$246.05/hr.	\$5,905.20
		24 hrs.	\$233.70/hr.	\$6,628.80
3	Make the motor and bowl assembly disconnection. Drain the motor, properly cage the seal, and place the Byron Jackson motor in its safe shipping position. <ul style="list-style-type: none"> • Byron Jackson Technician and tooling • Two Helpers 	4 hrs.	\$157.70	\$630.80
		4 hrs.	\$233.70	\$934.80
4	Transport, load, and unload, the column pipe (as required), bowl assembly, motor, and power cable to Aurora yard for inspection and testing. <ul style="list-style-type: none"> • Large Service crane with trailer and operator • Two Helpers 	8 Hrs.	\$246.05	\$1,968.40
		8 Hrs.	\$233.70	\$1,869.60
5	Downhole Video Survey with DVD copy and written report – Technician and Equipment	1 L.S.	\$1,260.00	\$1,260.00
6	Equipment inspection: sandblast column pipe and bowl assembly for inspection, disassemble the bowl assembly and prepare			



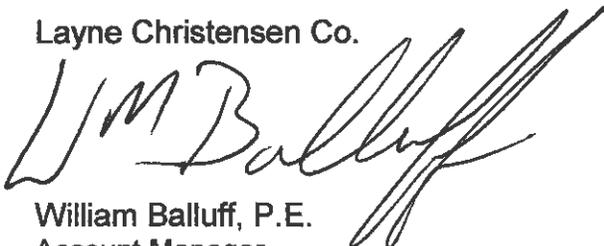
a micrometer report. Conduct a High Potential Test on the Power Cable. Prepare a complete equipment inspection report. <ul style="list-style-type: none"> • Sandblast equipment and operator • Serviceman with hand tools • Machinist • Helper • Technician and high potential testing equipment 	8 Hrs.	\$197.60	\$1,580.80
	8 Hrs.	\$133.00	\$1,064.00
	2 Hrs.	\$149.15	\$298.30
	16 Hrs.	\$116.85	\$1,869.60
	1 L.S.	\$639.00	\$639.00
Byron Jackson Type H motor inspection and Service: oil, gasket and filter change <ul style="list-style-type: none"> • Byron Jackson Service Technician • Oil, Gasket Set, Filter 	16 Hrs.	\$157.70	\$2,523.20
	Lot	\$1,020.00	\$1,020.00
Total estimated project cost			\$33,364.10

Note: The above unit pricing is established in Layne's Professional Services Contract with the Village of Sugar Grove dated and agreed upon August 1, 2012.

Additional costs would consist of any pumping assembly repairs, well rehabilitation, and pump installation costs. These costs will be submitted with the pumping equipment inspection report and rehabilitation plan. The actual hours conducted by the crew will be depicted on the final invoice utilizing the unit pricing shown above and established in our service agreement. The above estimate does assume that the pumping assembly can be removed in a normal fashion and without any unusual downhole circumstances.

Layne values its longstanding relationship with the Village of Sugar Grove, IL. We hope that we can be of continued service to the Village on this very important project. Please review this information and contact me if you have any questions or comments.

Layne Christensen Co.

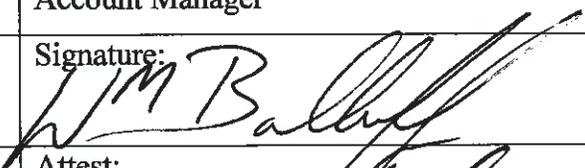
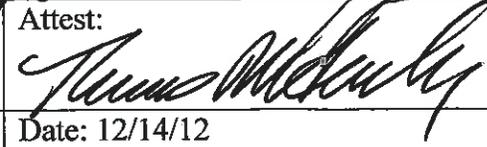


William Balluff, P.E.
Account Manager



**Exhibit 1
Task Order**

Date	12/14/12
Project Name	Sugar Grove Well #8 Pump Maintenance and Media Replacement
Project Scope	<p>PUMP MAINTENANCE Pump Removal Equipment Inspection including disassembly of bowl assembly, sandblast column for inspection (if required), high potential testing of power cable, Layne certified service of Byron Jackson 200 HP submersible motor (to be conducted at Aurora facility) Preparation of inspection report Downhole video survey of the well with Report and DVD copy</p> <p>MEDIA REMOVAL AND REPLACEMENT Supply sample to lab for testing Removal and replacement of all media, three vessels Assist with Bac-T testing</p>
Schedule / timeline	As required and dictated by the Village of Sugar Grove and within Layne Christensen's competences.
Additional Information	See attached proposals and cost estimates.

Village of Sugar Grove, IL	Layne Christensen Company
Print Name:	Print Name: William Balluff, P.E.
Title:	Title: Account Manager
Signature:	Signature: 
Attest:	Attest: 
Date:	Date: 12/14/12



Schedule B

The undersigned Purchaser hereby instructs Layne Christensen Company ("Contractor") to proceed with work on Purchaser's well and/or pumping equipment with the understanding that the Terms and Conditions shown on the reverse are hereby incorporated as part of this Work Order and with the specific understanding that Contractor will not be liable for any damage in any way whatsoever for failure to complete the described work, nor for any injury or damage, including damage to the well, well material, pump or water supply, resulting from Contractor's efforts to perform such work, or for any delay on Contractor's part in completing same. All work will be provided on a cost plus basis at the hourly rates described below. Charges will be made at the below listed rates for travel time from applicable Aurora or Beecher, Illinois equipment base to destination and return for men and equipment. All hours worked before or after Contractor's normal work day hours and all hours worked on Saturdays, will be billed at time and one-half rates. All work on Sundays and/or any federally recognized holiday will be billed at double time rates.

1. Serviceman or machinist with hand tools	\$ 140.00 per hour
2. Serviceman with service truck and tools or welding truck	\$169.00 per hour
3. Machinist with machine shop equipment	157.00 per hour
4. Machinist with 12" pipe threading machine	\$183.00 per hour
5. Serviceman with small hoist or winch truck or sandblast equipment	208.00 per hour
6. Operator and backhoe	208.00 per hour
7. Serviceman with small service rig or large hoist or flatbed crane	220.00 per hour
8. Serviceman with large service rig or large cable tool rig or 15 ton truck crane	259.00 per hour
9. Helpers (per helper)	123.00 per hour
10. Time and one half rate for serviceman	add 70.00 per hour
11. Double time rate for serviceman	add 140.00 per hour
12. Time and one half rate for helpers (per helper)	add 61.50 per hour
13. Double time rate for helpers (per helper)	add 123.00 per hour
14. Mileage from Layne shop or nearest point and return to shop, if not covered by hourly rate above:	
(a) Auto	0.55 per mile
(b) Pickup truck	0.70 per mile
(c) One-ton truck	1.00 per mile
(d) Flat-bed truck	2.20 per mile
(e) Semi-trailer truck	2.75 per mile
15. Per Diem:	
(a) Over 45 miles to 96 miles radius from base	35.00 + motel cost/man/day
(b) Over 96 miles from base	40.00 +motel cost/man/day

Remarks:

All Work shall be conducted within the terms of this agreement at the above stated unit pricing with a 5% reduction. All technical services such as Video Survey, Sonar Jet®, Boreblast™, High Potential Testing, CTU trailer, etc. shall be invoice at the standard pricing with a 10% reduction.

NOTE: The final invoice will reflect the actual time and materials used on the job multiplied by the unit rates/prices indicated above and in any estimates provided. Any applicable taxes are not included and would be added to the invoice.





RESOLUTION NO. 20121212PW1

VILLAGE OF SUGAR GROVE, KANE COUNTY, ILLINOIS

RESOLUTION AUTHORIZING EXECUTION OF AN AGREEMENT WITH LAYNE CHRISTENSEN COMPANY, INC.

WHEREAS, the Village of Sugar Grove Board of Trustees find that it is in the best interest of the Village to engage the services of Layne Christensen Company, Inc. to provide professional services for the Well #8 Pump Maintenance and Media Replacement to the Village of Sugar Grove, and to execute the attached agreement;

NOW, THEREFORE, BE IT RESOLVED by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, as follows:

That attached hereto and incorporated herein by reference as Exhibit A is an agreement between Layne Christensen Company, Inc. and the Village of Sugar Grove for professional services for the Well #8 Pump Maintenance and Media Replacement to the Village of Sugar Grove. The President and Clerk are hereby authorized to execute said agreement on behalf of the Village and to take such further actions as are necessary to fulfill the terms of said agreement.

Passed by the President and Board of Trustees of the Village of Sugar Grove, Kane County, Illinois, at a regular meeting thereof held on the 12th day of December, 2012.

P Sean Michels, President of the Board
of Trustees of the Village of Sugar Grove,
Kane County, Illinois

ATTEST: _____
Cynthia Galbreath, Clerk
Village of Sugar Grove

	Aye	Nay	Absent	Abstain
Trustee Robert E. Bohler	_____	_____	_____	_____
Trustee Kevin M. Geary	_____	_____	_____	_____
Trustee Mari Johnson	_____	_____	_____	_____
Trustee Rick Montalto	_____	_____	_____	_____
Trustee David Paluch	_____	_____	_____	_____
Trustee Thomas Renk	_____	_____	_____	_____

**VILLAGE OF SUGAR GROVE
BOARD REPORT**

TO: VILLAGE PRESIDENT & BOARD OF TRUSTEES
FROM: ANTHONY SPECIALE, DIRECTOR OF PUBLIC WORKS
BRAD MERKEL, PUBLIC UTILITIES SUPERVISOR
SUBJECT: RESOLUTION: WELL #8 PUMP MAINTENANCE AND MEDIA
REPLACEMENT
AGENDA: DECEMBER 18, 2012 REGULAR BOARD MEETING
DATE: DECEMBER 12, 2012

ISSUE

Should the Village Board approve the Well #8 Pump Maintenance and Media Replacement.

DISCUSSION

At the September 4, 2012 Regular Board Meeting, the Village Board approved an agreement with Layne Christensen Company, Inc for water system needs. Layne Christensen has been providing well rehabilitation and construction services to the Village of Sugar Grove for more than 50 years. The service agreement is non-binding and does not obligate the Village to utilize Layne Christensen for work. Individual Task Orders detailing the description of the work, costs, schedule, etc, will need to be executed for each project.

Attached for your review are two proposals and task order detailing the description of work, costs and schedules for the Well #8 Pump Maintenance and Media Replacement.

The Pump Maintenance Proposal includes equipment inspection, downhole video survey of the well, inspection reports and service of the Byron Jackson 200 HP submersible motor for an estimated cost of \$33,364.10. The Media Replacement Proposal includes the removal and replacement of all media, the required sampling and bacteriological testing for an estimated cost of \$39,980.00. The total estimated cost for the Task Order dated December 12, 2012 is \$73,344.10

Due to the excellent results with the Well #3 and Well #7 Rehabilitation Projects, staff recommends that the Village authorize Layne-Western to complete the Well #8 Pump Maintenance and Media Replacement.

COST

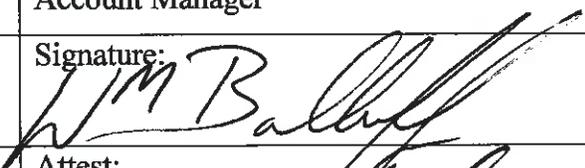
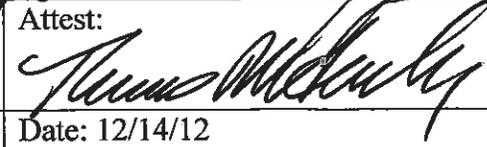
The estimated cost of the Well #8 Repairs is \$73,344.10. The Fiscal Year 12-13 Water Operations Budget, account number 50-60-6309: Other Professional Services includes \$200,000.00 for the Well 8 Repair Project.

RECOMMENDATION

The Village Board authorizes an agreement for the Well #8 Pump Maintenance and Media Replacement with Layne Christensen Company.

**Exhibit 1
Task Order**

Date	12/14/12
Project Name	Sugar Grove Well #8 Pump Maintenance and Media Replacement
Project Scope	<p>PUMP MAINTENANCE Pump Removal Equipment Inspection including disassembly of bowl assembly, sandblast column for inspection (if required), high potential testing of power cable, Layne certified service of Byron Jackson 200 HP submersible motor (to be conducted at Aurora facility) Preparation of inspection report Downhole video survey of the well with Report and DVD copy</p> <p>MEDIA REMOVAL AND REPLACEMENT Supply sample to lab for testing Removal and replacement of all media, three vessels Assist with Bac-T testing</p>
Schedule / timeline	As required and dictated by the Village of Sugar Grove and within Layne Christensen's competences.
Additional Information	See attached proposals and cost estimates.

Village of Sugar Grove, IL	Layne Christensen Company
Print Name:	Print Name: William Balluff, P.E.
Title:	Title: Account Manager
Signature:	Signature: 
Attest:	Attest: 
Date:	Date: 12/14/12



Schedule B

The undersigned Purchaser hereby instructs Layne Christensen Company ("Contractor") to proceed with work on Purchaser's well and/or pumping equipment with the understanding that the Terms and Conditions shown on the reverse are hereby incorporated as part of this Work Order and with the specific understanding that Contractor will not be liable for any damage in any way whatsoever for failure to complete the described work, nor for any injury or damage, including damage to the well, well material, pump or water supply, resulting from Contractor's efforts to perform such work, or for any delay on Contractor's part in completing same. All work will be provided on a cost plus basis at the hourly rates described below. Charges will be made at the below listed rates for travel time from applicable Aurora or Beecher, Illinois equipment base to destination and return for men and equipment. All hours worked before or after Contractor's normal work day hours and all hours worked on Saturdays, will be billed at time and one-half rates. All work on Sundays and/or any federally recognized holiday will be billed at double time rates.

1. Serviceman or machinist with hand tools	\$ 140.00 per hour
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3. Machinist with machine shop equipment	157.00 per hour
4. Machinist with 12" pipe threading machine	\$183.00 per hour
5. Serviceman with small hoist or winch truck or sandblast equipment	208.00 per hour
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7. Serviceman with small service rig or large hoist or flatbed crane	220.00 per hour
8. Serviceman with large service rig or large cable tool rig or 15 ton truck crane	259.00 per hour
9. Helpers (per helper)	123.00 per hour
10. Time and one half rate for serviceman	add 70.00 per hour
11. Double time rate for serviceman	add 140.00 per hour
12. Time and one half rate for helpers (per helper)	add 61.50 per hour
13. Double time rate for helpers (per helper)	add 123.00 per hour
14. Mileage from Layne shop or nearest point and return to shop, if not covered by hourly rate above:	
(a) Auto	0.55 per mile
(b) Pickup truck	0.70 per mile
(c) One-ton truck	1.00 per mile
(d) Flat-bed truck	2.20 per mile
(e) Semi-trailer truck	2.75 per mile
15. Per Diem:	
(a) Over 45 miles to 96 miles radius from base	35.00 + motel cost/man/day
(b) Over 96 miles from base	40.00 +motel cost/man/day

Remarks:

All Work shall be conducted within the terms of this agreement at the above stated unit pricing with a 5% reduction. All technical services such as Video Survey, Sonar Jet®, Boreblast™, High Potential Testing, CTU trailer, etc. shall be invoice at the standard pricing with a 10% reduction.

NOTE: The final invoice will reflect the actual time and materials used on the job multiplied by the unit rates/prices indicated above and in any estimates provided. Any applicable taxes are not included and would be added to the invoice.



Flexible Benefits Plan

Plan Document

Table of Contents

ARTICLE I DEFINITIONS	1
ARTICLE II PARTICIPATION	4
2.1 ELIGIBILITY	4
2.2 EFFECTIVE DATE OF PARTICIPATION.....	5
2.3 APPLICATION TO PARTICIPATE.....	5
2.4 TERMINATION OF PARTICIPATION.....	5
2.5 CHANGE OF EMPLOYMENT STATUS	5
2.6 FAMILY AND MEDICAL LEAVE ACT OF 1993.....	6
2.7 TERMINATION OF EMPLOYMENT	7
2.8 DEATH OF A PARTICIPANT	9
ARTICLE III CONTRIBUTIONS TO THE PLAN	9
3.1 SALARY REDIRECTION	9
3.2 APPLICATION OF CONTRIBUTIONS	10
3.3 PERIODIC CONTRIBUTIONS	10
ARTICLE IV BENEFITS.....	10
4.1 BENEFIT OPTIONS	10
4.2 HEALTHCARE FLEXIBLE SPENDING ACCOUNT BENEFIT.....	10
4.3 DEPENDENT CARE ASSISTANCE PROGRAM BENEFIT	11
4.4 ADOPTION ASSISTANCE PROGRAM BENEFIT	11
4.5 INSURANCE BENEFIT	11
4.6 CASH BENEFIT	11
4.7 NONDISCRIMINATION REQUIREMENTS.....	12
4.8 TAX-FREE TRANSPORTATION PROGRAM BENEFIT	12
4.9 HEALTH SAVINGS ACCOUNT PROGRAM BENEFIT	12
ARTICLE V PARTICIPANT ELECTIONS	13
5.1 INITIAL ELECTIONS	13
5.2 SUBSEQUENT ANNUAL ELECTIONS	13
5.3 FAILURE TO ELECT	13
5.4 CHANGE OF ELECTIONS	14
5.5 CONSISTENCY REQUIREMENT.....	16
ARTICLE VI HEALTHCARE FLEXIBLE SPENDING ACCOUNT.....	17
6.1 ESTABLISHMENT OF PLAN	17
6.2 DEFINITIONS.....	17
6.3 FORFEITURES	18
6.4 LIMITATION ON ALLOCATIONS	18
6.5 NONDISCRIMINATION REQUIREMENTS.....	18

6.6	COORDINATION WITH FLEXIBLE BENEFITS PLAN.....	19
6.7	HEALTHCARE FLEXIBLE SPENDING ACCOUNT CLAIMS.....	19
6.8	ALLOWABLE ROLLOVERS FOR QUALIFIED HSA DISTRIBUTIONS	19
ARTICLE VII DEPENDENT CARE ASSISTANCE PROGRAM		20
7.1	ESTABLISHMENT OF PROGRAM.....	20
7.2	DEFINITIONS.....	20
7.3	DEPENDENT CARE ASSISTANCE ACCOUNTS.....	21
7.4	INCREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS.....	21
7.5	DECREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS.....	21
7.6	ALLOWABLE DEPENDENT CARE ASSISTANCE REIMBURSEMENT	21
7.7	ANNUAL STATEMENT OF BENEFITS	22
7.8	FORFEITURES	22
7.9	LIMITATION ON PAYMENTS.....	22
7.10	NONDISCRIMINATION REQUIREMENTS.....	22
7.11	COORDINATION WITH FLEXIBLE BENEFITS PLAN.....	23
7.12	DEPENDENT CARE ASSISTANCE PROGRAM CLAIMS	23
ARTICLE VIII ADOPTION ASSISTANCE PROGRAM		24
8.1	ESTABLISHMENT OF PROGRAM.....	24
8.2	DEFINITIONS.....	24
8.3	ADOPTION ASSISTANCE ACCOUNTS	25
8.4	INCREASES IN ADOPTION ASSISTANCE ACCOUNTS	26
8.5	DECREASES IN ADOPTION ASSISTANCE ACCOUNTS	26
8.6	ALLOWABLE ADOPTION ASSISTANCE REIMBURSEMENT.....	26
8.7	ANNUAL STATEMENT OF BENEFITS	26
8.8	FORFEITURES	26
8.9	LIMITATION ON PAYMENTS.....	26
8.10	LIMITATION OF INCOME.....	26
8.11	NONDISCRIMINATION REQUIREMENTS.....	27
8.12	COORDINATION WITH FLEXIBLE BENEFITS PLAN.....	27
8.13	ADOPTION ASSISTANCE PROGRAM CLAIMS.....	27
ARTICLE IX TAX-FREE TRANSPORTATION PROGRAM.....		28
9.1	ESTABLISHMENT OF PROGRAM.....	28
9.2	DEFINITIONS.....	28
9.3	ELECTION OF BENEFITS	29
9.4	ACCOUNT	29
9.5	TIME PERIOD FOR MAKING, MODIFYING, OR REVOKING A SALARY REDIRECTION AGREEMENT	30
9.6	CARRYOVER OF UNUSED AMOUNT IN ACCOUNT.....	30

9.7	TERMINATION OF AGREEMENT	30
9.8	EXPENSE SUBSTANTIATION	30
9.9	REIMBURSEMENT OF EXPENSES	31
ARTICLE X HEALTH SAVINGS ACCOUNT PROGRAM		31
10.1	ESTABLISHMENT OF PROGRAM	31
10.2	ADDITIONAL DEFINITIONS	31
10.3	HEALTH SAVINGS ACCOUNTS	33
10.4	INCREASES IN HEALTH SAVINGS ACCOUNTS	33
10.5	DECREASES IN HEALTH SAVINGS ACCOUNTS.....	33
10.6	ALLOWABLE HEALTH SAVINGS ACCOUNT REIMBURSEMENT.....	33
10.7	ANNUAL STATEMENT OF BENEFITS	33
10.8	UNUSED HEALTH SAVINGS ACCOUNT BALANCES.....	33
10.9	LIMITATION ON CONTRIBUTIONS.....	34
10.10	COORDINATION WITH FLEXIBLE BENEFITS PLAN.....	34
10.11	COORDINATION WITH HEALTHCARE EXPENSE REIMBURSEMENT PROGRAM	34
10.12	HEALTH SAVINGS ACCOUNT PROGRAM CLAIMS.....	34
10.13	DISTRIBUTIONS FOR NON-HSA EXPENSES	34
ARTICLE XI ERISA PROVISIONS		35
11.1	CLAIM FOR BENEFITS	35
11.2	APPLICATION OF BENEFIT PLAN SURPLUS	36
11.3	NAMED FIDUCIARY	36
11.4	GENERAL FIDUCIARY RESPONSIBILITIES.....	37
11.5	NONASSIGNABILITY OF RIGHTS	37
ARTICLE XII ADMINISTRATION		37
12.1	PLAN ADMINISTRATION	37
12.2	METHOD OF BENEFIT PAYMENT	38
12.3	EXAMINATION OF RECORDS	39
12.4	PAYMENT OF EXPENSES.....	39
12.5	INSURANCE CONTROL CLAUSE	40
12.6	INDEMNIFICATION OF ADMINISTRATOR	40
ARTICLE XIII AMENDMENT OR TERMINATION OF PLAN		40
13.1	AMENDMENT.....	40
13.2	TERMINATION	40
ARTICLE XIV HIPAA PRIVACY REQUIREMENTS		40
14.1	DEFINITIONS.....	41
14.2	DISCLOSURE OF SUMMARY HEALTH INFORMATION.....	42
14.3	DISCLOSURE OF PHI	43

14.4	ADEQUATE SEPARATIONS.....	43
14.5	USES AND DISCLOSURES	44
ARTICLE XV MISCELLANEOUS		44
15.1	PLAN INTERPRETATION.....	44
15.2	GENDER AND NUMBER	44
15.3	WRITTEN DOCUMENT	45
15.4	EXCLUSIVE BENEFIT	45
15.5	PARTICIPANT’S RIGHTS	45
15.6	ACTION BY THE EMPLOYER.....	45
15.7	EMPLOYER’S PROTECTIVE CLAUSES.....	45
15.8	NO GUARANTEE OF TAX CONSEQUENCES.....	45
15.9	INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS.....	46
15.10	FUNDING.....	46
15.11	GOVERNING LAW.....	46
15.12	SEVERABILITY	46
15.13	CAPTIONS.....	46
15.14	CONTINUATION OF COVERAGE	46
15.15	UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS (USERRA) ACT	47
15.16	CLAIMS EXTENSION PERIOD	47
15.17	GENETIC INFORMATION NONDISCRIMINATION ACT.....	47
15.18	MENTAL HEALTH PARITY AND ADDICTION ACT.....	47
15.19	WOMEN’S HEALTH AND CANCER RIGHTS ACT.....	48
15.20	NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT	48

FLEXIBLE BENEFITS PLAN

INTRODUCTION

The Plan Sponsor designated in the Employer's Adoption Agreement (hereinafter referred to as the "Employer") hereby establishes a Flexible Benefits Plan (the "Plan") for its eligible Employees and for Eligible Employees of adopting Affiliated Employers. Its purpose is to reward them by providing Benefits for those Employees who shall qualify hereunder and their Dependents and Spouses. The concept of this Plan is to allow employees to choose among different types of Benefits based on their own particular goals, desires, and needs and to reimburse the Eligible Employees of the Employer for allowable expenses incurred by them, their Spouses, and Dependents. The Plan shall be known as a "Flexible Benefits Plan" (hereinafter referred to as the "Plan") and shall otherwise be referred to by the Plan Name provided within the Employer's completed Adoption Agreement.

The intention of the Employer is that, wherever appropriate, portions of the Plan shall qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the Benefits which an Employee elects to receive under such portions of the Plan be includable or excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended. If the Employer has elected in the Employer's Adoption Agreement to adopt a "Simple Cafeteria Plan," the intention of the Employer is that the Plan shall also qualify as a "Simple Cafeteria Plan" within the meaning of Section 125(j) of the Internal Revenue Code of 1986, as amended. Other Plan provisions, including the Tax-Free Transportation Program are not intended to qualify under Section 125, but instead shall separately qualify under other applicable sections (e.g., the Tax-Free Transportation Program would qualify as a Section 132(f) pre-tax benefit for Eligible Employees). Each program is consolidated under this Plan due to the joint administrative processes relating to each program; however, for purposes of applicable provisions of Section 125, Section 132(f), Section 223, and other applicable Code provisions, each program shall be considered as a separate Plan for purposes of the Code, ERISA and other applicable Regulations.

ARTICLE I

DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

- 1.1 "Administrator" or "Plan Administrator"** means the Plan Sponsor identified in the Employer's Adoption Agreement. The Plan Sponsor may delegate any or all of its authority as the Administrator under this Plan to any third-party, pursuant to the terms of this Plan and in accordance with the terms of any applicable Service Agreement.
- 1.2 "Affiliated Employer"** means the Employer and any corporation identified in the Employer's Adoption Agreement which is a member of a controlled group of corporations (as defined in Code Section 414(b)), which includes the Employer; any trade or business (whether or not incorporated) that is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) that is a member of an affiliated service group (as defined in Code Section 414(m)), which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury Regulations under Code Section 414(o).
- 1.3 "Benefit"** means any of the optional benefit choices selected by the Participant as outlined under Article IV below or as otherwise specified in the Employer's Adoption Agreement.
- 1.4 "Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time, and which shall also include any governing Regulations or applicable guidance thereunder.

1.5 "Compensation" means the total cash remuneration received by the Participant from the Employer during a Plan Year prior to any reductions pursuant to a Salary Redirection Agreement authorized hereunder. Compensation shall include overtime, commissions, and bonuses.

1.6 "Dependent" means any individual who is defined under an Insurance Contract or who is a Qualifying Child or Qualifying Relative who qualifies as a dependent under an Insurance Contract or under Code Section 152 (as modified by Code Section 105(b)), as applicable. A Dependent also includes an adult child of a Participant who as of the end of the calendar year has not attained age 27. A child for purposes of this Section 1.7 means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law.

1.7 "Effective Date" means the Effective Date specified in the Employer's Adoption Agreement.

1.8 "Election Period" means the period immediately preceding the beginning of each Plan Year established by the Administrator for the election of Benefits and Salary Redirection, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.9 "Eligible Employee" means any Employee who has satisfied the eligibility requirements necessary to participate in the Plan as stated in the Employer's Adoption Agreement, or as otherwise set forth herein.

1.10 "Employee" means any person who is employed by the Employer, but for all portions of the Plan other than provisions relating to the Health Savings Account Program, generally excludes any person who is employed as an independent contractor or any person who is considered self-employed under Code Section 401(c), as well as a greater than two percent (2%) shareholder in a Subchapter S corporation, as defined under Code Section 1372(b), a partner in a partnership or an owner or member of a limited liability company that elects partnership status on its tax return.

1.11 "Employer" means the Plan Sponsor and any Affiliated Employer which is listed on the Employer's Adoption Agreement; provided, however, that the Plan Sponsor retains authority as Plan Administrator for all purposes under the Plan and retains sole authority to amend or terminate the Plan in accordance with Article XIII, without the approval of any Affiliated Employer which has adopted the Plan.

1.12 "Employer Contribution" means the contributions as identified in the Employer's Adoption Agreement made by the Employer pursuant to Section 3.1 to enable a Participant to purchase Benefits. These contributions shall be converted to Flexible Benefits Plan Dollars and allocated to the accounts established under the Plan pursuant to the Participants' elections made under Article V and shall be reimbursed for the cost of eligible Benefits described under Article IV, as well as other amounts contributed or elected to be contributed by the Employee for their Health Savings Account.

1.13 "Entry Date" means the earlier of the Plan Effective Date or the date an Employee becomes entitled to participate in the Plan as specified in the Employer's Adoption Agreement.

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

1.15 "Flexible Benefits Plan Dollars" means the amount available to Participants, pursuant to Article III, to purchase Benefits. Each dollar contributed to this Plan, through either Employer Contribution or Employee Salary Redirection, shall be converted into one Flexible Benefits Plan Dollar.

1.16 "Health Savings Account" means an account established and maintained by the Plan in accordance with Code Section 223(d) to which part of any Eligible Employee's Flexible Benefits Plan Dollars may be allocated and from which all HSA Medical Expenses may be reimbursed or otherwise distributed as otherwise set forth herein.

1.17 "High-Deductible Health Plan" means the program of health insurance coverage that qualifies under Code Section 223(c)(2), with limits and coverages as elected under the Employer's Adoption Agreement.

- 1.18 “Highly Compensated Employee”** means, for the purposes of determining discrimination, an Employee described in Code Section 125 and the Treasury Regulations thereunder.
- 1.19 “Insurance Benefits”** means the benefits provided under any applicable insurance program or policy included within the list of qualifying, nontaxable benefit programs that have been selected as part of the Employer’s Adoption Agreement.
- 1.20 “Insurance Contract”** means any contract issued by an Insurer underwriting a Benefit.
- 1.21 “Insurance Premium Payment Plan”** means the plan of Insurance Benefits selected within the Employer’s Adoption Agreement, which provides for the payment of Premium Expenses under this Plan.
- 1.22 “Insurer”** means any insurance company that underwrites a Benefit under this Plan or, the Employer if the Benefit is self-funded and otherwise paid for out of the Employer’s general assets or paid for through a separate trust established by the Employer.
- 1.23 “Key Employee”** means an employee defined in Code Section 416(l)(1) and the Treasury Regulations thereunder.
- 1.24 “Leased Employee”** means any employee described under Code Section 414(n)(2).
- 1.25 “Participant”** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.
- 1.26 “Plan”** means this instrument, including all amendments and attachments thereto.
- 1.27 “Plan Year”** means the 12-month period designated in the Employer’s Adoption Agreement. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant’s date of entry and ending on the last day of such Plan Year.
- 1.28 “Premium Expenses” or “Premiums”** means the Participant’s cost for the Insurance Benefits described in the Employer’s Adoption Agreement or the actual cost of privately held insurance policies purchased in the names of specific Participants.
- 1.29 “Premium Reimbursement Account”** means the account established for a Participant pursuant to this Plan to which part of his/her Flexible Benefits Plan Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.
- 1.30 “Qualified HSA Distribution”**, means a direct distribution of an allowable amount from a Participant’s Healthcare Flexible Spending Account or Health Reimbursement Arrangement, as otherwise allowable based on the Employer’s signed Adoption Agreement and as otherwise applicable under the Code, to an Eligible Individual’s Health Savings Account.
- 1.31 “Qualifying Child”** means an individual who, unless otherwise described under Code Section 152(b):
- Is a child (as defined under Code Section 152(f)(1)) of the Employee, or a dependent of such child, or a brother, sister, stepbrother or stepsister of the Employee, or a descendent of any such relative;
 - Who has the same principal residence, if allowed under local law, as the Employee for more than one-half of the current taxable year;
 - Is under the age of 19 as of the end of the Plan Year in which the Employee was eligible under this Plan, or is under the age of 24 when covered as a full time student (as defined under Code Section 152(f)(2)), after consideration of Code Section 152(c)(3) as applicable; and
 - Has not provided over one-half of his or her own support during the current Plan Year.
- 1.32 “Qualifying Relative”** means an individual who, unless otherwise described under Code Section 152(d) or (e):

- Is a child (as defined under Code Section 152(f)(1)), or descendant of a child, or a brother, sister, stepbrother, stepsister, father, mother or any of their ancestors, or any other relative as described under Code Section 152(d)(2), including an individual who has the same principal residence as the Employee and who is a member of the Employee's household;
- Has (with the exception of certain handicapped dependents described under Code Section 152(d)(4)) gross income for the Plan Year that is less than the allowable income exemption amount (as defined under Code Section 151(d) for that taxable year;
- For whom the Employee provides over one-half of the individual's support for that calendar year; and
- Is not an otherwise Qualifying Child of the Employee for any portion of the Plan Year.

1.33 "Regulations" means either temporary, proposed or final regulations, as applicable, issued or released by the U.S. Department of Treasury, and any further or related guidance or interpretations, as well as such other federal or state regulations as otherwise applicable herein.

1.34 "Salary Redirection" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Flexible Benefits Plan Dollars and allocated to the accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.35 "Salary Redirection Agreement" means an agreement between the Participant and the Employer under which the Participant agrees to reduce his/her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.36 "Spouse" means the legally married husband or wife of a Participant in accordance with applicable federal law, unless legally separated by court decree or otherwise specified by the Insurance Contract.

1.37 "Temporary or Seasonal Employee" means any employee who is either designated on the Employer's personnel records as a Temporary Employee or who is expected to work less than six (6) months per year with the Employer.

1.38 "Uniformed Services" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

All other defined terms in this Plan shall have the meanings specified in the various Articles of the Plan in which they appear.

ARTICLE II

PARTICIPATION

2.1 ELIGIBILITY

Any Employee of the Employer and its Affiliates who meets the eligibility requirements specified in the Employer's Adoption Agreement becomes an Eligible Employee and who executes a written election to participate shall be eligible to participate in the Plan on the date he/she has satisfied any applicable waiting period(s) specified in the Employer's Adoption Agreement (or the Effective Date of the Plan, if later) or any other eligibility criteria set forth herein.

Except as otherwise provided in any applicable Benefit Plans or insurance policies, former Participants who are rehired within 30 days or less of the date of termination of employment will be reinstated with the same election(s) such individual

had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, the individual may make a new election.

2.2 EFFECTIVE DATE OF PARTICIPATION

Any Employee who is eligible under Section 2.1 may become a Participant effective as of the first day of the month coinciding with or next following date requirements are met. Any Employee who does not elect to participate in the Plan on the date the Employee first becomes eligible may later elect to begin participating as of the first day of any Plan Year or an earlier Entry Date following a Change in Status pursuant to Section 5.4 hereof. If this is a restated Plan, each Employee who was a Participant in the Plan on the day prior to the restated Effective Date and is an Employee of an Employer on the Effective Date shall remain a Participant.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate and election of Benefits form, which the Administrator shall furnish to the Employee. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his/her Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to execute a Salary Redirection Agreement during the Election Period for which he/she wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's Effective Date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- a) Termination of employment, subject to the provisions of Section 2.7;
- b) The end of the Plan Year during which the individual became a limited Participant because of a change in employment status pursuant to Section 2.5;
- c) Death, subject to the provisions of Section 2.8; or
- d) The termination of this Plan, subject to the provisions of Section 12.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be an Eligible Employee because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. An employee will become a limited Participant if he/she meets the following three conditions:

- a) The Participant has taken an unpaid leave of absence from the Employer or has changed from full-time to part-time employment with the Employer; and
- b) The Participant elects under Section 3.1 to reduce his/her Salary Redirection to \$0 as a result of the change in employment status or classification; and

- c) Upon return to employment after a leave of absence or return to full-time from part-time employment, the Participant re-elects under Section 5.1 to increase his/her Salary Redirection to the level that existed immediately before it was reduced to \$0 (or to some other level if on account of and consistent with a change in status).

If COBRA applies, the Participant, while on the unpaid leave or in part-time employment status, will be given the opportunity to continue his/her Insurance Plans and Healthcare Flexible Spending Account. Premiums for the Participant's Insurance Benefits, as well as any applicable Premiums for the Participant's Healthcare Flexible Spending Account, may continue to be paid on a pre-tax basis provided the Participant receives Compensation during the leave period. If, however, the Participant receives no Compensation during the leave period, the Participant may continue Benefits under the Plan through payment of all Premiums with after-tax dollars outside of the Plan. Regardless of how Premiums are paid (either pre-tax or after-tax), the Participant will remain a full Participant in the Plan provided all Premiums are paid within 30 days of any due date.

As a limited Participant, except as otherwise provided herein, no further Salary Redirection may be made on behalf of the Participant, and, except as otherwise provided herein, all further Benefit elections shall cease, subject to the limited Participant's right to continue coverage under any Insurance Contracts. However, any balances in the limited Participant's Dependent Care Assistance Account or Adoption Assistance Program may be used during such Plan Year to reimburse the limited Participant for any allowable employment-related dependent expenses or qualified adoption expenses incurred during the Plan Year, subject to any other terms and conditions that are applicable under Articles VII and VIII respectively herein.

Further, in accordance with Article VI, any balances in the limited Participant's Healthcare Flexible Spending Account may be used during such Plan Year to reimburse the limited Participant for any allowable medical expenses incurred during the portion of the Plan Year in which the Employee was a full Participant in the Plan, provided that any claims are submitted within the grace period. Lastly, a Health Savings Account Beneficiary may continue to request reimbursement for medical expenses incurred during the period of previous Eligibility, or may rollover such amounts to another Health Savings Account as set forth under Code Section 223 and Article X below.

Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he/she otherwise satisfies the participation requirements set forth in this Article II as if he/she were a new Employee and made an election in accordance with Section 5.1.

2.6 FAMILY AND MEDICAL LEAVE ACT OF 1993

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's Benefits under this Plan on the same terms and conditions as though he/she were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent the Employee opts to continue his/her coverage). If the Employee opts to continue his/her coverage, the Employee may pay his/her share of the Premium through one of the following methods:

- a) **Prepayment.** Under the prepayment option, the Participant increases his/her Salary Redirection in an amount sufficient to cover the Premiums and other expenses that will come due during the FMLA leave.
- b) **Pay-as-you go.** With the pay-as-you-go option, the Participant shall continue to pay Premiums on a regular basis throughout the FMLA leave. If the Participant continues to receive a salary while on FMLA leave, the applicable Premiums are to be paid with pre-tax contributions as if they had not taken the leave. On the other hand, if the Participant's FMLA leave is unpaid, the Administrator provides the funding for necessary coverage during the FMLA period, but the Participant is required to reimburse the Employer at regular intervals with after-tax funds for the Premiums that come due during the leave.

- c) **Catch Up.** The Administrator provides the funding for necessary coverage during the leave and subsequently withholds “catch-up” amounts from the Employee’s pay upon his/her return.

Upon return from such leave, that has been or is being paid for under one of the methods referred to above, the Employee will be permitted to re-enter the Plan on the same basis the Employee was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

However, for the Healthcare Flexible Spending Account, if the coverage terminates due to revocation of the Benefit due to nonpayment of contributions by the Participant, two options will be offered upon the Participant’s return to work:

- d) **Proration.** The actual amounts contributed by the Participant would remain in effect for the duration of the Plan Year, but the expenses incurred by the Participant during the lapse in coverage period would not be reimbursable and the maximum contribution amount would be reduced proportionately for the time that the Participant was not paying Premiums.
- e) **Reinstatement.** The Participant may elect to reinstate the level of coverage in effect when the leave began, with applicable contribution amounts being made up for the remainder of the Plan Year. The maximum coverage level will remain in effect from the Participant’s Election, but the Participant cannot submit claims for reimbursement that were incurred during the lapse in coverage period.

Furthermore, if a Participant goes on a qualifying paid leave under the FMLA, to the extent required by the FMLA, the Employee will continue coverage while on FMLA by the method normally used during any paid leave.

In all instances, a paid or unpaid leave under FMLA will be treated in the same manner and consistent with a non-FMLA paid or unpaid leave.

2.7 TERMINATION OF EMPLOYMENT

If a Participant terminates employment with the Employer for any reason other than death, his/her participation in the Plan shall be governed in accordance with the following:

- a) With regard to Benefits that are insured, the Participant’s participation in the Plan shall cease, subject to the Participant’s right to continue coverage under any Insurance Contract for which Premiums have already been paid.
- b) With regard to the Dependent Care Assistance Program, the Participant’s participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related dependent care expense reimbursements for the remainder of the Plan Year in which termination occurs, provided the claims are submitted within the grace period. Reimbursement for such claims will be based on the level of the Participant’s Dependent Care Assistance Account as of the date of termination.
- c) With regard to the Health Savings Account Program, the Participant may be able to take distribution of any remaining Health Savings Account (HSA) balance amounts, or roll over any unused HSA balances to another qualifying Health Savings Account, in accordance with the terms of such other plan and in compliance with Code Section 223.
- d) With regard to the Adoption Assistance Program, the Participant’s participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for qualified adoption expense reimbursements for the remainder of the Plan Year in which termination occurs, provided the claims are submitted within the grace period. Reimbursement of such claims will be based on the level of the Participant’s Adoption Assistance Account as of the date of termination.

- e) With regard to the Healthcare Flexible Spending Account, the Participant may be able to elect to continue participation in the Plan in accordance with final and proposed IRS Regulations and as further provided below:
- 1) COBRA continuation coverage will not be offered to Healthcare Flexible Spending Account Participants under the following circumstances:
 - (a) The Healthcare Flexible Spending Account has a deficit at the time of the Qualifying Event (i.e., if, taking into account all claims submitted on or before the date of the Qualifying Event, the Qualified Beneficiary's remaining Healthcare Flexible Spending Account balance for the Plan Year is less than the maximum required COBRA Premiums for the rest of the year); and
 - (b) The Healthcare Flexible Spending Account is exempt from HIPAA. For purposes of these rules, the Healthcare Flexible Spending Account is exempt from HIPAA if a major medical plan is available in addition to the Healthcare Flexible Spending Account, and the Healthcare Flexible Spending Account benefit does not exceed two times the Salary Redirection or, if greater, the Salary Redirection plus \$500.
 - 2) The Participant can elect to continue participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year in which the Qualifying Event occurs if:
 - (a) The Healthcare Flexible Spending Account is exempt from HIPAA, under the procedures set forth under subparagraph (1)(b) above; and
 - (b) For the Plan Year in which the Qualifying Event occurs, the maximum amount the Qualified Beneficiary could be required to pay for a full year of Healthcare Flexible Spending Account COBRA coverage equals or exceeds the maximum Benefit available to the Qualified Beneficiary for the Plan Year.
 - 3) If the Healthcare Flexible Spending Account is exempt from HIPAA under the procedures set forth under subparagraph (1)(b) above, the Participant's ability to continue coverage under the Healthcare Flexible Spending Account shall cease as of the end of the Plan Year in which the Qualifying Event occurs;
 - 4) If the Healthcare Flexible Spending Account is not exempt from HIPAA, the Participant shall have the ability to continue coverage under the Healthcare Flexible Spending Account under procedures and conditions set forth below.

For purposes of these rules, "Qualifying Event" means the occurrence of any of the following:

- a) Death of a Covered Employee;
- b) Termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment;
- c) Divorce or legal separation of a Covered Employee from the Employee's Spouse;
- d) A Covered Employee's becoming eligible to receive Medicare benefits under Title XVIII of the Social Security Act; or
- e) A Dependent child of a Covered Employee ceasing to be a Dependent.

A "Qualified Beneficiary" is any person who is, as of the day before a Qualifying Event, (i) an Employee of the Employer (including persons who are considered to be "employees" within Code Section 401(c), directors, and independent contractors) covered under a health plan offered under the Plan as of such day (such persons are typically referred to as "Covered Employees"); (ii) the Spouse of the Covered Employee; or (iii) a Dependent of the Covered Employee. A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (other than for gross misconduct) or a reduction of hours of the Covered Employee's employment. A child born or placed for adoption with the Covered Employee during continuation coverage will also be considered as a Qualifying Beneficiary. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will also be treated as a Qualified Beneficiary for purposes of these rules.

The Plan Administrator will notify Healthcare Flexible Spending Account Participants as to their COBRA eligibility (if any). The Plan Administrator shall also notify Healthcare Flexible Spending Account Participants as to their HIPAA rights and responsibilities under Code Section 9801 (including applicable provisions pertaining to HIPAA certification, portability, creditable coverage, and special enrollment procedures) if the Plan is not exempt from HIPAA under Section 2.7(e)(2) above.

If the Participant elects to continue participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year in which such termination occurs, the Participant may continue to seek reimbursement from the Healthcare Flexible Spending Account. The Participant shall be required to make contributions to the account based on the elections made prior to the beginning of the Plan Year.

If the Participant does not elect to continue participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year in which such termination occurs, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses incurred during the portion of the Plan Year preceding his/her date of termination, provided the claims are submitted within the grace period. In the event a Participant terminates participation in the Healthcare Flexible Spending Account during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or Benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

2.8 DEATH OF A PARTICIPANT

If a Participant dies during any Plan Year and at the time of death he/she has not received the total reimbursements available for the Plan Year, the Participant's surviving Spouse, children, or legal representatives can continue to submit claims for expenses incurred during the Plan Year pursuant to COBRA provisions stated in Section 2.7. In addition, the Spouse or other qualifying legal representatives shall have other rights to the remaining Health Savings Account balance in accordance with Code Section 223(h)(8) and as directed under Section 10.13 below. A Participant may designate a specific Beneficiary for this purpose. If no such Beneficiary is specified, the Administrator may designate the Participant's Spouse, a Dependent, or a representative of his/her estate.

ARTICLE III

CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

If a Participant's Employer Contribution to this Plan is not sufficient to cover the cost of Benefits or Premium Expenses being provided and elected pursuant to Article IV, the Participant's Compensation will be reduced in an amount equal to the difference between the cost of Benefits he/she elected and the amount of Employer Contribution available to the Participant. Such reduction in Compensation shall be his/her Salary Redirection, which the Employer will use on behalf of the Participant, together with his/her Employer Contribution, to pay for the Benefits elected by the Participant. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year.

Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's Entry Date up to and including the last day of the Plan Year. These contributions shall be converted to Flexible Benefits Plan Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election and/or Salary Redirection Agreement with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Employer Contribution and Salary Redirection to provide the Benefits elected by the affected Participants.

Any contributions made or withheld from an Employee's Compensation, pursuant to the Employee's signed Salary Redirection Agreement for the Healthcare Flexible Spending Account, Dependent Care Assistance Account, Adoption Assistance Account, Tax-free Transportation Program, or Health Savings Account shall be credited to such account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Healthcare Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 3.1.

ARTICLE IV

BENEFITS

4.1 BENEFIT OPTIONS

Upon becoming a Participant prior to each Plan Year, a Participant must allocate his/her Flexible Benefits Plan Dollars, and Salary Redirection amounts, if any, among the Plan of Benefit Options indicated in the Employer's Adoption Agreement.

4.2 HEALTHCARE FLEXIBLE SPENDING ACCOUNT BENEFIT

If selected as an available Benefit Option under the Employer's Adoption Agreement, each Participant may elect coverage under the Healthcare Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE ASSISTANCE PROGRAM BENEFIT

If selected as an available Benefit Option under the Employer's Adoption Agreement, each Participant may elect coverage under the Dependent Care Assistance Program option, in which case Article VII shall apply.

4.4 ADOPTION ASSISTANCE PROGRAM BENEFIT

If selected as an available Benefit Option under the Employer's Adoption Agreement, each Participant may elect coverage under the Adoption Assistance Program option, in which case Article VIII shall apply.

4.5 INSURANCE BENEFIT

- a) Each Participant may elect to be covered under the Employer's Insurance Contract(s) selected in the Employer's Adoption Agreement for the Participant, his/her Spouse, and his/her Dependents. The Employer may select suitable Insurance Contracts for use in providing his/her health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit. The rights and conditions with respect to the benefits payable from such Insurance Contract shall be determined therein, and such Insurance Contract shall be incorporated herein by reference.
- b) In the alternative to being covered under the Employer's Insurance Contract(s) for health insurance, the Participant may choose to purchase separate, individual insurance coverage, with the payment for such coverage being made from the Participant's Premium Expense Reimbursement Account as a payment or reimbursement to the Participant upon substantiation of the payment of applicable insurance Premium amount. The amount that shall be allocated for this Benefit, if selected, is an amount equal to the Premium otherwise payable by the Participant for coverage of the Participant and the Participant's Spouse or other Dependent(s), if applicable. However, no payment or other type of reimbursement will be made for such coverage if the Participating Employee under this Plan is not the named Insured under the other privately held individual health insurance policy. Moreover, payment shall not be made for any coverage obtained through a Spouse's employment. The cost of such other coverage shall also only be paid or reimbursed on adequate proof of coverage that is provided to the Plan Administrator.

4.6 CASH BENEFIT

To the extent that a Participant elects to have less than the maximum amount of his/her Compensation contributed as a pre-tax Contribution or after-tax Contribution hereunder, such amount not contributed to the Plan as an allowable pre-tax Benefit option shall be paid to the Participant in the form of regular Compensation that is subject to applicable withholding and other employment tax obligations.

If, before the end of the applicable Election Period but after choosing Benefit options, some of a Participant's Flexible Benefits Plan Dollar or Salary Redirection amounts are not applied toward available Benefits (other than Vacation Conversion), then such amounts not so applied shall be forfeited to the Plan or paid to the Participant as additional cash Compensation, subject to any applicable limitations, as determined by the Employer's Adoption Agreement.

With the exception of the applicable cost of any Insurance Premium that will be automatically paid for on a pre-tax basis through use of Flexible Benefits Plan Dollars, or as otherwise set forth under Section 3.1 above (unless the Participant elects otherwise), if a Participant fails to make any election of Benefit options or does not elect any Salary Redirections, such Participant shall be deemed to have chosen the Cash benefit as his/her sole Benefit option. Participants deemed to have chosen the Cash benefit as their sole Benefit option shall have their Participant Flexible Benefits Plan Dollars applied in the form of regular Compensation in such amount and in the manner specified in the Employer's Adoption Agreement.

4.7 NONDISCRIMINATION REQUIREMENTS

- a) It is the intent of this Plan to provide Benefits to a classification of employees that the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.
- b) It is the intent of this Plan not to provide Qualified Benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, "Qualified Benefits" do not include: 1) any separate payment of Insurance Premiums by the Employer that are not paid for through this Plan, or 2) any Benefits to Key Employees that (without regard to this paragraph) would be includable in gross income.
- c) If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or nontaxable Benefits in order to assure compliance with this Section. Any action taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or nontaxable Benefits, it shall be done in the following manner. First, the nontaxable Benefits of the affected Participant (either an Employee who is Highly Compensated or a Key Employee, whichever is applicable) who has elected the highest amount of nontaxable Benefits for the Plan Year shall have his/her nontaxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his/her nontaxable Benefits equals the nontaxable Benefits of the affected Participant who has elected the second highest amount of nontaxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among non-Insurance Benefits, and once all non-Insurance Benefits are expended, proportionately among delineated Benefits. Insurance contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.
- d) If the Employer has elected in the Employer's Adoption Agreement to adopt a "Simple Cafeteria Plan" within the meaning of Section 125(j) of the Internal Revenue Code of 1986, as amended, and the Employer satisfies the eligibility and contribution requirements for implementing such a plan, this Plan shall be treated as satisfying the nondiscrimination requirements set forth in this Section 4.7.

4.8 TAX-FREE TRANSPORTATION PROGRAM BENEFIT

If selected as an available Benefit option under the Employer's Adoption Agreement, each Participant may elect coverage under the Tax-Free Transportation Program option, in which case Article IX shall apply.

4.9 HEALTH SAVINGS ACCOUNT PROGRAM BENEFIT

If selected as an available Benefit option under the Employer's Adoption Agreement, each Eligible Individual may elect coverage under the Health Savings Account Program option, in which case Article X shall apply.

ARTICLE V

PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he/she elects to do so before his/her Effective Date of participation pursuant to Section 2.2, or for a newly eligible Employee, no more than 30 days after their date of hire. For any such newly eligible Employee, if coverage is effective as of the date of hire pursuant to Section 2.1 above, such Employee shall be eligible to participate retroactively as of their date of hire. Newly eligible Employee Election amounts will be collected on the first pay period on or after his/her election was received. However, if such employee does not complete an application to participate and Benefit election form and deliver it to the Administrator before such date, his/her Election Period shall extend 30 calendar days after such date, or for such further period as the Administrator shall determine and apply on a uniform and nondiscriminatory basis. However, any election during the extended 30-day election period pursuant to this Section 5.1 shall not be effective until the first pay period following the later of such Participant's Effective Date of participation pursuant to Section 2.2 or the date of the receipt of the election form by the Administrator, and shall be limited to the Benefit expenses incurred for the balance of the Plan Year for which the election is made.

5.2 SUBSEQUENT ANNUAL ELECTIONS

With the exception of an Insurance Benefit or a Tax-Free Transportation Program premium election that is made as of the initial enrollment in the Plan without being required to make a new annual election during the Election Period for each subsequent Plan Year and subject to the following conditions with respect to other Benefits that the Participant can provide for payment under this Plan, each Participant shall be given the opportunity to annually elect, on an election of Benefits form to be provided by the Administrator, which Benefit options he/she wishes to select and purchase with his/her Flexible Benefits Plan Dollars. Any such election shall be effective for any Benefit expenses incurred during the Plan Year, which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

- a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;
- b) A Participant may terminate participation in the Plan by notifying the Administrator in writing during the Election Period that he/she does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;
- c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, or until a change in status event pursuant to Section 5.4 would justify an earlier mid-year election change.

5.3 FAILURE TO ELECT

Any Participant failing to complete an election of Benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year for the Healthcare Reimbursement, Dependent Care Assistance, Adoption Assistance Benefit, and/or Health Savings Account. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year, until a change in status event pursuant to Section 5.4 would justify an earlier mid-year election change. Elections under the Insurance Benefit or Tax-free Transportation Program shall remain in effect for such subsequent Plan Year.

5.4 CHANGE OF ELECTIONS

- a) With the exception of any specific circumstances otherwise described below, any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, 1) a change in status occurs, and 2) the requested revocation and new election satisfy the consistency requirements in Section 5.5. Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For this purpose, a change in status includes the following events:
- 1) **Legal Marital Status.** Events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation, or annulment;
 - 2) **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
 - 3) **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or returns from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment under this subsection. Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status;
 - 4) **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements.** An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance;
 - 5) **Residency:** A change in the place of residence of the Participant, Spouse, or Dependent;
 - 6) **Special requirements** concerning the Family and Medical Leave Act (FMLA) and the Health Insurance Portability and Accountability Act (HIPAA); and
 - 7) **Other.** Such other events that the Administrator (in its sole discretion) determines to be consistent with and attributable to a change in status. Additional proof may be required by the Administrator to support any change of status election submitted by a Participant.
- b) The Participant may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f).
- c) If the change in status is due to a change in the Participant's marital status, under item 1) above, or a change in employment status of the Participant's Spouse or covered Dependents under item 3) above, the Participant may elect to increase or decrease group-term life coverage and/or group disability coverage corresponding with that change in status.
- d) In the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child:
- 1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's Plan; or

- 2) **Error! No document variable supplied.**The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child and such coverage is actually provided.
- e) A Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). Further, if the Participant or the Participant's Spouse or Dependent that has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.
- f) A Participant may make a prospective election change to add group health coverage for the Participant or the Participant's Spouse or Dependent if such individual(s) lose coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a medical care program of an Indian Tribal government (as defined in Code Section 7701 (a) (40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable benefit package option(s).
- In addition, to the extent permitted under the Children's Health Insurance Program Reauthorization Act of 2009, an Eligible Employee may enroll and a Participant may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), in the event that either (i) the Employee or his Dependent is covered under a plan offered under Medicaid or a State Children's Health Insurance Program (SCHIP) established under Title XXI of the Social Security Act and such coverage is terminated as the result of a loss of eligibility, or (ii) the Employee or Dependent becomes eligible for a state premium assistance subsidy from a plan offered under Medicaid or through a SCHIP). In either case, the Employee must meet the 60 day notice requirements imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.
- g) If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments; or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage; or drop coverage prospectively if there is no other benefit package option available that provides similar coverage. This Plan treats coverage by another employer, such as a Spouse's or Dependent's employer, as similar coverage.
- h) If the cost of a Benefit provided under the Plan decreases significantly during a Plan Year, the Administrator shall permit the affected Participants to either make corresponding changes in their payments; and employees who are otherwise eligible under the Plan may elect the benefit package option, subject to the terms and limitations of the benefit package option.
- i) If the coverage under a Benefit is significantly curtailed and such curtailment results in a loss of coverage, or ceases during a Plan Year, any affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another Plan with similar coverage or drop coverage prospectively if there is no other benefit package option available that provides similar coverage.

- j) If the coverage under a Benefit is significantly curtailed and such curtailment does not result in a loss of coverage, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another Plan with similar coverage.
- k) If, during the period of coverage, a new benefit package option or other coverage option is added (or an existing benefit package option or other coverage option is eliminated), or a significantly improved existing benefit package option is added, then the affected Participants and employees who are otherwise eligible under the Plan may elect the newly added or significantly improved option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
- l) A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's, or Dependent's employer if 1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's, or Dependent's employer permits its Participants to make a change; or 2) the cafeteria plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's, or Dependent's employer.
- m) A cost change is allowable in the Dependent Care Assistance Program only if the cost change is imposed by the dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8). A cost change is allowable in the Adoption Assistance Program if there is the commencement or termination of an adoption proceeding. However, a Participant shall not be permitted to change an election to the Healthcare Flexible Spending Account as a result of a cost or coverage change under this subsection.
- n) Generally, the termination of employment by a Participant shall not be considered a change in status. Therefore, upon termination, such Participant shall not be entitled to change existing Benefit elections. Rather, such termination shall constitute a revocation of all existing Benefit elections, except with regard to the Healthcare Flexible Spending Account, in which case the Participant's election shall be governed by Section 2.7.
- o) Notwithstanding any other provision of this Plan, the Administrator may 1) permit a Participant to revoke (and subsequently reinstate) his/her election of one or more Benefit coverages under the Plan and 2) adjust a Participant's Compensation redirection as a result of a revocation or reinstatement to the extent the Administrator deems necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1993 and any Regulations pertaining thereto.

5.5 CONSISTENCY REQUIREMENT

- a) A Participant's requested revocation and new election will be consistent with a change in status 1) if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a Plan of the Employer or under a Plan maintained by the employer of the Participant's Spouse or Dependent, and 2) with respect to dependent care assistance, if the election change is on account of and corresponds with a change in status that affects expenses described in Code Section 129 (including employment-related expenses defined in Code Section 21(b)(2)). A change in status election is not consistent if the change in status is due to the Participant's divorce, annulment, or legal separation from a Spouse; the death of a Spouse or Dependent; or a Dependent ceases to satisfy the eligibility requirements for coverage, yet the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. Likewise, if the Participant, Spouse, or Dependent gains eligibility for coverage under a family member plan as a result of a change in marital status or a change in employment status, then a Participant's election under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

- b) Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage.

ARTICLE VI

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Healthcare Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury Regulations thereunder. Participants who elect to participate in this Healthcare Flexible Spending Account may submit claims for the reimbursement of medical expenses. All amounts reimbursed under this Healthcare Flexible Spending Account shall be periodically paid from amounts allocated to the Participant's Healthcare Flexible Spending Account. Periodic payments reimbursing Participants from the Healthcare Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefits Plan, the terms below have the following meaning:

- a) **"Healthcare Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Flexible Benefits Plan Dollars may be allocated and from which all allowable medical expenses may be reimbursed.
- b) **"Healthcare Flexible Spending Account Plan"** means the Plan of Benefits contained in this Article, which provides for the reimbursement of eligible medical expenses incurred by a Participant or his/her Dependents.
- c) **"Highly Compensated Employee"** means for the purpose of this Article and determining discrimination under Code Section 105(h) a Participant who is:
 - 1) One of the five highest paid officers;
 - 2) A shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
 - 3) Among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).
- d) **"Incurred"** means a medical expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed for, charged for, or pays for the medical care.
- e) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury Regulations thereunder, and not otherwise used by the Participant as a deduction in determining his/her tax liability under the Code. However, a Participant may not be reimbursed for the cost of other health coverage such as Premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his/her Spouse or Dependent.

Furthermore, a Participant may not be reimbursed for “qualified long-term care services” as defined under Code Section 7702B.

Effective January 1, 2011, over-the-counter drug expenses shall not be reimbursed under the Plan, except as permitted by law.

- f) The definitions in Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Healthcare Flexible Spending Account.

6.3 FORFEITURES

The amount in the Healthcare Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 11.2.

6.4 LIMITATION ON ALLOCATIONS

Effective January, 1 2012, notwithstanding any provision contained in this Healthcare Flexible Spending Account to the contrary, the maximum amount cannot exceed the IRS amount set forth for each calendar year. For example, the maximum amount allowed for each employee in 2013 is \$2,500. The \$2,500 limit will be indexed for cost-of-living adjustments for plan years beginning after December 31, 2013. The \$2,500 limit applies only to employee salary deduction contributions to health FSAs. It does not take into consideration salary reductions to other benefits such as dependent care assistance, adoption benefits or insurance premium accounts. The new limit does not apply to health savings accounts (HSAs) or health reimbursement arrangements (HRAs). A Limit applies on an employee-by-employee basis. Married couples, dependents or adult children working for the same company may each elect the \$2,500 maximum. One person working for multiple companies, that are not members of a controlled group, may elect the \$2,500 maximum for each employer’s health FSA benefit. Controlled groups are counted as one employer. The limit is not based on underlying insurance coverage. For instance, participants with family insurance coverage may not elect more than those with single insurance coverage. Cafeteria plans that provide for a “grace period” following the end of any plan year need not worry about exceeding the \$2,500 statutory limit if leftover contributions are rolled forward into the following plan year. The funds carried forward into the grace period do not count against the \$2,500 limit applicable for the subsequent plan year.

6.5 NONDISCRIMINATION REQUIREMENTS

- a) It is the intent of this Healthcare Flexible Spending Account not to discriminate in violation of the Code and the Treasury Regulations thereunder.
- b) If the Administrator deems it necessary to avoid discrimination under this Healthcare Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Healthcare Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Sections 105 or 125 that elected to contribute the highest amount of the account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the account equals the amount designated for the account by the next member of the group in whose favor discrimination may not occur pursuant to Code Sections 105 or 125 who has elected the second highest contribution to the Healthcare Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions, which are not utilized to provide Benefits

to any Participant by virtue of any administrative act under this paragraph, shall be forfeited and credited to the benefit plan surplus.

- c) If the Employer has elected in the Employer's Adoption Agreement to adopt a "Simple Cafeteria Plan" within the meaning of Section 125(j) of the Internal Revenue Code of 1986, as amended, and the Employer satisfies the eligibility and contribution requirements for implementing such a plan, this Plan shall be treated as satisfying the nondiscrimination requirements set forth in this Section 6.5.

6.6 COORDINATION WITH FLEXIBLE BENEFITS PLAN

All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Healthcare Flexible Spending Account. The enrollment and termination of participation under the Flexible Benefits Plan overall shall constitute enrollment and termination of participation under this Healthcare Flexible Spending Account Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan overall.

6.7 HEALTHCARE FLEXIBLE SPENDING ACCOUNT CLAIMS

- a) All Medical Expenses incurred by a Participant shall be reimbursed during the Plan Year subject to Sections 2.5 through 2.8, even though the submission of such a claim occurs after his/her participation hereunder ceases; but provided that the medical expenses were incurred during the applicable Plan Year.
- b) The Administrator shall direct the reimbursement to each eligible Participant for all allowable medical expenses, up to a maximum of the amount designated by the Participant for the Healthcare Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Flexible Benefits Plan Dollars which have been allocated to the account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any healthcare plan covering the Participant and/or the Participant's Spouse or Dependents.
- c) Claims for the reimbursement of medical expenses incurred in any Plan Year shall be paid within 30 days after receipt by the Administrator; provided however, that if a Participant fails to submit a claim within the 60-day period immediately following the end of the Plan Year or the 30-day period immediately following a Participant's date of termination, those medical expense claims shall not be considered for reimbursement by the Administrator.

Unless payment arrangements are as directed within this paragraph or as otherwise specified below, reimbursement payments under this Plan shall be made directly to the Participant. However, at the Administrator's discretion, payments may also be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt for the service. The application shall include a written statement from an independent third party stating that the medical expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the medical expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Healthcare Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such statements and applications.

6.8 ALLOWABLE ROLLOVERS FOR QUALIFIED HSA DISTRIBUTIONS

If otherwise allowable in accordance with the Employer's Adoption Agreement and effective as of the first Plan Year elected therein, a Participant may request a one-time Qualified HSA Distribution of amounts remaining in the Participant's Account in the Plan as of the last day of the Plan Year, subject to a maximum distribution that is the lesser of the amount in the

Participant's Account as of September 21, 2006, or the end of the Plan Year for which the distribution is being requested. In such circumstances, upon receipt of a written election by the Participant to request a Qualified HSA Distribution that is otherwise allowable, the Administrator shall distribute such amounts directly to the HSA trustee or custodian. After such distribution is made, the Participant's Healthcare Flexible Spending Account shall be considered as being a zero balance for that Plan Year and no further claims may be submitted or paid as of that date under the Plan for that period regardless of whether such claims were submitted or incurred, received or otherwise under review prior to that date.

ARTICLE VII

DEPENDENT CARE ASSISTANCE PROGRAM

7.1 ESTABLISHMENT OF PROGRAM

This Dependent Care Assistance Program is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of employment-related dependent care expenses. All amounts reimbursed under this Dependent Care Assistance Program shall be periodically paid from amounts allocated to the Participant's Dependent Care Assistance Account.

7.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefits Plan, the terms below shall have the following meaning:

- a) **"Dependent Care Assistance Account"** means the account established for a Participant pursuant to this Plan to which part of their Flexible Benefits Plan Dollars may be allocated and from which all employment-related dependent care expenses of the Participant may be reimbursed.
- b) **"Dependent Care Assistance Program"** means the program of Benefits contained in this Article, which provides for the reimbursement of eligible expenses for the care of the Qualifying Dependents of Participants.
- c) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.
- d) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services, which if paid by the Participant, would be considered employment-related expenses under Code Section 21(b)(2).

Generally, they shall include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there is one or more Qualifying Dependents with respect to such Participant. The determination of whether an amount qualifies as an employment-related dependent care expense shall be made subject to the following rules:

- 1) If such amounts are paid for expenses incurred outside of the Participant's household, they shall constitute employment-related dependent care expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(f)(1) (or deemed to be, pursuant to Section 7.2(f)(3)), or for a Qualifying Dependent as defined in Section 7.2(f)(2) (or deemed to be, pursuant to Section 7.2(f)(3)) who regularly spends at least 8 hours per day in the Participant's household;

- 2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable State and local laws and regulations, including licensing requirements, if any; and
 - 3) Employment-related dependent care expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a dependent of such Participant or such Participant's Spouse.
- e) **"Highly Compensated Employee"** means an Employee who is a Highly Compensated Employee within the meaning of Code Section 414(q) and the Treasury Regulations thereunder.
 - f) **"Qualifying Dependent"** means, for Dependent Care Assistance Program purposes,
 - 1) A Dependent (as defined under Code Section 152(a)(1) who is under the age of 13;
 - 2) A Qualifying Child, a Qualifying Relative or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of residence as the Participant for more than one-half of year; or
 - 3) A Dependent that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).
 - g) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Program.

7.3 DEPENDENT CARE ASSISTANCE ACCOUNTS

The Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to apply Flexible Benefits Plan Dollars to Dependent Care Assistance Program Benefits.

7.4 INCREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be increased each pay period by the portion of Flexible Benefits Plan Dollars that he/she has elected to apply toward his/her Dependent Care Assistance Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance Account shall be reduced by the amount of any employer-related dependent care expense reimbursements incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE ASSISTANCE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Assistance Account, a Participant who incurs employment-related dependent care expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he/she is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

By February 1 of each calendar year, the Employer shall furnish to each Employee who was a Participant and received Benefits under Section 7.6 during the prior calendar year, a statement of all such Benefits paid to or on behalf of such Participant during the prior calendar year.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Assistance Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 11.2.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or (\$5,000 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)) or such lesser or greater amount as determined by the Department of Treasury.

7.10 NONDISCRIMINATION REQUIREMENTS

- a) It is the intent of this Dependent Care Assistance Program that contributions or Benefits not discriminate in favor of Highly Compensated Employees or their Dependents, as prohibited by Code Section 129(d).
- b) It is the intent of this Dependent Care Assistance Program that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.
- c) If the Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Employees defined under Section 7.2(e) or to principal shareholders or owners as set forth in this Section, it may, but shall not be required to, reject any elections or reduce contributions or nontaxable Benefits in order to assure compliance with this Section. Any action taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Assistance Account by the Highly Compensated Employee that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the Highly Compensated Employee who has elected the second highest contribution to the Dependent Care Assistance Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph, shall be forfeited.
- d) If the Employer has elected in the Employer's Adoption Agreement to adopt a "Simple Cafeteria Plan" within the meaning of Section 125(j) of the Internal Revenue Code of 1986, as amended, and the Employer satisfies the eligibility and contribution requirements for implementing such a plan, this Plan shall be treated as satisfying the nondiscrimination requirements set forth in this Section 7.10.

7.11 COORDINATION WITH FLEXIBLE BENEFITS PLAN

All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Dependent Care Assistance Program. The enrollment and termination of participation under the Flexible Benefits Plan shall constitute enrollment and termination of participation under this Dependent Care Assistance Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan.

7.12 DEPENDENT CARE ASSISTANCE PROGRAM CLAIMS

The Administrator shall direct the payment of all such Dependent Care Assistance claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, at the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for employment-related dependent care expenses submit a statement, which may contain some or all of the following information:

- a) The Dependent or Dependents for whom the services were performed;
- b) The nature of the services performed for the Participant, the cost of each he/she wishes reimbursement;
- c) The relationship, if any, of the person performing the services to the Participant;
- d) If the services are being performed by a child of the Participant, the age of the child;
- e) A statement as to where the services were performed;
- f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
- g) If the services were being performed in a daycare center, a statement
 - 1) That the daycare center complies with all applicable laws and regulations of the state of residence,
 - 2) That the daycare center provides care for more than six individuals (other than individuals residing at the center), and
 - 3) Of the amount of fee paid to the provider.
- h) If the Participant is married, a statement containing the following:
 - 1) The Spouse's salary or wages if he/she is employed, or
 - 2) If the Participant's Spouse is not employed, that
 - (a) He/she is incapacitated, or
 - (b) He/she is a full-time student attending an educational institution and the months during the year which he/she attended such institution.

- i) If a Participant fails to submit a claim within the 60-day period immediately following the end of the Plan Year, the Administrator shall not consider those claims for reimbursement.
- j) All Dependent Care Assistance claims incurred by a Participant shall be reimbursed during the Plan Year subject to Sections 2.5 through 2.8 of the Plan, even though the submission of such a claim occurs after his/her participation hereunder ceases, provided that the Dependent Care Assistance Expenses were incurred during the applicable Plan Year.
- k) The Administrator shall direct the reimbursement to each eligible Participant for all allowable employment-related dependent care expenses, up to a maximum of the amount designated by the Participant for the Dependent Care Assistance Program for the Plan Year. Reimbursements shall be made available to the Participant throughout the year up to the level of Flexible Benefits Plan Dollars which have been allocated to the account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any Dependent Care Assistance Plan covering the Participant and/or the Participant's Spouse or Dependents.

Furthermore, the Participant shall provide a written statement that the Dependent Care Assistance Expense has not been reimbursed or is not reimbursable under any other Dependent Care Assistance Plan coverage and, if reimbursed from the Dependent Care Assistance Program, such amount will not be claimed as a tax credit. The Administrator shall retain a file of all such applications.

ARTICLE VIII

ADOPTION ASSISTANCE PROGRAM

8.1 ESTABLISHMENT OF PROGRAM

This Adoption Assistance Program is intended to qualify as a program under Code Section 137 and shall be interpreted in a manner consistent with such Code Section. The purpose of this Program is to reimburse such Participants for all or a portion of the cost of adopting a child. Participants who elect to participate in this program may submit claims for the reimbursement of qualified adoption expenses. All amounts reimbursed under this Adoption Assistance Program shall be periodically paid from amounts allocated to the Participant's Adoption Assistance Account.

8.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefits Plan, the terms below shall have the following meaning:

- a) **"Adoption Assistance Account"** means the account established for a Participant pursuant to this Plan to which part of their Flexible Benefits Plan Dollars may be allocated to the reimbursement of qualified adoption expenses.
- b) **"Adoption Assistance Program"** means the program of Benefits contained in this Article, which provides for the reimbursement of qualified adoption expenses in connection with the adoption of a child by Participants.
- c) **"Child with Special Needs"** means any child if:
 - 1) A State has determined that the child cannot or should not be returned to the home of his parents;

- 2) Such State has determined that there exists, with respect to the child, a specific factor or condition (such as his/her ethnic background, age, or membership in a minority or sibling group; or the presence of factors such as handicaps) because of which it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance; and
 - 3) Such child is a citizen or resident of the United States (as defined in Section 217(h)(3)).
- d) **“Earned Income”** means earned income as defined under Code Section 32(c)(2), as amended, but excluding such amounts paid or incurred by the Employer for adoption assistance to the Participant.
 - e) **“Eligible Child”** means any individual who has not attained the age of 18, or is physically or mentally incapable of caring for himself, including a child with special needs, as determined under Code Section 36C(d)(2).
 - f) **“Foreign Adoption”** means the adoption of a child who is not a citizen or resident of the United States (as defined in Code Section 217(h)(3)) when the adoption proceedings begin.
 - g) **“Highly Compensated Employee”** means an Employee who is a Highly Compensated Employee within the meaning of Code Section 414(q) and the Treasury Regulations thereunder.
 - h) **“Modified Adjusted Gross Income (Modified AGI)”** means Adjusted Gross Income as defined in Code Section 62, with adjustments and application of Code Section 137(b)(3).
 - i) **“Qualified Adoption Expenses”** means the amounts incurred for expenses of a Participant for those services, which if paid by the Participant would be considered qualified adoption expenses under Code Section 36C(d)(1). Generally, they shall include reasonable and necessary adoption fees, court costs, attorney fees, and other expenses that are:
 - 1) Directly related to, and the principal purpose of which is for, the legal adoption of an eligible child by the Participant;
 - 2) Not incurred in violation of State or Federal law or in carrying out any surrogate parenting arrangement;
 - 3) Not expenses in connection with the adoption by an individual of a child who is the child of such individual’s Spouse; and
 - 4) Not reimbursed under any other employer program or a credit allowance, as described under Code Section 36C, or otherwise.

The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Adoption Assistance Program.

8.3 ADOPTION ASSISTANCE ACCOUNTS

The Administrator shall establish an Adoption Assistance Account for each Participant who elects to apply Flexible Benefits Plan Dollars to Adoption Assistance Program Benefits.

8.4 INCREASES IN ADOPTION ASSISTANCE ACCOUNTS

A Participant's Adoption Assistance Account shall be increased each pay period by the portion of Flexible Benefits Plan Dollars that the Participant has elected to apply toward his/her Adoption Assistance Account pursuant to elections made under Article V hereof.

8.5 DECREASES IN ADOPTION ASSISTANCE ACCOUNTS

A Participant's Adoption Assistance Account shall be reduced by the amount of any qualified adoption expense reimbursements incurred on behalf of a Participant pursuant to Section 8.13 hereof.

8.6 ALLOWABLE ADOPTION ASSISTANCE REIMBURSEMENT

Subject to limitations contained in Sections 8.9 and 8.10 of this Program, and to the extent of the amount contained in the Participant's Adoption Assistance Account, a Participant who incurs qualified adoption expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he/she is a Participant.

8.7 ANNUAL STATEMENT OF BENEFITS

By February 1 of each calendar year, the Employer shall furnish to each Employee who was a Participant and received Benefits under Section 8.6 during the prior calendar year, a statement of all such Benefits paid to or on behalf of such Participant during the prior calendar year.

8.8 FORFEITURES

The amount in a Participant's Adoption Assistance Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 8.13 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 11.2.

8.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Adoption Assistance Account in or on account of any taxable year of the Participant shall not exceed \$13,700 (as adjusted for inflation, in accordance with Code Section 137(f)) for each effort to adopt an Eligible Child. The amount is the maximum amount of qualified adoption expenses taken into account over all taxable years. Therefore, the \$13,700 must be reduced by the amount of qualified adoption expenses taken into account in previous taxable years for the same adoption effort. For purposes of the adoption of a Child with Special Needs, the \$13,700 limit shall be without regard to actual qualified adoption expenses. In the case of Foreign Adoption circumstances, qualifying adoption expenses shall not be excluded from income until the taxable year in which the adoption becomes final.

8.10 LIMITATION OF INCOME

Notwithstanding any provision contained in the Article to the contrary, if applicable, amounts paid from a Participant's Adoption Assistance Account in or on account of any taxable year of the Participant shall not only be limited, in accordance with the provisions of Section 8.9 above, but may also be reduced (but not below zero) by a percentage amount prescribed

by Code Section 137(b), as amended, that increases in percentage reduction based on any increases in Modified Adjusted Gross Income (AGI) over the amounts specified under Code Section 137(b)(2).

8.11 NONDISCRIMINATION REQUIREMENTS

It is the intent of this Adoption Assistance Program that the Program shall benefit all Eligible Employees in a nondiscriminatory manner that is in accordance with Code Section 137(C)(2)(b). It is the intent of this Adoption Assistance Program that not more than 5 percent of the amounts paid or incurred by the employer for adoption assistance during the year may be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents) each of whom (on any day of the year) owns more than 5 percent of the stock or the capital or profits interest in the employer.

If the Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Employees defined under Section 8.2(g) or to principal shareholders or owners as set forth in this Section, it may, but shall not be required to, reject any elections or reduce contributions or nontaxable Benefits in order to assure compliance with this Section. Any action taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. Contributions, which are not utilized to provide Benefits to any Participant by virtue of any administrative action under this paragraph, shall be forfeited.

8.12 COORDINATION WITH FLEXIBLE BENEFITS PLAN

All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Adoption Assistance Program. The enrollment and termination of participation under the Flexible Benefits Plan shall constitute enrollment and termination of participation under this Adoption Assistance Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan.

8.13 ADOPTION ASSISTANCE PROGRAM CLAIMS

- a) With the exception of Foreign Adoption situations, all qualified adoption expenses incurred by a Participant shall be reimbursed during the Plan Year subject to Sections 2.5 through 2.8 of the Plan, even though the submission of such a claim occurs after his/her participation hereunder ceases, provided that the qualified adoption expenses were incurred during the applicable Plan Year.
- b) The Administrator shall direct the reimbursement to each eligible Participant for all allowable qualified adoption expenses, up to the lesser of the maximum of the amount designated by the Participant for the Adoption Assistance Account for the Plan Year, or the maximum \$13,700 limit per child (as adjusted for inflation). Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any previous payments or other reimbursements previously made under this, or any other, Adoption Assistance Program covering the Participant and/or the Participant's Spouse or Dependents.
- c) Reimbursement payments under this Plan shall be made directly to the Participant. However, at the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt for the service. The application shall include a written statement from an independent third party stating that the qualified adoption expense has been incurred and the amount of such expense.
- d) If a Participant fails to submit a claim within the 60-day period immediately following the end of the Plan Year, the Administrator shall not consider those claims for reimbursement.
- e) The Participant shall provide a written statement that the qualified adoption expense has not been reimbursed or is not reimbursable under any other Adoption Assistance Plan coverage and, if reimbursed

from the Adoption Assistance Account, such amount will not be claimed as a tax credit. The Administrator shall retain a file of all such applications.

ARTICLE IX

TAX-FREE TRANSPORTATION PROGRAM

9.1 ESTABLISHMENT OF PROGRAM

If elected as part of the Employer's Adoption Agreement, the Employer has made available this Tax-Free Transportation Program to provide tax-free transportation Benefits in lieu of otherwise taxable Compensation. It is intended that this Program comply with the requirements of Internal Revenue Code Section 132(f).

9.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefits Plan, the terms below shall have the following meaning (to the extent not inconsistent, all other definitions identified under Article I shall be incorporated by reference):

- a) **"Commuter Highway Vehicle"** means any highway vehicle:
 - 1) Which has a seating capacity of at least six adults (not including the driver), and
 - 2) Of which at least 80% of the mileage use is reasonably expected to be used:
 - 3) For purposes of transporting Employees in connection with travel between their residences and their places of Employment, and
 - 4) On trips during which places the number of Employees transported for such purposes is, on average, at least half of the adult seating capacity of such vehicle (not including the driver).
- b) **"Commuter Highway Vehicle (Van Pool) Expenses"** means expenses incurred for transportation in a Commuter Highway Vehicle if such transportation is in connection with travel between the Employee's residence and place of Employment.
- c) **"Coverage Period"** means the monthly, quarterly, semi-annual, annual, or other period, designated on the Salary Redirection Agreement during which a Salary Redirection Agreement is in effect and irrevocable.
- d) **"Eligible transportation expenses"** means those qualified expenses incurred by the Employee to purchase or pay for Transit Pass Expenses, Commuter Vehicle Expenses, or Qualified Parking Expenses incurred for purposes of transportation between an Employee's residence and place of Employment.
- e) **"Program"** means the Employer's Tax-Free Transportation Program as set forth in its entirety in this document as may be amended from time to time.
- f) **"Program Year"** means the 12-month period beginning and ending on the dates specified in Item (f) of the Adoption Agreement - provided, however, that a period of less than 12 months may be a Program Year for the initial and final Program Year, and a transition period to a different Program Year. The Program Year shall be the coverage period for the eligible transportation expenses provided under this Program. In the event a Participant commences participation during a Program Year, then the initial coverage period

shall be that portion of the Program Year commencing on such Participant's date of entry and ending on the last day of such Program Year.

- g) **"Qualified Parking Expenses"** means the following parking expenses, unless such expenses are incurred for any parking on or near property used by the Employee for residential purposes:
- 1) Expenses incurred by an Employee to park his/her car on or near the business premises of the Employer; or
 - 2) Expenses incurred by an Employee to park his/her car on or near a location from which the Employee commutes to work:
 - (a) By mass transit facilities, whether or not publicly owned;
 - (b) By using the services of any person in the business of transporting persons for compensation or hire, if such transportation is provided in a Commuter Highway Vehicle, as defined in this Program;
 - (c) By Commuter Highway Vehicle; or
 - (d) By carpool (i.e., two or more individuals who commute together in a motor vehicle on a regular basis).
- h) **"Transit Pass Expenses"** means expenses incurred for any pass, token, fare card, voucher, or similar item entitling a person to transportation (or transportation at a reduced price) if such transportation is:
- 1) Provided by any mass transit facilities, whether or not publicly owned; or
 - 2) Provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver).

9.3 ELECTION OF BENEFITS

Eligible Employees may enter into a Salary Redirection Agreement with the Employer whereby the Employee agrees to reduce his/her unearned Compensation by the amount of his/her anticipated future eligible transportation expenses for the upcoming Coverage Period. The amount elected for reduction will be divided by the remaining payroll periods in the Coverage Period. The resulting per payroll period reduction amount will be deducted on a pre-tax basis from the Employee's Compensation per payroll period until such time as the Employee changes his/her election for an upcoming Coverage Period.

9.4 ACCOUNT

The Administrator will create and maintain a bookkeeping account on behalf of each Employee who enters into a Salary Redirection Agreement, which account will reflect the accumulated amount of Compensation that has been deducted on a pre-tax basis from the Employee's Compensation. When cash reimbursement is made to the Employee for his/her eligible transportation expenses, the balance of said account will be reduced by the amount of the reimbursement. The amount of any reimbursement shall not exceed the accumulated amount in said account at the time of the reimbursement, nor any of the following monthly limitations:

- a) Monthly Limitation for Qualified Parking Expenses. Reimbursements for Qualified Parking Expenses will not exceed the monthly value as set forth in Code Section 32(f)(2)(B), as adjusted for inflation;
- b) Monthly Limitation for Transit Pass Expenses and Commuter Highway Vehicle Expenses. Reimbursements for combined expenses for Transit Pass Expenses and Commuter Highway Vehicle Expenses will not exceed the monthly value as set forth in Code Section 132(f)(2)(A), as adjusted for inflation; and
- c) Special Rules for Transit Passes. A cash reimbursement may not be provided for an employee's mass transit expenses if a voucher (or similar item that may be exchanged only for a transit pass) is readily available to the Employer for direct distribution to Employees. A voucher (or similar item) is readily available if:
 - 1) The Employer can obtain the voucher on terms that are no less favorable than the terms available to an Employee directly, and
 - 2) The Employer does not incur a significant administrative cost in obtaining the voucher. An administrative cost will be determined to be "significant" if the Program Administrator (in its sole discretion) determines that the average administrative cost incurred by the Employer (excluding delivery charges of \$15 or less) is more than one percent (1.0%) of the average monthly value of the vouchers for a particular transit system (i.e., train, bus, subway).

9.5 TIME PERIOD FOR MAKING, MODIFYING, OR REVOKING A SALARY REDIRECTION AGREEMENT

A Salary Redirection Agreement must be made before the earlier of 1) the Coverage Period to which it relates; and 2) the receipt of eligible transportation expense Benefits to which it relates. Such election shall be effective for the first pay period after the Employer processes the change. Once a Salary Redirection Agreement is made, it cannot be changed during the Coverage Period to which it relates. Salary Redirection Agreements may only be changed for future Coverage Periods.

9.6 CARRYOVER OF UNUSED AMOUNT IN ACCOUNT

Any amount in the Employee's Tax-Free Transportation Program Account that has not been used to reimburse the Employee for eligible transportation expenses incurred prior to the end of the Coverage Period to which the Employee's Salary Redirection Agreement applies will be carried over into future Coverage Periods.

9.7 TERMINATION OF AGREEMENT

The Employee's Salary Redirection Agreement shall terminate upon termination or any other discontinuation of employment. Amounts remaining in the Employee's Tax-Free Transportation Program Account will be forfeited.

9.8 EXPENSE SUBSTANTIATION

The Employee may request reimbursement for eligible transportation expenses by submitting in the manner and form approved by the Administrator a record of the expenses incurred, including the usage of established claim payment and substantiation processes set forth under Article XII. However, the Employee shall generally provide information showing that any eligible transportation expenses were in fact incurred by the Employee. The Employee generally must certify in writing the amount paid and the date of the expenses for which reimbursement is requested, as well as submit evidence of such payment (parking receipt, used transit pass, etc.). The information submitted by the Employee may vary depending on the facts and circumstances surrounding the expenses, including the method of payment and the particular transportation method used by the Employee.

9.9 REIMBURSEMENT OF EXPENSES

The Administrator will provide reimbursement of substantiated eligible transportation expenses on an administratively convenient periodic basis and will debit the Employee's Tax-Free Transportation Program Account accordingly, but under no circumstances will the Administrator provide reimbursement for any expense submitted more than 180 days after the date in which the eligible transportation expense was incurred.

ARTICLE X

HEALTH SAVINGS ACCOUNT PROGRAM

10.1 ESTABLISHMENT OF PROGRAM

This Health Savings Account Program (hereinafter the "HSA") is intended to qualify as a program under Code Section 223 and shall be interpreted in a manner consistent with such Code Section. Eligible Individuals who elect to participate in this program may make contributions to the HSA if provided for under the Employer's Adoption Agreement and may submit claims for the reimbursement of eligible HSA Medical Expenses. All amounts reimbursed under this Health Savings Account Program shall be periodically paid from amounts allocated to the Account Beneficiary's Health Savings Account. If elected in the Employer's Adoption Agreement, the Employer shall also make contributions to the HSA as provided for herein, including any provisions related to allowable limits on annual contributions and applicable nondiscrimination standards.

10.2 ADDITIONAL DEFINITIONS

For the purposes of this Article and the Plan, the terms below shall have the following additional meaning from that otherwise provided under Article I:

- a) **"Account Beneficiary"** means a qualifying Participant on whose behalf the Health Savings Account has been established.
- b) **"Eligible Individual"** means an Eligible Employee or Dependent who:
 - 1) Is covered under a qualifying High-Deductible Health Plan, in accordance with requirements set forth under Code Section 223(c)(2), but which may also provide "preventive care," which includes:
 - (a) Periodic health evaluations, including tests and diagnostic procedures ordered or in connection with routine examinations, such as annual physicals;
 - (b) Routine prenatal and well-child care;
 - (c) Child and adult immunizations;
 - (d) Tobacco-cessation programs;
 - (e) Obesity weight-loss programs;
 - (f) Certain screening services and other programs and services as approved by Code Section 223(c)(2)(C) and applicable Treasury Regulations and guidance information.
 - 2) Is not an individual that may be claimed as a Dependent by another person for tax purposes, under Code Section 151; and

- 3) Is not covered under any other health plan, with the exception of any policy or program that only provides coverage for the following:
- (a) Accidents;
 - (b) Disability;
 - (c) Dental;
 - (d) Vision;
 - (e) Long-term care;
 - (f) Or other “permitted insurance” defined under Code Section 223(c)(3), as otherwise amended from time to time, including insurance for a specified disease or illness.

Notwithstanding the above, an individual or his/her Dependents will no longer be considered as an “Eligible Individual” that is entitled to receive additional contributions of Flexible Benefits Plan Dollars to any Health Savings Account under this Plan when such individual becomes enrolled in Medicare Benefits under Title XVII of the Social Security Act. For purposes of this Section and an Employee's status as an “Eligible Individual”, the Plan shall only take into consideration an Employee's participation in a qualifying High-Deductible Health Plan during any applicable Claim Extension Period as otherwise provided for in the Employer's Adoption Agreement and as otherwise allowable under Code Section 223(c)(1)(iii).

- c) **“Health Savings Account Program”** means the program of Benefits contained in this Article, which provides for the payment or reimbursement of eligible expenses for qualifying HSA Medical Expenses of any Account Beneficiary or Beneficiaries.
- d) **“HSA Medical Expenses”** means, unless otherwise provided for under this Plan, the amounts paid by or for an Account Beneficiary for medical care (as defined under Code Section 213(d)) for such individual, his/her Spouse, or any other qualifying Dependent, but only to the extent not compensated by or paid for by insurance, or as otherwise described under Code Section 223(d)(2). HSA Medical Expenses shall also not include the cost of purchasing health insurance unless the purchase of such coverage is related to:
 - 1) Any health insurance paid for during any period of health continuation coverage required under Federal law (COBRA);
 - 2) Any qualifying long-term care Insurance Contract (defined under Code Section 7702B(b)(1));
 - 3) Any health plan coverage provided during any period in which an individual is receiving unemployment compensation under any Federal or State law;
 - 4) Any health insurance coverage (other than Medicare Supplemental Insurance Coverage, as defined under Section 1882 of the Social Security Act) provided under Medicare to any Account Beneficiary who has attained the age specified in Section 1811 of the Social Security Act; or
 - 5) Such other coverages as provided for under Code Section 223(d)(2)(C).
- e) **“Trustee”** means the designated Trustee (as defined under Code Section 223(d)(1)(B)) of any Trust established for qualifying Account Beneficiaries who elect to establish a Health Savings Account as set forth hereunder.

The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Savings Account Program.

10.3 HEALTH SAVINGS ACCOUNTS

The Administrator shall establish a Health Savings Account for each Account Beneficiary who elects to apply Flexible Benefits Plan Dollars, allowable IRA rollovers or Qualified HSA Distributions to Health Savings Account Program Benefits.

10.4 INCREASES IN HEALTH SAVINGS ACCOUNTS

An Account Beneficiary's Health Savings Account shall be increased each pay period by the portion of Flexible Benefits Plan Dollars that he/she has elected to apply toward his/her Health Savings Account pursuant to elections made under Article V hereof, including consideration of any applicable Employer Contribution amounts. The Account Beneficiary's Health Savings Account may also be increased by any rollover amounts that are accepted by this Plan from another qualifying Health Savings Account as otherwise provided for under the Employer's Adoption Agreement, including through the receipt of allowable distributions from an Individual Retirement Account, or Qualified HSA Distributions if received within the period of time and manner set forth under applicable law or any Regulations thereunder. Periodic interest income or other investment earnings accumulations may also be credited to the balance of the Account Beneficiary's Health Savings Account as directed by the Plan, any applicable Trust, the Employer's Adoption Agreement, or other applicable law.

10.5 DECREASES IN HEALTH SAVINGS ACCOUNTS

An Account Beneficiary's Health Savings Account shall be reduced by the amount of any HSA Medical Expenses reimbursements incurred on behalf of an Account Beneficiary pursuant to Section 10.12 hereof. The Account Beneficiary's Health Savings Account may also be reduced by any depreciation in interest earnings or other investment accumulations, to the extent required by the Plan, any applicable Trust, the Employer's Adoption Agreement or other applicable law. The Account Beneficiary's Health Savings Account balance may also be reduced or eliminated by any other distribution made in accordance with Section 10.13 below.

10.6 ALLOWABLE HEALTH SAVINGS ACCOUNT REIMBURSEMENT

Subject to limitations contained in Section 10.9 of this Program, and to the extent of the amount contained in the Account Beneficiary's Health Savings Account, an Account Beneficiary who incurs HSA Medical Expenses shall be entitled to receive from the Employer reimbursement for the entire amount of such qualifying HSA Medical Expenses incurred during the Plan Year or portion thereof during which he/she is an Account Beneficiary.

10.7 ANNUAL STATEMENT OF BENEFITS

By February 1 of each calendar year, or as otherwise specified by the applicable HSA Trustee or Custodian if applicable, the Employer shall furnish to each Employee who was an Account Beneficiary and received benefits under Section 10.6 during the prior calendar year, a statement of all contributions made to the Health Savings Account as well as such benefits or other distributions paid to or on behalf of such Account Beneficiary during the prior calendar year.

10.8 UNUSED HEALTH SAVINGS ACCOUNT BALANCES

The amount in an Account Beneficiary's Health Savings Account as of the end of any Plan Year (and after the processing of all claims and authorized expenditures for such Plan Year pursuant to Section 10.12 hereof) shall be carried over and available for use in the subsequent Plan Year.

10.9 LIMITATION ON CONTRIBUTIONS

Notwithstanding any provision contained in this Article to the contrary, amounts contributed through Flexible Benefits Plan Dollars or otherwise allocated to the Health Savings Account of any Account Beneficiary, including any Qualified HSA Distributions and other allowable rollover contributions in accordance with the Employer's Adoption Agreement, shall be subject to the annual contribution limitations, applicable testing periods and other conditions set forth under Code Section 223(b) or as otherwise specified under the Employer's Adoption Agreement. Any excess contributions (as defined by Code Section 223(b)(3)(B)) made by any Account Beneficiary in accordance with these limitations shall be distributed in accordance with Code Section 223(b)(3)(A) or as otherwise directed by the HSA Trustee or Custodian.

10.10 COORDINATION WITH FLEXIBLE BENEFITS PLAN

All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Health Savings Account Program, as long as they otherwise meet the definition of an Eligible Individual set forth under this Article. The enrollment and termination of participation under the Flexible Benefits Plan shall constitute enrollment and termination of participation under this Health Savings Account Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan.

10.11 COORDINATION WITH HEALTHCARE EXPENSE REIMBURSEMENT PROGRAM

If the Employer offers the Healthcare Flexible Spending Program under this Plan to its Eligible Employees in addition to this Health Savings Account, to the extent an Eligible Individual elects to participate in both programs, any qualifying HSA Medical Expense amounts that can be paid under the Health Savings Account Program of this Plan may be paid under the Health Savings Account Program with the exception of those "limited benefits" (including vision and dental) in accordance with Code Section 223(c)(2)(B) that are to be paid from the Healthcare Flexible Spending Account.

10.12 HEALTH SAVINGS ACCOUNT PROGRAM CLAIMS

The HSA Trustee or other HSA Custodian shall make payment of eligible Health Savings Account claims to the Account Beneficiary, or any Designated Beneficiary, upon the presentation of documentation of such expenses in a manner specified by the HSA Trustee or Custodian of such account and in accordance with the method of benefit payment processes set forth under Article XII, as applicable.

10.13 DISTRIBUTIONS FOR NON-HSA EXPENSES

Any amounts within an Account Beneficiary's Health Savings Account may also be distributed under the following circumstances:

- a) **Non-HSA Expenses.** An Account Beneficiary, or any authorized representative upon death or disability, may make a request for distribution of any amount within the Health Savings Account that is not a qualifying HSA Medical Expense or has been denied in accordance with the procedures set forth under Section 10.12 above. The Trustee or HSA Custodian shall make distribution of such amounts to the Account Beneficiary, or any designated beneficiary, as soon as reasonably practicable after the Trustee or Custodian receives the Account Beneficiary's written distribution request, in accordance with the HSA Trustee or HSA Custodian's applicable procedures. Amounts distributed under these circumstances will be reported in accordance with applicable Federal and State law requirements.
- b) **Rollovers.** An Account Beneficiary may request that the balance of his or her Health Savings Account be distributed upon termination of employment, unless other terms and conditions are applicable under Section 2.7

above. The Trustee or HSA Custodian shall determine the manner of distribution of the Account Beneficiary's remaining Health Savings Account balance, minus applicable expense or other incurred HSA Medical Expenses not yet paid or reimbursed, either directly to the Account Beneficiary, or other designated beneficiary, or through a direct trustee-to-trustee transfer to another individual or employer Health Savings Account as directed in writing by the Account Beneficiary.

c) Domestic Relations Orders. To the extent applicable and agreed to as part of its HSA Trustee or Custodial agreement, the Trustee shall comply with a domestic relations court order calling for the distribution of all or a portion of a Account Beneficiary's Health Savings Account to any current or former spouse, child or other dependent (the "Account Recipient") of the Account Beneficiary if such order is pursuant to a binding divorce or separation instrument meeting the standards of Code Section 71(b). Notwithstanding any other Plan restrictions or criteria set forth above, even if a Account Beneficiary continues to be an Employee of the Employer or that the Alternate Recipient does not meet the eligibility criteria under Section 7.2(b)(2) set forth above, a binding domestic relations order may require distribution of all or a portion of the Account Beneficiary's Health Savings Account or maintenance of a portion of the Health Savings Account on the Alternate Recipient's behalf. The Trustee shall comply with the terms of any such order in the manner necessary under the then-existing circumstances as specified within its HSA Trustee or Custodial agreement. Amounts distributed under these circumstances will be reported in accordance with Code Section 223(h)(7) or as required under any other applicable Federal and State law.

ARTICLE XI

ERISA PROVISIONS

11.1 CLAIM FOR BENEFITS

a) Any Claim for Benefits underwritten by an Insurance Contract shall be made to the Insurer. If the Insurer denies any Claim, the Participant or Beneficiary shall follow the Insurer's claims review procedure as set forth by the terms of that plan or other plan description. Any other Claim for Benefits shall be made to the Administrator. If the Administrator denies a Claim, the Administrator will provide notice to the Participant or Beneficiary, in writing, within 30 days after the Claim is filed unless special circumstances require an extension of time for processing the Claim. The notice of a denial of a Claim shall be written in a manner calculated to be understood by the Claimant and shall set forth:

- 1) The reason(s) for the denial;
- 2) Specific reference to the provisions of the Plan on which the denial was based;
- 3) A description of any additional material or information needed to further process the Claim and an explanation of why such material or information is necessary;
- 4) A description of the Plan's review procedures and time limits applicable to such procedures, as well as the Participant's right to bring a civil action under Section 502 of ERISA following a final appeal;
- 5) A statement of a Participant's right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
- 6) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon written request.

- b) Within 180 days after receipt of the above material, the Claimant shall have a reasonable opportunity to appeal the Claim denial to the Administrator for a full and fair review. The Claimant or his duly authorized representative may:
 - 1) Request a review upon written notice to the Administrator;
 - 2) Review pertinent documents; and
 - 3) Submit issues and comments in writing, setting forth which of the reasons for denial that he/she disagrees with along with any supporting documents of additional comments related to the appeal.
- c) A decision on the review by the Administrator will be made not later than 30 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the Claimant, with specific references to the pertinent Plan provisions on which the decision is based.

11.2 APPLICATION OF BENEFIT PLAN SURPLUS

- a) Any balance remaining in the Participant's Insurance Benefit, Healthcare Flexible Spending Account, Dependent Care Assistance Account, and/or Adoption Assistance Account as of the end of each Plan Year, after consideration of any applicable Claim Extension Period or any Qualified HSA Distribution under this Plan, shall be forfeited and deposited in the "benefit plan surplus" of the Employer pursuant to Section 6.3, Section 7.8, or Section 8.8, whichever is applicable, unless the Participant had made a Claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the Claim shall be held in his/her account until the Claim appeal procedures set forth above have been satisfied or the Claim is paid. If any such Claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.
- b) Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner, as well as any previous checks that have been paid to a Participant but remain unendorsed, will be returned to the Employer after the close of the Plan Year (or after such further time specified herein for the filing of Claims) in which such forfeitures arose. With the exception of the Tax-Free Transportation Program or Health Savings Account Program, in no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury Regulations or any applicable State law. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses and thereafter be retained by the Employer. In addition, any account Benefit payments that are unclaimed (e.g., uncashed Benefit checks) by the end of the Plan Year following the Period of Coverage in which the medical care expense was incurred shall be forfeited and returned to the Employer.

11.3 NAMED FIDUCIARY

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

11.4 GENERAL FIDUCIARY RESPONSIBILITIES

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their Beneficiaries and

- a) For the exclusive purpose of providing Benefits to Participants and their Beneficiaries and defraying reasonable expenses of administering the Plan;
- b) With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- c) In accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

11.5 NONASSIGNABILITY OF RIGHTS

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

ARTICLE XII

ADMINISTRATION

12.1 PLAN ADMINISTRATION

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full authority and discretion to administer the Plan in all of its details or may delegate a portion of such authority to any third party, subject, however, to applicable requirements of law. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

- a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- b) To interpret the Plan, with the Administrator's interpretations thereof to be final and conclusive on all persons claiming Benefits under the Plan;
- c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive Benefits provided under the Plan;
- d) To reject elections or to limit contributions or Benefits for certain Highly Compensated Participants or other affected Participants if the Administrator deems such to be necessary in order to avoid discrimination under the Plan in violation of applicable provisions of the Code, or maintain compliance with any other applicable provisions of the Plan or other requirements of the law;
- e) To provide Employees with a reasonable notification of their Benefits available under the Plan;
- f) To approve reimbursement requests and to authorize the payment of Benefits; and

- g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan; and
- h) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be in writing.

Any determination by the Administrator shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator acted arbitrarily and capriciously. Notwithstanding the foregoing, any claim which arises under any plan of Insurance Benefits selected by the Employer under Paragraph 8 of its signed Adoption Agreement shall not be subject to review under this Plan, and the Administrator's authority under this Section 12.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan or policy. Any procedure, discretionary act, interpretation, or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury Regulations thereunder.

12.2 METHOD OF BENEFIT PAYMENT

- a) The Administrator shall make, or otherwise direct any Trustee to make (if applicable) any and all payments or other reimbursements in the manner specified herein and as otherwise elected by the Employer (e.g., direct reimbursement by check, automatic deposit via automated clearing house (ACH)).
- b) If a Participant agrees to the terms and conditions of any applicable cardholder agreement that provides for the payment of qualifying Benefit expenses through use of a debit or credit card, stored value card or other similar electronic media (hereinafter the "Debit Card"), payments under this Plan shall be made directly to the service provider, authorized merchant, or other independent third party that provides products or services that are eligible for payment of qualifying Benefit expenses as otherwise set forth herein.
 - 1) Within the cardholder agreement, the Participant agrees that payment for qualifying Benefit expenses can only be made on behalf of the Participant, the Participant's Spouse, or other qualifying Dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth in the Employer's signed Adoption Agreement or as otherwise specified by the Participant's signed Election. The Participant also certifies that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. The Participant-cardholder also understands that the certification, which shall be printed on the back of the Debit Card, is reaffirmed each time the card is used. The Participant-cardholder also agrees to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate or as required by law. The Participant-cardholder also understands that the Debit Card is automatically cancelled at termination of employment or under such other situations that are otherwise set forth within the cardholder agreement itself.
 - 2) Unless other more stringent procedures or requirements are implemented and communicated to the Employer and its Employees, the Administrator agrees that it shall separately adhere to the terms and conditions of any separate Employer cardholder servicing agreement, including but not limited to, a requirement to maintain the program in compliance with applicable standards under the Code and any mandates that payments for Qualifying Expenses only be made to authorized merchants and service providers. The Administrator also agrees that it shall establish and maintain procedures for substantiation of any payments after the card has been used for qualifying Benefit payments that are in accordance with applicable provisions of the Code, any underlying Regulations and other applicable guidance thereunder.
 - 3) If the Benefit reimbursement request is being submitted for any non-qualifying Benefit expense in a manner other than as specified under any of the methods allowable under existing IRS

guidelines, the Administrator may make a conditional payment of an allowable Benefit item to the authorized service provider, merchant, or approved independent third party, but shall also require the Participant-cardholder to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which shall be subject to further review and substantiation.

- 4) If a Participant attempts to utilize the Debit Card or other form of electronic payment for any improper or non-allowable purpose, the Participant shall be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by the Participant.
- 5) If any conditional payment or other Benefit payment has been made but is not deemed to be qualifying Benefit expense reimbursement, the Administrator shall ensure that proper correction procedures are maintained with respect to the improper payment(s):
 - (a) Upon identification of any improper payment, the Administrator shall require the Participant to pay back to the Plan an amount equal to the improper payment;
 - (b) If the Participant does not immediately repay the Plan, the Administrator shall ensure that the proper amount is withheld from the Participant's wages or other Compensation (with such amounts then being immediately remitted to the Plan by the Employer) to the extent consistent with applicable law;
 - (c) To the extent that neither (a) nor (b) above are allowable or effective, the Administrator shall have the authority to utilize a Claim substitution or offset approach to resolve the improper Claim amount(s), with such methodology being clearly explained to the Participant-cardholder as part of his/her cardholder agreement.
 - (d) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the Debit Card until the indebtedness is repaid by the Participant. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or Participant-cardholder agreement.

12.3 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee, and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours; provided, however, the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

12.4 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Plan or by any Trust Fund that may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of Highly Compensated Employees.

12.5 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of a particular Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the Benefits Participants are entitled to, and the circumstances under which insurance terminates.

12.6 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs, and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE XIII

AMENDMENT OR TERMINATION OF PLAN

13.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any Benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, State, or local laws, statutes, or regulations.

13.2 TERMINATION

By signing the Adoption Agreement, the Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made and no further additions shall be made to the Insurance Benefit program, Healthcare Flexible Spending Account, Dependent Care Assistance Account, Adoption Assistance Account, Tax-Free Transportation Program, or Health Savings Account. Payments from such account(s)/program(s) shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of Claims), or until the balances of all accounts have been reduced to zero, whichever occurs first. Any amounts remaining in any such account(s)/program(s) as of the end of the Plan Year in which Plan termination occurs shall be forfeited and deposited in the benefit plan surplus after the expiration of the Claim filing period. The above notwithstanding, Benefits under any Insurance Contract shall be paid in accordance with the terms of that Contract.

ARTICLE XIV

HIPAA PRIVACY REQUIREMENTS

As of the required Effective Date, the Employer has implemented or amended the Plan to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in 45 C.F.R. Parts 160 through 164;

14.1 DEFINITIONS In addition to the specific definitions set forth below, all other capitalized terms used that are not otherwise defined herein have the meanings ascribed in HIPAA:

- a) **“Designated Record Set”** has the meaning in 45 CFR Section 164.501.
- b) **“Electronic Media”** has the meaning in 45 CFR Section 160.103, which is:
 - 1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
 - 3) Transmission media used to exchange information already in electronic storage media.
 - 4) Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- c) **“Electronic Protected Health Care Information”** (also known as “ePHI”) has the meaning in 45 CFR Section 160.103, and is limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of the Plan.
- d) **“Plan Administration Functions”** is defined as activities that would meet the definition of Payment or Healthcare Operations by HIPAA as set forth in 45 C.F.R. Section 164.501, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administration includes quality assurance, claims processing, auditing, monitoring, and management of carve-out plans (i.e., vision and dental). Plan administration does not include any employment-related functions or functions in connection with any other Benefits or Benefit plans, and the Plan(s) may not disclose information for such purposes absent an authorization from an individual for whom the information pertains. In addition, enrollment functions performed by the Employer are not considered Plan Administration Functions.
- e) **“PHI”** is defined as Protected Health Information, as set forth in 45 C.F.R. Section 164.501. It is information that is created or received by a health plan, employer, healthcare provider, or healthcare clearing house and includes information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. In addition, the information either identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. This information may be maintained or transmitted either electronically or in any other form or medium.
- f) **“Secretary”** means the Secretary of the Department of Health and Human Services or designee.
- g) **“Security Incident”** has the meaning in 45 CFR Section 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- h) **“Summary Health Information”** is defined by HIPAA as set forth in 45 C.F.R. Section 164.504 as information that may be PHI, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided health benefits under the Plan; and from which the following information has been deleted, except that the geographic information described in 2) need only be aggregated to the level of a five-digit zip code:
 - 1) Names;

- 2) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:
 - (a) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
 - (b) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
- 3) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
- 4) Telephone numbers;
- 5) Fax numbers;
- 6) Electronic mail addresses;
- 7) Social Security numbers;
- 8) Medical record numbers;
- 9) Health plan beneficiary numbers;
- 10) Account numbers;
- 11) Certificate/license numbers;
- 12) Vehicle identifiers and serial numbers, including license plate numbers;
- 13) Device identifiers and serial numbers;
- 14) Web Universal Resource Locators (URLs);
- 15) Biometric identifiers, including finger and voice prints;
- 16) Full face photographic images and any comparable images; and
- 17) Any other unique identifying number, characteristic, or code.

14.2 DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan, its Administrator, or any contracted representatives of the Plan, may disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of:

- a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
- b) Modifying, amending, or terminating the Plan.

14.3 DISCLOSURE OF PHI

The Plan, its Administrator, or any contracted representatives of the Plan, may release PHI to the Employer, so long as the Employer agrees to do the following:

- a) The Employer shall not use or further disclose the PHI other than as permitted or required by the Plan's documents or as required by law;
- b) The Employer shall ensure that any agents, including a subcontractor, to whom it provides PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- c) The Employer shall not use or disclose the PHI for employment-related actions and decisions, or in connection with any other Benefit or employee Benefit plan of the Employer;
- d) The Employer agrees to report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures providing herein, if and when the Employer becomes aware of such inconsistent use or disclosure;
- e) The Employer, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with the Employer Privacy Policy, has authorized the Plan to make PHI available to individuals;
- f) The Employer, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with the Employer Privacy Policy, has authorized the Plan to make PHI available to individuals for amendment and to incorporate such amendments of PHI;
- g) The Employer, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.528 and consistent with the Employer Privacy Policy, has authorized the Plan to make available the information required to provide an accounting of disclosures;
- h) The Employer, agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for purposes of determining the Plan's compliance with HIPAA;
- i) If feasible, the Employer shall return or destroy all PHI that the Employer received from the Plan and which the Employer no longer needs for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible;
- j) The Employer agrees to use appropriate safeguards to prevent unauthorized use or disclosure of PHI, and have reasonable and appropriate safeguards in place to protect the confidentiality, integrity and availability of ePHI;
- k) The Employer agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement;
- l) The Employer agrees to report to the Plan, any use or disclosure of PHI of which it becomes aware that is not permitted or required by HIPAA; and
- m) The Employer agrees to report to the Plan any Security Incident of ePHI of which it becomes aware.

14.4 ADEQUATE SEPARATIONS

The Employer shall ensure that the following adequate separations are established:

- a) The Employer shall designate specific people who shall use and disclose PHI on behalf of the Plan for purposes of Plan Administration Functions.
- b) Access and use of PHI by the Group shall be limited to Plan Administration Functions that the Employer performs on behalf of the Plan;
- c) Any issues of noncompliance by the Group shall result in disciplinary measures specified in the Employer Privacy Policy.

14.5 USES AND DISCLOSURES

The Plan, its Administrator, or any contracted representatives of the Plan, may:

- a) Disclose PHI to the Employer in order for the Employer to carry out Plan Administration Functions consistent with the provisions of Subsections a) through i) and Subsection 14.4 above;
- b) Permit an insurance company, insurance service, insurance organization, or HMO to disclose PHI to the Employer, so long as the disclosure is made to an authorized person, and the disclosure is only for the purpose described in this Section 14.5;
- c) Not disclose or permit an insurance, insurance service, insurance organization, or HMO to disclose PHI to the Employer unless the Employer’s privacy notice contains a provision which permits such disclosure; and
- d) Not disclose PHI to the Employer for the purpose of employment-related actions or decisions or in connection with any other Benefit or employee Benefit plan of the Employer.

ARTICLE XV

MISCELLANEOUS

15.1 PLAN INTERPRETATION

- a) All provisions of this Plan shall be governed and interpreted by the Administrator in its full and complete discretion and shall be otherwise applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 15.12.
- b) In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of the Administrators of the plans for any Insurance Benefits selected as part of Paragraph 8 of the signed Adoption Agreement, or by accountants, counsel, or other experts employed or engaged by the Administrator.

15.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine, or gender neutral, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

15.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document, which may be required by law, is intended to satisfy the written plan requirement of Code Section 125 and any Regulations thereunder relating to cafeteria plans.

15.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

15.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect that such discharge shall have upon him/her as a Participant of this Plan.

15.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

15.7 EMPLOYER'S PROTECTIVE CLAUSES

- a) Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect, or otherwise), the Participant's Benefits shall be limited to the insurance premium, if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's Claim.
- b) The Employer's liability to the Participant shall only extend to and shall be limited to any payment actually received by the Employer from the Insurer. In the event that the full insurance Benefit contemplated is not promptly received by the Employer within a reasonable time after submission of a Claim, then the Employer shall notify the Participant of such facts and the Employer shall no longer have any legal obligation whatsoever (except to execute any document called for by a settlement reached by the Participant). The Participant shall be free to settle, compromise, or refuse to pursue the Claim as the Participant, in his/her sole discretion, shall see fit.
- c) The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss that may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

15.8 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for Federal or State income tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the

obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

15.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or State income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and State income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash Compensation, plus the Participant's share of any Social Security tax that would have been paid on such Compensation, less any such additional income and Social Security tax actually paid by the Participant.

15.10 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but shall instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.

15.11 GOVERNING LAW

This Plan is governed by the Code and the Treasury Regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced, and administered according to the laws of the State or Commonwealth identified as part of the Employer's completed Adoption Agreement.

15.12 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

15.13 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge, or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

15.14 CONTINUATION OF COVERAGE

Notwithstanding anything in the Plan to the contrary, in the event any Benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B.

15.15 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS (USERRA) ACT

Notwithstanding any provision of this Plan to the contrary, contributions, Benefits, and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

15.16 CLAIMS EXTENSION PERIOD

The provisions of the Plan concerning the payment of qualifying expenses or other similar benefits, which may include but is not limited to payment from healthcare flexible spending accounts, dependent care assistance accounts or other similar arrangements, that would otherwise be forfeited if not incurred by the end of the Plan Year are amended in the following respects:

- a) Claims Incurred Prior to the End of the Plan Year. For purposes of any provisions within the Plan that require qualifying expenses or other similar benefits to have been incurred by the end of the Plan Year to be eligible for reimbursement by the Plan, as of the Effective Date, the Plan shall also reimburse any qualifying expenses or other similar benefits that are incurred within the Claims Extension Period immediately following the end of the Plan Year. Any Plan provisions related to the deadline for forfeiture of any unused Plan accounts that are not utilized by the end of the Plan Year shall also take into consideration the Claims Extension Period.
- b) Claims Extension Period—Defined. For purposes of these rules, the “Claims Extension Period” shall be the period that ends on the 15th day of the third month immediately following the end of the most recent Plan Year.
- c) Order of Expense or Benefit Payment. Amounts remaining in the participant’s applicable flexible spending, health care reimbursement, dependent care assistance or other similar Plan account as of the end of the Plan Year shall be used first for the payment of any claims submitted during the Claims Extension Period. If all prior year amounts have been fully utilized, claims incurred during the Claims Extension Period shall be paid from any amounts elected for the Plan Year immediately coinciding with the Claims Extension Period. For these purposes, amounts remaining in one Plan account cannot be used to supplement the lack of available funds from another Plan account (e.g., excess amounts within a participant’s dependent care assistance account may not be used to fund flexible spending account health claims incurred during the Claims Extension Period).
- d) Forfeitures. Any amount(s) that remain as of the end of any Plan Year (including the processing all allowable claims submitted during the Claims Extension Period, pursuant to b) above) shall be forfeited and credited to any benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to any claims appeal rights otherwise set forth herein.
- e) Claims Submission Deadline. All claims reimbursement requests must be submitted by the end of the month following the end of the Claim Extension Period deadline.

15.17 GENETIC INFORMATION NONDISCRIMINATION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

15.18 MENTAL HEALTH PARITY AND ADDICTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712. Specifically, as of January 1, 2010, the Plan shall no longer apply a specific annual or lifetime maximum coverage limitation, daily visit limitation or separate per day limit on coverage or services for mental and

nervous disorders and/or substance abuse that is different from any other inpatient or outpatient treatment provided for under the Plan, and coverage shall be provided the same as any other medical procedure.

15.19 WOMEN’S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women’s Health and Cancer Rights Act.

15.20 NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns’ and Mothers’ Health Protection Act.

Authorized Signatures:

By _____ Date _____

Authorized Signature

By _____ Date _____

Authorized Signature

Summary Plan Description

For: (Village of Sugar Grove)

Flexible Benefits Plan

FLEXIBLE BENEFITS PLAN

Summary Plan Description

INTRODUCTION

We are pleased to announce that we have established a Flexible Benefits Plan (the “Plan”) for you and other eligible employees. Under this program, you will be able to choose among certain Benefits that we make available. The Benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the Benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this summary plan description carefully so that you understand the provisions of our Plan and the Benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a Participant. You should direct any questions you have to the Administrator. There is a Plan Document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan Document, the Plan Document will control. Also, if there is a conflict between an Insurance Contract and either the Plan Document or this Summary Plan Description, the Insurance Contract will control.

GENERAL INFORMATION ABOUT OUR PLAN

Adoption Agreement

This Section contains certain general information, which you may need to know about the Plan.

1. GENERAL PLAN INFORMATION

The Village of Sugar Grove Employee Benefit Plan is the name of the Plan.

2. The provisions of the amended Plan became effective on 1/1/2013.

3. Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The plan begins on 01/01 and ends on 12/31.

4. Your Employer has assigned Plan Number 501 to your Plan.

5. Employer Information

Your Employer's name, address, and identification number are:

Village of Sugar Grove
10 S. Municipal Drive

Sugar Grove, IL 60554

FIN: 366009121

Organization Type: Government

6. Plan Administrator Information

The name, address, and business telephone number of your Plan's Administrator (also referred to as the "Administrator") is:

Village of Sugar Grove
10 S. Municipal Drive

Sugar Grove, IL 60554

630-466-4507

The Administrator keeps the records for the Plan and is responsible for the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

7. Service of Legal Process

The Administrator is the Plan's agent for service of legal process.

8. Type of Administration

The type of Administration is Employer Administration.

9. Eligibility Requirements

All Employees shall be eligible to participate in the Plan, except:

Self-employed person(s), within the meaning of Code Section 401(c), including independent contractors, a greater than 2% shareholder in a Subchapter S corporation, a partner in a partnership, or any owner or member of a limited liability company that is treated like a partnership for tax purposes AND
A relative, within the meaning of IRC Section 318, of one of the above self-employed person(s) AND:

- Employees not eligible under Employer's group medical plan.
- Employees not electing Employer group medical plan.
- Part-time Employees expected to work at less than 30 hours per week.
- Commissioned Employees
- Union Employees (which shall include any Employee of the Employer who is included in a unit of employees covered by an agreement which the Secretary of Labor finds to be a collective bargaining agreement between employee representatives and one or more employers), unless the collective bargaining agreement requires the employee to be included within the Plan.
- Temporary or seasonal Employees (working for the Employer less than 6 months of the year)
- Leased Employees, as well as any independent contractor, or other "statutory employee" who is not treated as a common law employee of the Employer for payroll purposes, regardless of any other court or administrative agency determination.

10. Entry Date.

The Entry Date for eligible Employees will be: First of the month following date of hire.

11. Under our Plan, you can choose to receive your entire Compensation or use a portion to pay for the following Benefits or expenses during the year:

Healthcare Flexible Spending Contributions, subject to IRS maximums contained in adoption agreement;

Dependent Care Assistant Program, subject to the maximums contained in Section 7.9 of the Plan Document;

Employer Group Health Insurance (including health insurance, dental, and vision insurance, AD&D, etc);

COBRA continuation coverage (if COBRA payment is taken from final paycheck);

The above is not an all-inclusive list. The Plan Sponsor reserves the right to allow pre-tax handling of the costs of other benefits to the extent allowed by law.

The applicable cost for any of these selected Benefits, enumerated above, will be paid for within each Participant's applicable Flexible Benefits Plan Dollars Account.

12. Contributions:

The contributions for this Plan shall be: Employee (Salary Redirection) contributions only. Employer Contributions, **which shall be:** Determined annually by the Employer (but not less than the minimum amounts specified below, and with annual notice provided before the beginning of the next Plan Year).

13. Maximum Contributions:

- a) The maximum amount you can contribute to the Healthcare Flexible Spending Account each Plan Year shall be \$2500. Effective January, 1 2012, notwithstanding any provision contained in this Healthcare Flexible Spending Account to the contrary, the maximum amount cannot exceed the IRS amount set forth for each calendar year. For example, the maximum amount allowed for each employee in 2013 is \$2,500. The \$2,500 limit will be indexed for cost-of-living adjustments for plan years beginning after December 31, 2013. The \$2,500 limit applies only to employee salary deduction contributions to health FSAs. It does not take into consideration salary reductions to other benefits such as dependent care assistance, adoption benefits or insurance premium accounts. The new limit does not apply to health savings accounts (HSAs) or health reimbursement arrangements (HRAs). A Limit applies on an employee-by-employee basis. Married couples, dependents or adult children working for the same company may each elect the \$2,500 maximum. One person working for multiple companies, that are not members of a controlled group, may elect the \$2,500 maximum for each employer's health FSA benefit. Controlled groups are counted as one employer. The limit is not based on underlying insurance coverage. For instance, participants with family insurance coverage may not elect more than those with single insurance coverage. Cafeteria plans that provide for a "grace period" following the end of any plan year need not worry about exceeding the \$2,500 statutory limit if leftover contributions are rolled forward into the following plan year. The funds carried forward into the grace period do not count against the \$2,500 limit applicable for the subsequent plan year.
- b) The maximum amount you can contribute to the Dependent Care Assistance Plan each Plan Year (or calendar year) shall be the lesser of: 1) \$5,000 (if you are married, filing a joint return or you are head of a household) or \$2,500 (if you are married, filing separate returns); 2) one-half of your taxable compensation; 3) your spouse's actual or deemed earned income (a spouse which is a full-time student or incapable of self-care has monthly earned income of \$250 for one dependent or \$500 for two or more dependents).
- c) The maximum amount you can contribute to the pre-tax premiums will be the maximum contribution levels for qualified benefits eligible for pre-tax handling of premiums.

14. Expense Allocation and Order of Benefit Payments:

If the Employer sponsors a Health Reimbursement Arrangement ("HRA"), in addition to a Health Savings Account, Eligible Medical Expenses under the HRA shall: only include expense payments for vision and/or dental coverage, which can be paid before or commensurate with the Health Savings Account.

15. Rollovers of IRAs or Qualified HSA Distributions to HSA Accounts:

Beginning with the Plan Year dated on or after 11/01/2011, the Plan shall not allow a one-time rollover of available funds from the following sources to an Eligible Individual's Health Savings Account.

17. Claims Incurred During the Claims Extension Period

Shall include the provision for "Claims Extension Period": 77 Days

18. Claim run out period shall be 4/30/ of every year.

19. Authorized Signatures:

Date _____
Village of Sugar Grove

By _____
Authorized Signature

Date _____
Witness

By _____
Authorized Signature

II

ELIGIBILITY

1. **When Can I Become a Participant in the Plan?**

Before you become a member or a “Participant” in the Plan, there are certain rules that you must satisfy. First, you must meet the eligibility requirements. After that, the next step is to actually join the Plan on the Entry Date that we have established for all employees. You will also be required to complete certain application forms before you can enroll in the Plan. Please refer to Section I, “General Information about Our Plan” of this document for a description of the Entry Date for our plan.

2. **What are the Eligibility Requirements for our Plan?**

You will be eligible to join the Plan once you have satisfied the conditions for eligibility. If you are not eligible to participate in this Plan on the Effective Date of the Plan, you will be eligible to join the Plan once you have satisfied the eligibility requirements under this Plan. Please refer to Section I, “General Information About Our Plan” of this document for a description of our eligibility requirements.

3. **When is my Entry Date?**

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

4. **Are there any Employees Who are not Eligible?**

Yes, there are certain employees who are not eligible to join the Plan. Please refer to Section I, “General Information About Our Plan” of this document for a description of ineligible employees.

5. **What Must I do to Enroll in the Plan?**

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the Benefits that are being offered under the Plan. You must also authorize us to set aside some of your earnings to pay for a portion of the Benefits you have elected.

However, if you are already covered under any of the insured Benefits, you will automatically participate in this Plan to the extent of your Premiums, unless during the Election Period, you elect not to participate in the Plan.

III

OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts, which must be set up for you in order to pay for the Benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal or Social Security taxes and in most cases State income taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you would normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

IV

CONTRIBUTIONS

1. Will my employer make contributions to the Plan on my behalf?

Your Employer may choose to make contributions to the Plan to assist you in offsetting the cost of Benefits offered under the Plan. These Employer Contributions are referred to as "Flexible Benefits Plan Dollars." Please refer to Section I, "General Information About Our Plan," to determine what, if any, amount your Employer has indicated it will contribute towards the cost of your Benefits under this Plan.

2. How much of my pay may the employer redirect?

To the extent your Employer either does not provide Flexible Benefits Plan Dollars to this Plan or the cost of Benefits offered under the Plan are greater than the Flexible Benefits Plan Dollar amount provided by your Employer, you may make an election, known as a Salary Redirection, to make additional pre-tax contributions to the Plan from your own Salary amount. Each year, for the insured Benefits provided under this Plan we will automatically contribute on your behalf enough of your Compensation to pay for the insurance coverage provided. In addition, you may elect to pay for the Benefits that you elect under the Plan. These amounts will be deducted from your Compensation each pay period on a pro rata basis over the course of the year.

3. How is my compensation measured under the Plan?

Compensation under our Plan means the total cash amount that is paid to you each year.

4. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the Benefits you want and how much of the contributions should go toward each Benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered Benefit or expense during the Plan Year. Later, they will be used to pay for expenses as they arise during the Plan Year.

5. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the Election Period. You must decide two things. First, which Benefits you want, and second, how much should go toward each benefit.

If you are already covered by any of the insured Benefits offered by this Plan, you will automatically become a Participant to the extent of the Premiums for such insurance unless, during the Election Period, you elect not to participate in the Plan.

6. When is the “Election Period” for our Plan?

Your election period will start on the date you first meet the eligibility requirements and end 30 days after your Entry Date. (You should review Section I, “General Information About Our Plan” and Section II, “Eligibility” to better understand the terms “eligibility requirements” and “Entry Date.”) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See Section I, “General Information About Our Plan” for the definition of “Plan Year.”)

7. May I change elections during the Plan Year?

Generally, no. You cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change if you have a “change in status,” you make an election change that is consistent with the change in status, and provided your request for change is made within 30 days from the date of change in status. Any new election will be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. Currently, Federal law considers the following events to be changes in status:

- a) Changes in legal marital status by you because of marriage, divorce, death of a spouse, legal separation, or annulment;
- b) Changes in the number of your dependents because of a dependent’s birth, adoption, placement for adoption, or death;
- c) Changes in your employment status because of employment termination or commencement by you, your spouse, or a dependent; strike or lockout; the beginning or end of an unpaid leave of absence; or any other change in employment status that affects eligibility for benefits.
- d) Changes in one of your dependents who satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or a similar circumstance;
- e) Changes in health plan access due to a change in residence or worksite by you, your spouse, or a dependent that affect eligibility for benefits;
- f) Changes due to judgment, decree, or order resulting from divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order. You may also change an election to cancel coverage for the child if the order requires a former spouse to provide coverage for such child and such coverage is actually provided.
- g) Changes due to entitlement to Medicare or Medicaid.
- h) Changes due to entitlement to health insurance continuation coverage, as prescribed under the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), as amended; application of the

Family and Medical Leave Act of 1993 (“FMLA”); or the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as amended.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, the Salary Redirection election you have made for the remainder of the Plan Year if there is a change in the premium expense. If there is an increase or decrease in premium expense that is significant, we will let you either make corresponding changes to the Salary Redirection election or allow you to revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may change or revoke your election. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly added option, elect another option if an option has been eliminated, or revoke your election. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse’s, former spouse’s or dependent’s employer.

These rules on change due to cost or coverage do not apply to the Healthcare Flexible Spending Account, and you may not change your election to the Healthcare Flexible Spending Account if you make a change due to cost or coverage for insurance.

For the Dependent Care Assistance Program, a dependent becoming or ceasing to be your qualified dependent will qualify as a change in status. However, you may not change your election under the Dependent Care Assistance Program if it is due to a cost change, and a dependent care provider who is your relative imposes that change. You may, however, change your election under the Dependent Care Assistance Program if there is a cost change imposed by a non-related dependent care provider.

For the Adoption Assistance Program, a commencement or termination of an adoption proceeding will also qualify as a change in status.

Under current rules, there are no special provisions or other criteria for any type of qualified change in status circumstances under the Tax-Free Transportation Plan or Health Savings Account Program. Accordingly, changes to any existing elections to these plans will not be considered for these programs, unless described under any other specific provisions described elsewhere in this document or the Plan itself.

There may be other events considered to be a change in status as determined by the IRS Regulations. There are detailed rules on when a change in election is deemed to be consistent with a change in status. If you have any type of change in status, you should contact the Administrator, who will provide you with the required forms for changing your benefit elections.

The Administrator makes the determination of whether a valid change of status has occurred. In making this determination, the Administrator has the authority to require additional evidence to support your stated reasons for changing any prior benefit election.

8. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, you will be considered to have elected to have a portion of your pay redirected for the upcoming Plan Year for the Premium Expense and/or Tax-Free Transportation Program portion(s) of this Plan only. You would not be considered a Participant for the Healthcare Flexible Spending Account, the Dependent Care Assistance Account, Adoption Assistance Account, or Health Savings Account portions of the Plan without completion of new elections prior to the beginning of the subsequent Plan Year.

9. How does the Family and Medical Leave Act (FMLA) affect this Plan?

Generally, if you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your benefits under this Plan on the same terms and conditions as though you were still an active Employee. If you take a paid leave under the FMLA, you may participate in annual enrollment, and you will be required to continue coverage while on FMLA, your share of the Premiums being paid by the method normally used during any paid leave. If you take an unpaid leave under the FMLA, you may revoke or change your existing elections for health insurance and the Healthcare Flexible Spending Account, and participate in annual enrollment.

Or, your employer may choose to continue coverage on your behalf during your FMLA leave. In such situations, you would be entitled to receive reimbursement of any qualifying expenses that you incurred during your FMLA leave period. However, if you continue your coverage during your unpaid leave, you may continue to make payment for coverage under one of the following methods:

- a) **Prepayment.** Under the prepayment option, you can increase your Salary Redirection in an amount sufficient to cover the Premiums and other expenses that will come due during the FMLA leave.
- b) **Pay-as-you go.** With the pay-as-you-go option, you must continue to pay Premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while on FMLA leave, the applicable Premiums are to be paid with pre-tax contributions as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid, the Administrator provides the funding for necessary coverage during the FMLA period, but you are required to reimburse the Employer at regular intervals with after-tax funds for the Premiums that come due during the leave.
- c) **Catch Up.** The Administrator provides the funding for necessary coverage during the leave and subsequently withholds "catch-up" amounts from your pay upon your return.

Upon return from such leave that has been or is being paid for under one of the methods referred to above, you will be permitted to re-enter the Plan on the same basis as you were participating in the Plan prior to your leave, or as otherwise required by the FMLA.

If your coverage in these Benefits terminates, due to your revocation of the Benefit while on leave or due to your non-payment of contributions, your coverage will be reinstated for the remaining portion of the Plan Year upon your return. However, for the Healthcare Flexible Spending Account, if your coverage terminates due to your revocation of the benefit while on leave or due to your non-payment of contributions, two options will be offered upon your return:

- a) **Proration.** The actual amounts contributed by you would remain available for your use the duration of the Plan Year, but the expenses you incur during that lapse in coverage would not be reimbursable and your maximum contribution amount would be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900; or...
- b) **Reinstatement.** You may elect to reinstate the level of coverage in effect when the leave began, with your maximum contribution level remaining the same as previously elected. Any deficiencies in contributions will be made up when you return based on a payment schedule that is established by your employer. You will not, however, be entitled to receive reimbursement of any expenses that you incur during any previous lapse in coverage.

In all instances, a paid or unpaid leave under FMLA will be treated in the same manner and consistent with a non-FMLA paid or unpaid leave.

10. How does the Uniformed Services Employment and Reemployment Rights Act (USERRA) affect this Plan?

If you are going into or returning from military service, you may have special rights to healthcare coverage under your Healthcare Flexible Spending Account and under the Health Savings Account, pursuant to USERRA. These rights can include extended healthcare coverage. If this law may affect you, ask your Administrator for further details.

11. What happens if I don't spend all Plan contributions?

It depends on the program in which you are enrolled. For example, if you are enrolled in either a Tax-Free Transportation Plan or a Health Savings Account, any unused amounts will be carried over to the next Plan Year and will generally be available for use in future years.

However, with respect to other Benefit options, subject to the applicable filing deadlines discussed in Article V, any contributed monies left at the end of the Plan Year will generally be forfeited. Having said this, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, if your Plan has adopted a Claims Extension Period (also known as an extended Grace Period) as further described within Section IX below, you have the additional period specified within Section I, "General Information About Our Plan", to incur claims for you or your Dependents and still receive reimbursement for the Prior Year under the Plan. However, under all circumstances, you must make your requests for reimbursement no later than 60 days after the end of the Plan Year or by the end of the month following the end of the Claims Extension Period deadline.

In addition to the general rule above, you may also have a limited opportunity to rollover any unused amounts in your Healthcare Flexible Spending Account to a Health Savings Account if otherwise permitted by the Plan. More information about the payment of reimbursable expenses, payments or allowable rollovers of any other distributions is further discussed in Section V.

Because a number of different options are available to you and it is possible that you might forfeit amounts in the Plan if you do not fully use or rollover any allowable contributions that have been made, it is important that you decide how much to place in each account carefully before the Plan Year begins. You want to be as certain as possible that the amount you decide to place in your accounts will be used entirely. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) by the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

V

BENEFITS

1. What benefits are available?

Under our Plan, you can choose to receive your entire compensation in cash or use a portion to pay for certain other benefits or expenses during the year. The benefits or expenses that are available for payment under the Plan have been selected by your Employer and are identified under Section I, "General Information About Our Plan," referring to the Plan of Benefit Options. Notwithstanding the individual benefit selections that are available to you under your Plan, a discussion of pertinent issues that impact some of the more common benefit alternatives follows:

Premium Expense Account

A Premium Expense Account allows you to use tax-free dollars to pay for certain Premium Expenses under various Insurance Programs that we offer you. Please refer to Section I, "General Information About Our Plan," Plan of Benefit Options, for information on Insurance Programs for which Premium Expenses can be paid for by our Plan.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any Insurance Contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after 1) you have provided the Administrator the necessary information to apply for insurance, and 2) the insurance is in effect for you.

Healthcare Flexible Spending Account

The Healthcare Flexible Spending Account enables you to pay for expenses that are not covered by our health plan(s) and save taxes at the same time. The account allows you to be reimbursed by the Employer for out-of-pocket medical, dental, and vision expenses incurred by you, your spouse, and your dependents. A medical expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when you are formally billed for, or are charged or, or pay for the medical care. The medical expenses, including any expense for medical care, which qualify are those permitted by Section 213(d) and Section 105 of the Internal Revenue Code and the rulings and Treasury Regulations thereunder. A list of covered expenses is available from the Administrator. (Please note that these covered expenses may also include the payment for certain over-the-counter medications.) You may not, however, be reimbursed for the cost of other healthcare coverage maintained outside of the Plan, or for long-term care insurance coverage or expenses. Effective January 1, 2011, over-the-counter drug expenses will not be reimbursed under the Plan, except as permitted by law.

Effective January, 1 2012, notwithstanding any provision contained in this Healthcare Flexible Spending Account to the contrary, the maximum amount cannot exceed the IRS amount set forth for each calendar year. For example, the maximum amount allowed for each employee in 2013 is \$2,500. The \$2,500 limit will be indexed for cost-of-living adjustments for plan years beginning after December 31, 2013. The \$2,500 limit applies only to employee salary deduction contributions to health FSAs. It does not take into consideration salary reductions to other benefits such as dependent care assistance, adoption benefits or insurance premium accounts. The new limit does not apply to health savings accounts (HSAs) or health reimbursement arrangements (HRAs). A Limit applies on an employee-by-employee basis. Married couples, dependents or adult children working for the same company may each elect the \$2,500 maximum. One person working for multiple companies, that are not members of a controlled group, may elect the \$2,500 maximum for each employer's health FSA benefit. Controlled groups are counted as one employer. The limit is not based on underlying insurance coverage. For instance, participants with family insurance coverage may not elect more than those with single insurance coverage. Cafeteria plans that provide for a "grace period" following the end of any plan year need not worry about exceeding the \$2,500 statutory limit if leftover contributions are rolled forward into the following plan year. The funds carried forward into the grace period do not count against the \$2,500 limit applicable for the subsequent plan year. Please refer to Section I, "General Information About Our Plan" for the maximum amount that you can contribute to your Healthcare Flexible Spending Account each Plan Year. In order to be reimbursed for a healthcare expense, you must submit your claim in the manner set forth under Section VI below. Reimbursement from the Plan will generally be paid no later than 30 days after receipt by the Administrator of a reimbursement claim.

Dependent Care Assistance Account

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent daycare costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time instead of being gainfully employed (but note the income limitations discussed below). Single employees can also use the account, subject to the applicable dollar limitations specified below.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent care arrangements which qualify for expense reimbursement include:

- a) A Dependent (Day) Care Center provided that, if care is provided by the facility for more than six individuals, the facility complies with applicable State and local laws.
- b) An Educational Institution for pre-school children. For children beyond pre-school age, only expenses for non-school care (e.g., after-care) are eligible.
- c) An individual who provides care inside or outside your home. The individual may not be a child of yours under age 19 or anyone you claim as a dependent for Federal income tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of: 1) \$5,000 (if you are married, filing a joint return or you are head of a household) or \$2,500 (if you are married, but filing separate returns); 2) your taxable compensation; 3) your spouse's actual or deemed earned income (a spouse who is a full-time student or incapable of self-care has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents), or such other amount as otherwise set forth and described under Section I, "General Information About Our Plan".

Also, in order to have reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan.

You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser which is better for you. Even if you do not take the Federal tax credit you will still be required to complete Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses" with your annual tax return.

VI

BENEFIT PAYMENTS

1. How do I request reimbursements from my account?

During the course of the Plan Year, you may submit requests for reimbursement of expenses that you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when they are paid for. The Administrator will provide you with forms, or other online claim processing instructions, for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement, which is payment, soon thereafter. Remember, reimbursements that are made from the Plan are generally not subject to Federal income tax or withholding. Nor are they subject to Social Security taxes. Also note that you must submit all requests for reimbursement of any health care, dependent care, or adoption expenses no later than 60 days after the end of the Plan Year, or as of a later date if your Employer has adopted a Claims Extension Period, as otherwise described under Section IX below. Requests for payment of insured benefits should be made directly to the Insurer. The provisions of the insurance policies will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Assistance Plan, Adoption Assistance Program, Tax-Free Transportation Program, or Health Savings Accounts to the extent that there are sufficient funds in the applicable accounts to cover your request.

2. How are benefits paid to me?

- a) The Administrator will make any and all payments or other reimbursements to you as soon as administratively feasible or as otherwise set forth herein and will be distributed in the manner elected by your Employer (including direct reimbursement by check, automatic deposit via automated clearing house (ACH)).
- b) As an alternative to the method of Benefit payment referenced above, if you agree to the terms and conditions of any applicable cardholder agreement (that is also agreed to by your Employer and the Administrator, with any additional provisions or requirements) that provides for the payment of qualifying Benefit expenses through use of a debit or credit card, stored value card or other similar electronic media (generally referred to as the "Debit Card"), payment of qualifying Benefit expenses may be made directly to the service provider, authorized merchant, or other independent third party using claim substantiation procedures and policies in accordance with existing IRS guidelines and other applicable laws set forth below:
- c) If the Benefit reimbursement request is being submitted for any non-qualifying Benefit expense in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator will make a conditional payment of an allowable Benefit item to the authorized service provider, merchant, or approved independent third party, but will also require you to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which will be subject to further review and substantiation;
- d) If any conditional payment or other Benefit payment has been made but is not deemed to be a qualifying expense reimbursement, the Administrator will ensure that proper correction procedures are maintained with respect to the improper payment(s):
 - (1) Upon identification of any improper payment, the Administrator will require you to pay back to the Plan an amount equal to the improper payment;
 - (2) If you do not immediately repay the Plan, the Administrator will ensure that the proper amount is withheld from your wages or other compensation (with such amounts then being immediately remitted to the Plan by your Employer) to the extent consistent with applicable law;
 - (3) To the extent that neither (1) or (2) above are allowable or effective, the Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to you as part of your cardholder agreement;
 - (4) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the Debit Card until the indebtedness is repaid by you. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or your cardholder agreement.

Under all circumstances, you must agree that payment for qualifying Benefit expenses can only be made on behalf of you, your spouse, or other qualifying dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth herein.

By signing the cardholder agreement, you are also certifying that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. You are also certifying that you understand this agreement is reaffirmed each time the card is used. You will further agree to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate. Lastly, in signing the cardholder agreement, you certify that you understand that the Debit Card is automatically cancelled at termination of employment or under such other situations that are otherwise set forth within the cardholder agreement itself.

If you attempt to utilize the debit card or other form of electronic payment for any improper or non-allowable purpose, you will be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by you.

3. What happens if I terminate employment?

If you leave our employ during the Plan Year, your right to benefits will be determined in the following manner:

- a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- b) You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Assistance Account at the time of termination of employment, provided the expenses are submitted no later than 60 days after the end of the Plan Year. However, no further salary redirection and Employer contributions will be made on your behalf after you terminate.
- c) You may elect to continue your participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year subject to current COBRA provisions (including applicable provisions that may reduce or eliminate your ability to maintain COBRA eligibility). Please refer to the initial COBRA notification in Attachment A for additional information. The Plan Administrator will notify you as to your COBRA eligibility (if any) at the time of your qualifying event.
 - 1) If you elect to continue your participation in the Healthcare Flexible Spending Account, you must continue to make any required contributions to the Plan at the same level you had prior to your termination. Depending on the elections made by your Employer, you may be able to continue making such contributions on a pre-tax basis if you continue to receive compensation after your termination from employment. Otherwise, your contributions would be required on an after-tax basis only.
 - 2) If you elect not to continue participation in the Healthcare Flexible Spending Account, participation will cease and no further salary redirection and Employer contributions will be made on your behalf.
 - 3) If your participation in the Healthcare Flexible Spending Account ceases, you will be able to submit claims for healthcare expenses incurred prior to your date of termination provided the expenses are submitted no later than 60 days after the end of the prior Plan Year, if you are employed at the end of the Plan Year, or within 30 days of your date of termination for all other circumstances.

4. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced. That is because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VII

HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to Highly Compensated Employees?

Under the Internal Revenue Code, “Highly Compensated Employees” and “Key Employees” generally are Participants who are officers, shareholders, or highly paid employees. You will be notified by the Administrator each Plan Year whether you are a “Highly Compensated Employee” or a “Key Employee.”

If you are within these categories, the amount of contributions and benefits paid for you under this Plan may be limited so that the Plan, as a whole, does not unfairly favor those who are highly paid, their spouses, or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the Key Employees if they, as a group, receive more than 25 percent of all of the nontaxable benefits provided for under our Plan.

Your own circumstances will dictate whether contribution limitations on “Highly Compensated Employees” or “Key Employees” will apply. You will be notified of these limitations if you are affected.

VIII

PLAN ACCOUNTING

The Administrator will make available to you a statement of your account during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember that you want to spend all of the money you have designated for a particular benefit by the end of the Plan Year.

IX

ADDITIONAL PLAN INFORMATION

1. Your rights under ERISA

Plan participants, eligible employees, and all other employees of the Employer are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that participants, eligible employees, and all other employees are entitled to:

- a) Examine, without charge, at the Administrator’s office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and
- b) Obtain copies of all Plan documents and other Plan information upon request to the Administrator. The Administrator may charge a reasonable fee for the copies.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the best interest of you and other plan participants.

No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 (or such greater amount as determined by the U.S. Department of Labor) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a Claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about this statement or your rights under ERISA you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

2. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than 60 days after the end of a Plan Year. Any claims submitted after that time will not be considered. Claims for benefits that are insured will be received in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

- a) The reasons for the denial;
- b) Reference to the specific provisions of the Plan on which the denial was based;
- c) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
- d) A description of the Plan's review procedures and time limits applicable to such procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
- e) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- f) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request.

You or your beneficiary will have 180 days following the receipt of any notification of claim denial to appeal the decision, making a written request for reconsideration to the Administrator. Documents, comments, records, or any other information in support of your appeal should be submitted in writing and accompany any such request. You or your beneficiary may review pertinent documents and receive copies of all documents and records, free of charge.

The Administrator will review the claim, without deference to the initial denial and after taking into account all comments, information, documents, records, and other information submitted as part of the appeal. Unless a 15-day written extension is utilized to review further information, the Administrator will provide a written response to the appeal within 120 days from the date of receipt of any appeal request. In this response, the Administrator will explain the reason for the decision,

with reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to review and interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

3. CLAIMS INCURRED DURING THE “CLAIMS EXTENSION PERIOD”

The provisions of the Plan concerning the payment of qualifying expenses or other similar benefits, which may include, but is not limited to payment from, health care reimbursement accounts, dependent care assistance accounts or other similar arrangements, that would otherwise be forfeited if not incurred by the end of the Plan Year. The provision for the “Claims Extension Period” under the Plan is identified under Section I, “General Information about Our Plan”. Please refer to “General Information about Our Plan” to determine if this provision applies to your Plan.

1. Claims Incurred Prior to the End of the Plan Year. For purposes of any provisions within the Plan that require qualifying expenses or other similar benefits to have been incurred by the end of the Plan Year to be eligible for reimbursement by the Plan, as of the Effective Date of this amendment, the Plan shall also reimburse any qualifying expenses or other similar benefits that are incurred within the Claims Extension Period immediately following the end of the Plan Year with amounts remaining in the participant’s applicable flexible spending, health care reimbursement, dependent care assistance or other similar Plan account as of the end of the Plan Year.. Any Plan provisions related to the deadline for forfeiture of any unused Plan accounts that are not utilized by the end of the Plan Year shall also take into consideration the Claims Extension Period.
2. Claims Extension Period—Defined. For purposes of these rules, the “Claims Extension Period” shall be the period that ends on the 15th day of the third month immediately following the end of the most recent Plan Year. For example, if your Plan Year ends on December 31st, you have until March 15th of the following Plan Year to incur and submit qualifying expenses during the Claims Extension Period.
3. Order of Expense or Benefit Payment. Amounts remaining in the participant’s applicable flexible spending, health care reimbursement, dependent care assistance or other similar Plan account as of the end of the Plan Year shall be used first for the payment of any claims submitted during the Claims Extension Period. If all prior year amounts have been fully utilized, claims incurred during the Claims Extension Period shall be paid from any amounts elected for the Plan Year immediately coinciding with the Claims Extension Period. For these purposes, amounts remaining in one Plan account cannot be used to supplement the lack of available funds from another Plan account (e.g., excess amounts within a participant’s dependent care assistance account may not be used to fund flexible spending account health claims incurred during the Claims Extension Period).
4. Forfeitures. Any amount(s) that remain as of the end of any Plan Year (including the processing of all allowable claims submitted during the Claims Extension Period, pursuant to Section 1 above) shall be forfeited and credited to any benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to any claims appeal rights otherwise set forth herein.
5. Claims Submission Deadline. All claims reimbursement requests must be submitted by the end of the month following the end of the Claim Extension Period deadline. For example, if your Plan Year ends on December 31st, and your Claims Extension Period ends on March 15th, you have until April 30th to submit claims incurred during the previous Plan Year and the Claims Extension Period.

4. HIPAA Privacy

Title II of the Health Insurance Portability and Accountability Act of 1996 and the regulations at 45 CFR Parts 160 through 164 (“HIPAA”), contain provisions governing the use and disclosure of Protected Health Information by health plans, and provide privacy rights to Participants in those plans. HIPAA applies to the Plan Year of this Plan.

Protected Health Information or “PHI” is health information that is created or received by the Plan. PHI relates to your physical or mental health or condition, the provision of health care to you, or the payment for the provision of health care to you. Typically, the information identifies you, your diagnosis, and treatment or supplies used in the course of your treatment.

The Plan may disclose PHI to the Employer only for limited purposes as described in the Plan's documents. The Employer agrees to use and disclose PHI only as permitted or required by the Plan's documents or as required by HIPAA. PHI may be used or disclosed for plan administration functions that the Employer performs on behalf of the Plan. Such functions include:

- Enrollment of Eligible Employees and their eligible dependents
- Eligibility determinations
- Payment for coverage
- Claim payment activities
- Coordination of benefits
- Claim appeals

In order to perform these functions, the Plan will use and disclose PHI only to the following individuals:

- Plan Administrator
- HIPAA Privacy Official
- Other Personnel, specifically designated by the Plan's Privacy Official

The Plan shall maintain policies and procedures that govern the Plan's use and disclosure of PHI, as well as the use and safeguarding of electronic PHI that is otherwise subject to applicable HIPAA Security guidelines as well. These policies and procedures include provisions to restrict access solely to the above individuals and only for the functions listed above. The Plan's policies and procedures also include a mechanism for resolving issues of noncompliance. A notice has been provided to you summarizing the Plan's policies and procedures. A copy of this notice is also attached as Attachment B.

X

SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities, and save for the future. Our Flexible Benefits Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Plan Administrator listed under Section I, "General Information About Our Plan."

Attachment A

****CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

You may elect to continue participation in the Plan in accordance with proposed IRS Regulations. However, unless the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) applies to your Plan, the continuation coverage will be offered until the end of the Plan Year in which the qualifying event occurs. COBRA continuation coverage generally will not be offered to Healthcare Flexible Spending Account Participants under the following circumstances:

- a) The Healthcare Reimbursement Account has a deficit at the time of the qualifying event. If, taking into account all claims submitted on or before the date of the qualifying event, your remaining Healthcare Flexible Spending Account balance for the Plan Year is less than the maximum required COBRA Premiums for the rest of the year.
- b) COBRA continuation will not be offered to a Healthcare Flexible Spending Account Participant in any Plan Year following the Plan Year in which the qualifying event occurs if:
 - 1) The Healthcare Flexible Spending Account is Exempt from HIPAA. The Healthcare Flexible Spending Account is exempt from HIPAA if a major medical plan is available in addition to the Healthcare Flexible Spending Account, and the Healthcare Flexible Spending Account benefit does not exceed two times the salary redirection or, if greater, the salary redirection plus \$500; and
 - 2) For the Plan Year in which the qualifying event occurs, the maximum amount you could be required to pay for a full year of Healthcare Flexible Spending Account COBRA coverage equals or exceeds the maximum benefit available to you for the Plan Year.

However, your Employer may choose to offer COBRA continuation coverage, notwithstanding the exceptions detailed above. If your Employer chooses to provide such additional COBRA continuation coverage, you will be provided with additional information about any other rights you may also have at that time.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Please refer to Section I, “General Information about Our Plan” of this document for your Plan Administrator’s name and address

How is COBRA coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his/her employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide written notice of any such disability, along with copies of any such written determination received from the Social Security Administration and the date it was received, to: [Name of the appropriate party to whom notice must be sent]. This information must be received by the applicable Plan representatives no less than 30 days before the end of the 18-month continuation coverage period.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep your Plan Administrator informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For more information about the Plan and your rights thereunder, contact the Plan Administrator listed under Section I, "General Information About Our Plan."

Attachment B

****HIPAA NOTICE OF PRIVACY PRACTICES****

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Purpose

This notice is intended to inform you of the privacy practices followed by your employer's Healthcare Flexible Spending Account Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor your employer often needs access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you \$0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Requirements

We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact the Plan Administrator listed under Section I, "General Information about Our Plan."

Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information.

Health Reimbursement Arrangement Plan Document

**For: Village of Sugar Grove
Health Reimbursement Arrangement**

HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

The Plan Sponsor, Village of Sugar Grove (hereinafter called "Company" or "Employer") hereby establishes a self-funded medical expense reimbursement arrangement, the "Plan", to be effective as of the Effective Date 1/1/2013.

This Plan has been established to reimburse the eligible Employees of the Employer for the reimbursement of allowable medical deductible expenses incurred by them, their Spouses and Dependents. It is intended that the Plan meet the requirements for qualification under Code Sec. 105, and that benefits paid Employees hereunder be excludible from their gross incomes by virtue of Sec. 105(b) and Sec. 106(a).

ARTICLE I DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

- 1.1 "Adoption Agreement"** means the separate agreement adopting the Employer's Plan.
- 1.2 "Affiliated Employer"** refers to all employers that are connected to and/or associated with the hiring Employer that have adopted this Plan by signing the Employer's Adoption Agreement.
- 1.3 "Benefits"** means the benefits provided for in the Employer's signed Adoption Agreement.
- 1.4 "Code"** means the Internal Revenue Code of 1986, as amended.
- 1.5 "Company"** means the Employer, or any affiliate or successor thereof that adopts this Plan pursuant to the terms of the Employer's Adoption Agreement. Such term also includes any other organization that is a member of a controlled group of businesses within the meaning of Code Sec. 414(b), (c) and (m) or any organization that is exempt from federal taxation under Code Sec. 501.
- 1.6 "Coverage Period"** means the Plan Year, during which period the benefits provided by this Plan shall be available to a Participant hereunder.
- 1.7 "Dependent"** means any individual who is a Qualifying Child or Qualifying Relative under Code Section 152 (as modified by Code Section 105(b)), as applicable. A Dependent also includes an adult child of a Participant who as of the end of the calendar year has not attained age 27. A child for

purposes of this Section 1.7 means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law.

1.8 "Effective Date" means the Effective Date in the Employer's Adoption Agreement.

1.9 "Eligible Individual" means an Eligible Employee or Dependent who: (a) is covered under a qualifying High-Deductible Health Plan, in accordance with requirements set forth under Code Section 223(c)(2); (b) is not an individual that may be claimed as a Dependent by another person for tax purposes, under Code Section 151; (c) meets other applicable testing period requirements set forth under Code Section 223 generally; and (d) is not covered under any other health plan, with the exception of any policy or program that only provides coverage for the following:

- (a) Accidents;
- (b) Disability;
- (c) Dental;
- (d) Vision;
- (e) Long-term care;
- (f) Or other "permitted insurance" defined under Code Section 223(c)(3), as otherwise amended from time to time, including insurance for a specified disease or illness.

1.10 "Eligible Medical Expenses" means those expenses incurred by the Employee, or the Employee's Spouse or Dependents that are eligible for reimbursement, as determined by the Employer's Adoption Agreement and in accordance with Article IV, and are otherwise allowable as deductions under Code Secs. 105 and 213 (without regard to the limitations contained in Code Sec. 213(a)) and any accompanying regulations or other applicable Treasury guidance information. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense. However, the following shall not be considered as being eligible expenses:

- (a) an illness or injury (or aggravation of an illness or injury) incurred by an Employee during a period of duty with the Uniformed Services.
- (b) a medical expense incurred before the Plan is in existence.
- (c) medical expenses incurred before the employee first becomes enrolled in the Plan.

1.11 "Employee" means an individual described within the Employer's Adoption Agreement as being eligible to participate in this Plan. However, the term employee does not include a "self-employed individual", as defined in Code Sec. 401(c).

1.12 “Employer” means the Plan Sponsor and any Affiliated Employer which is listed on the Employer’s Adoption Agreement; provided, however, that the Plan Sponsor retains authority as Plan Administrator for all purposes under the Plan and retains sole authority to amend or terminate the Plan in accordance with Article VIII, without the approval of any Affiliated Employer which has adopted the Plan.

1.13 “Entry Date” means the Effective Date provided for in the Plan Entry Date provision of the Employer’s Adoption Agreement.

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

1.15 “FMLA” means the Family and Medical Leave Act of 1993 (29 USCS Section 2601 et seq.).

1.16 “FMLA Leave” means a leave of absence that the Company is required to extend to an Employee under the provisions of the FMLA.

1.17 “Health Savings Account” means an account established and maintained by the Plan in accordance with Code Section 223(d) to which part of any Eligible Employee’s Flexible Benefits Plan Dollars may be allocated and from which all HSA Medical Expenses may be reimbursed or otherwise distributed as otherwise set forth herein.

1.18 “Highly Compensated Employee” means, for the purposes of determining discrimination, an Employee described in Code Section 105(h) and the Treasury regulations thereunder.

1.19 “Participant” means any Employee who has met the eligibility requirements set forth in Article III.

1.20 “Plan” means this instrument, including all amendments and attachments thereto.

1.21 “Plan Administrator” means the “plan sponsor” identified in the Employer’s Adoption Agreement, or any person or other third party appointed by the Company who has the authority and responsibility to manage and direct the operation and administration of the Plan.

1.22 “Plan Year” means the annual accounting period of the Plan as set out in the Employer’s Adoption Agreement.

1.23 “Qualified HSA Distribution” means a direct distribution of an allowable amount from a Health Reimbursement Arrangement, as otherwise allowable based on the Employer’s signed Adoption Agreement and as otherwise applicable under the Code, to an Eligible Individual’s Health Savings Account.

1.24 “Retiree” means those terms as defined in the Employer’s Adoption Agreement.

1.25 “Spouse” means an individual who is legally married to a Participant, but shall not include an individual separated from the Participant under a legal separation decree.

1.26 “Uniformed Services” means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty,

the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

All other defined terms in this Plan shall have the meanings specified in the various Articles of the Plan in which they appear.

ARTICLE II ELIGIBILITY

2.1 General requirements

Any Employee of the Employer and its Affiliates who meets the eligibility requirements specified in the Employer's Adoption Agreement shall be eligible to participate in the Plan on the Plan Entry Date specified in the Employer's Adoption Agreement (or the Effective Date of the Plan, if later). An Employee may remain eligible to participate in the Plan under other coverage continuation circumstances stated within Article V below.

2.2 Reentry after Uniformed Service Duty

No reentry eligibility requirements will be imposed on any Employee who returns to active employment within 30 days of completing a period of absence from employment for duty in the Uniformed Services.

2.3. Termination of a Participant's Coverage

Except as provided in Article V, coverage of a Participant shall terminate automatically on the date—

- (a) the Participant terminates his employment;
- (b) he is no longer in a class of Employees that is eligible for Plan coverage;
- (c) of the Participant's death; or
- (d) of termination of this Plan.

2.4. Termination of Coverage of an Eligible Dependent

Except as provided in Article V, an Eligible Dependent's coverage shall terminate—

- (a) on the dates described in Section 2.3, as if the references to "Participant" were to "Eligible Dependent";

- (b) for an Eligible Dependent other than the Spouse of a Participant, when an individual who had been an Eligible Dependent no longer qualifies as such.

2.5. Certificates of Coverage

The Plan normally will provide a Certificate of Coverage to any Participant or Dependent automatically after the individual loses coverage in the Plan. For the applicable timeframes when the Participant or Dependent has the right to elect Continuation Coverage, see Article VI. In addition, a Certificate will be provided upon request, if the request is made within 24 months after the individual loses coverage under the Plan. In that case, the Certificate will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish it. In either case, the Certificate will contain the following information:

- (a) the date the Certificate was issued;
- (b) the name of the group health plan that provided the coverage;
- (c) the name of the Participant or Dependent to whom the certificate applies;
- (d) the name, address, and telephone number of the plan administrator or issuer providing the certificate;
- (e) a telephone number for further information (if different);
- (f) either (i) a statement that the Participant or Dependent has at least 18 months (546 days) of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage (which means a period of 63 or more consecutive days during all of which an individual did not have any Creditable Coverage, exclusive of waiting periods and affiliation periods); or (ii) the date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and
- (g) the date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate.

If the Plan is requested to provide a Certificate for a Dependent, the Plan will make reasonable efforts to obtain and provide that person's name. The Plan will not issue an automatic Certificate for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

For these purposes: (1) "Certificate of Coverage" means a written certification of the period of creditable coverage of the individual under the Plan and the coverage (if any) under COBRA continuation described in Article V, and the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under this Plan; and (2) "Creditable Coverage" means prior medical coverage that an individual had from any of the following sources: a group health plan (including this Plan), health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who

have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

ARTICLE III AMOUNT OF BENEFITS

3.1 Annual Benefits Provided by the Plan

Each Participant shall be entitled to reimbursement for his documented, Eligible Medical Expenses incurred during the Plan Year in an annual amount not to exceed the amount specified on the Employer's Adoption Agreement and in accordance with the payment ordering rules, which determine whether benefits are paid under this Plan before or after some other plan or reimbursement arrangement.

If provided for under the Employer's Adoption Agreement, each Participant is entitled to carryover all or the allowable portion of any unused benefits to the subsequent plan year for use in that year, or any future periods in which the Participant remains eligible under the Plan.

3.2 Cost of Coverage

With the exception of coverage continuation situations under Article V below, the Employer shall bear the entire expense of providing the benefits set out in Section 3.1.

ARTICLE IV PAYMENT OF BENEFITS

4.1 Eligibility for Benefits

Each Participant in the Plan shall be entitled to a benefit hereunder for all Eligible Medical Expenses incurred by the Participant on or after the effective date of his or her participation, (and after the effective date of the Plan) subject to the limitations contained in Article IV, below, regardless whether the mental or physical condition for which the Participant makes application for benefits under this Plan was detected, diagnosed, or treated before the Participant became covered by the Plan.

4.2 Claims for Benefits

No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits to the Plan Administrator on a form specified by the Plan Administrator, or pursuant to the procedures set out in Article VII, below. Upon receipt of a properly documented claim, the Plan Administrator shall pay the Participant the benefits provided under this Plan as soon as is administratively feasible. A Participant may submit a claim for reimbursement for an Eligible Medical Expense arising during the Plan Year at any time during the period that begins when the expense is incurred, and any unused Benefits may be carried forward for use in future years to the extent provided for within the Employer's Adoption Agreement.

The Participant may not submit a claim that is attributable to a deduction under Section 213 for any prior taxable year or any claim that was incurred before the individual became eligible for coverage under this Plan, or which has already been paid through any other health insurance plan, Section 125 “cafeteria” plan, or other similar medical expense reimbursement arrangement.

4.3 Required Information

Each Participant's claim for benefits shall contain a written statement containing the following information:

- (a) the person or persons on whose behalf Eligible Medical Expenses have been incurred;
- (b) the nature of the expenses so incurred; and
- (c) the amount of the requested reimbursement;
- (d) a statement that such expenses have not otherwise been paid through insurance or reimbursed from any other source.

4.4 Termination of Benefits

Unless coverage is continued in accordance with Article V, coverage under this Plan shall cease immediately upon any of the following events:

- (a) a Participant is no longer employed by the Company;
- (b) a Participant fails to return to active employment with the Company at the earlier of (i) the end of an FMLA Leave or (ii) the date the Participant who is on FMLA leave gives notice to the Company of an intent not to return to active employment; or
- (c) the Participant fails to continue to fulfill the eligibility requirements as otherwise set forth herein.

Such Participant shall have the right to submit a claim for reimbursement, and receive benefits hereunder, for any Eligible Medical Expense arising during the Coverage Period at any time prior to the expiration of the earlier of: (1) 30 days following the date the Participant ceased their employment or eligibility; or (2) the end of the 60-day period following the close of the Plan Year in which the expense arose.

4.5 Ordering Rules if a Health Reimbursement Plan is Offered in Conjunction with a Section 125 Flexible Spending Account

Unless the Employer’s Adoption Agreement specifies that Eligible Medical Expenses under a Code Section 125 Flexible Spending Account must be reimbursed first before this Plan, if coverage for an Eligible Medical expense is provided under both a Code Section 125 Flexible Spending Account and the Plan, then the amounts available under the Plan must be exhausted before reimbursements can be made from the Flexible Spending Account. The Flexible Spending Account may then reimburse

employees for those costs that are not covered by the Plan. The above notwithstanding, to the extent the Employer also sponsors a Section 223 Health Savings Account (“HSA”) for the benefit of its Employees, Eligible Medical Expenses under this Plan shall only be paid in the manner specified under the Employer’s Adoption Agreement or, alternatively if no elections have been made or an individual HSA exists, Eligible Medical Expenses shall only be paid after applicable HSA deductibles have been satisfied.

4.6 Allowable Rollovers for Qualified HSA Distributions

If, in accordance with the Adoption Agreement, the Company allows a Participant to request a one-time Qualified HSA Distribution of amounts remaining in the Participant’s account in the Plan as of the last day of the Plan Year, subject a maximum distribution that is the lesser of the amount in the Participant’s Account as of September 21, 2006, or the end of the Plan Year for which the distribution is being requested, then upon receipt of a written election by the Participant to request a Qualified HSA Distribution that is otherwise allowable, the Plan shall distribute such amounts directly to the HSA trustee or custodian. After such distribution is made, the Participant's account balance under this Plan shall be considered as being a zero balance for that Plan Year and no further claims may be submitted or paid as of that date under the Plan for that period regardless of whether such claims were submitted or incurred, received or otherwise under review prior to that date.

4.7 Family and Medical Leave Act of 1993

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant’s benefits under this Plan on the same terms and conditions as though he were still an active Employee, although the Employee may be responsible for the incremental cost of coverage continuation during such leave period (i.e., the Employee will remain eligible under the Plan to the extent the Employee opts to continue his coverage during the FMLA Leave period). If the Employee opts to continue his coverage, the Employee may pay his share of the applicable premium through whatever arrangements that are agreed upon between the Employee and Employer, as subsequently administered by the Administrator (e.g., based on the Employer’s direction, the Administrator may fund coverage during the leave and withhold “catch-up” amounts upon the Employee’s return). Upon return from such leave, the Employee will be permitted to re-enter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

Furthermore, if a Participant goes on a qualifying paid leave under the FMLA, to the extent required by the FMLA, the Employee will continue coverage while on FMLA by the method normally used during any paid leave.

ARTICLE V
CONTINUATION COVERAGE

5.1 Continuation Coverage after Termination of Normal Participation

During any Plan Year during which the Employer has more than twenty (20) employees (including persons who are considered to be “employees” within Code Sec. 401(c), directors, and independent contractors to the extent that any of the three categories is eligible to participate in this Plan), each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under this Plan upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage hereunder. Such extended coverage under the plan is known as “Continuation Coverage.”

5.2 Who is a “Qualified Beneficiary”

A “Qualified Beneficiary” is any person who, as of the day before a Qualifying Event, (a) an Employee of the Employer (including persons who are considered to be “employees” within Code Sec. 401(c), directors and independent contractors) covered under the Plan as of such day (such persons are called “Covered Employees”), (b) the Spouse of the Covered Employee, or (c) a Dependent of the Covered Employee. (For these purposes, a Spouse or other Dependent is called a “Covered Dependent.”) A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct), or reduction of hours of the Covered Employee's employment. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will be treated as a “Qualified Beneficiary”.

5.3 Who is not a “Qualified Beneficiary”

A person is not a Qualified Beneficiary if, as of such day, either the individual is covered under the Plan by virtue of the election of continuation coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event, or is entitled to Medicare coverage under Title XVIII of the Social Security Act. Furthermore, an individual who fails to elect Continuation Coverage within the election period provided in Section 5.7, below, shall not be considered to be a Qualified Beneficiary.

5.4 What is a “Qualifying Event”

Any of the following is a “Qualifying Event”:

- (a) Death of a Covered Employee.
- (b) Termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment below any minimum level of hours required for participation herein. In the case of a Covered Employee who:
 - (i) does not return to covered employment at the end of an FMLA leave, the Qualifying Event of termination occurs on the *earlier* of the last day of the FMLA

Leave or the date that the Employee notifies the Company of the intention not to return to active employment, or

- (ii) is absent more than 31 days due to a period of duty with the Uniformed Services, the Qualifying Event occurs on the first day of such absence.
- (c) Divorce or legal separation of a Covered Employee from the Employee's Spouse.
- (d) A Covered Employee's becoming eligible to receive Medicare benefits under title XVIII of the Social Security Act.
- (e) A dependent child of a Covered Employee ceasing to be a Dependent.
- (f) Retirement of the employee.

5.5 What Benefit Is Available under Continuation Coverage

Each person who is eligible to elect to continue coverage under Article V shall have the right to submit claims for eligible medical expenses equal to the unused reimbursement amount remaining at retirement or other termination of employment as well as reimbursement for any additional contributions made in accordance with the applicable COBRA election. If the employee elects COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) continuation coverage, then the Employer shall fund the account as provided in Section 5.12. Amounts paid will be reduced by any administrative costs for continuing such coverage.

5.6 Notice Requirements

- (a) When an Employee becomes covered under this Plan, the Plan Administrator must inform the Participant (and spouse, if any) in writing of the rights to continued coverage, as described in Article V.
- (b) The Employer shall give the Plan Administrator written notice of a Qualifying Event within thirty (30) days of the occurrence thereof.
- (c) Within fourteen (14) days of receipt of the Employer's notice, the Plan Administrator shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the Plan, as well as a recital of the rights of any such Beneficiary to elect Continuation Coverage, as required by Code Sec. 4980B and ERISA Section 601, in accordance with the terms of this Plan.
- (d) In the case of a Qualifying Event described in Section 5.4(c) or (e), a Covered Employee or a Qualified Beneficiary who is a Spouse or Dependent of such Employee must notify the Plan Administrator within sixty (60) days of the occurrence thereof. The Plan Administrator shall give written notification of Conversion Coverage rights to any other affected Qualified Beneficiary within fourteen (14) days of receipt of the notice described in this Section 5.6(d). Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a spouse of a Covered Employee is treated as notification

to all other Qualified Beneficiaries residing with that person at the time notification is made.

5.7 Election Period

Any Qualified Beneficiary entitled to Continuation Coverage shall have 60 days from the date of the notice required by Section 5.6, in the case of occurrence of a Qualifying Event, in which to return a signed election to the Plan Administrator indicating the choice to continue benefits under this Plan.

5.8 Duration of Continuation Coverage

- (a) Continuation Coverage shall extend for a period of 18 months after the date that regular coverage ends due to the Employee's termination of employment or reduction of hours of employment to a level that disqualifies him or her from participation in the Plan, or for a period of 29 months if the Social Security Administration (SSA) determines within the 18-month period that any Qualified Beneficiary was disabled during the first 60 days of Continuation Coverage. However, if the Covered Employee was entitled to Medicare benefits at the time of the Qualifying Event of his or her termination of employment or reduction of hours, each Covered Dependent shall be eligible to continue coverage for up to 36 months from the date the Covered Employee first became so entitled. For purposes of determining continuation coverage rights "entitlement" means actual enrollment for Medicare benefits.
- (b) In order to secure the extended coverage after a determination of disability, the disabled Qualified Beneficiary must notify the plan administrator of SSA's finding within 60 days of its issue. If, during the 18-month period, a subsequent Qualifying Event occurs, the Covered Employee and each other Qualified Beneficiary having Continuation Coverage shall be entitled to elect to continue coverage under the Plan for up to 36 months following the date coverage was originally lost due to termination of employment or reduction of hours.
- (c) In addition, 36 months of Continuation Coverage shall be available to: (i) the Employee's spouse who loses coverage under this plan by ceasing to be a "Dependent" (as defined in Section 1.7) by virtue of a divorce or legal separation; (ii) a dependent child of the Employee who loses coverage by ceasing to be a dependent as defined by Code Sec. 152; (iii) any Covered Dependent who loses coverage where the Qualifying Event is the Employee's death; (iv) any Covered Dependent, where the Employee's entitlement to Medicare benefits results in loss of coverage under this Plan; or (v) any of the Employee's Covered Dependents if the Qualifying Event is the Employer's entering bankruptcy proceedings (or 36 months from the Employee's death, if later). In no event, however, shall Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

5.9 Automatic Termination of Continuation Coverage

Continuation Coverage shall automatically cease if (a) the Employer no longer offers the Plan coverage to any of its employees, (b) the required premium for continuation coverage is not paid within

30 days of the date due, (c) an electing Beneficiary becomes covered under another group health plan, or (d) an electing Beneficiary becomes eligible to receive benefits under Medicare.

Upon the termination of the Continuation Coverage, the Plan will only reimburse the former employee for medical care expenses only up to an amount equal to the unused reimbursement expenses that were incurred prior to the end of the period in which eligibility for coverage continued. Claims for any benefits must also be made in accordance with Section 4.2.

5.10 Continuation Coverage for Employees in the Uniformed Services

For purposes of this Article V, an Employee is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services has a Qualifying Event as of the first day of the Employee's absence for such duty. Such an individual shall be treated as any other Qualified Beneficiary for all purposes of COBRA under this Article V. The Plan Administrator shall furnish the Employee a notice of the right to elect COBRA continuation coverage (as provided in Section 5.6) and shall afford the Employee the opportunity to elect such coverage (in accordance with Section 5.7), except the maximum period of coverage available to the Covered Employee and the Employee's Covered Dependents is the lesser of (a) 18 months beginning on the date of the employee's absence or (b) the day after the date on which the employee fails to apply for or return to active employment with the Employer.

5.11 Premium requirements

- (a) A Qualified Beneficiary who has elected Continuation Coverage under this Article V must pay a premium of 102% of the applicable premium for the period of coverage. In the case of an individual who is determined to have been disabled (as described in Section 5.8(b)), the premium for Continuation Coverage is 150% of the applicable premium for any month after the eighteenth (18th) month of Continuation Coverage, as described in Section 5.8.
- (b) The required premium for Continuation Coverage may, at the Qualified Beneficiary's election, be paid in monthly installments.
- (c) Premiums for Continuation Coverage become payable 45 days after the day on which the Qualified Beneficiary makes the initial election for Continuation Coverage.
- (d) "Applicable premium" means the incremented cost of providing the coverage under the Plan, up to the maximum reimbursement amount, as is provided to other similarly-situated non-COBRA beneficiaries.

5.12 COBRA continuation coverage requirements

If an employee elects COBRA continuation coverage, then the Employer fulfills the COBRA requirement as provided in Section 4980B by increasing the amount available to the Employee under the Plan by the same increment as similarly situated non-COBRA beneficiaries.

**ARTICLE VI
PLAN ADMINISTRATION**

6.1 Allocation of Authority

Except as to those functions reserved within the Plan to the Employer or the Employer's board of directors (the "Board"), the Plan Administrator shall control and manage the operation and Administration of the Plan. The Plan Administrator shall have the exclusive right (except as to matters reserved to the Board by the Plan or which the Board may reserve to itself) to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator or the Board with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

- (a) To require any person to furnish such reasonable information as it may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;
- (b) To make and enforce such rules and regulations and prescribe the use of such forms as shall be deemed necessary for the efficient administration of the Plan;
- (c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan;
- (d) To determine the amount of benefits that shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer, as appropriate, of the amount of such Benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part; and
- (e) To designate other persons to carry out any duty or power which would otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan.

6.2 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Board, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. The Plan Administrator, the Employer (and any person to whom it may delegate any duty or power in connection with the administration of the Plan), and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant, (including Employees who are actuaries or accountants), consultant, third party administration service provider, legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive and binding as to all persons.

6.3 Fiduciary Liability

To the extent permitted by law, neither the Plan Administrator nor any other person shall incur any liability for any acts or for failure to act except for his own willful misconduct or willful breach of this Plan.

6.4 Compensation of Plan Administrator

Unless otherwise agreed to by the Board, the Plan Administrator shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of his duties shall be paid by the Employer.

6.5 Bonding

Unless otherwise determined by the Board, or unless required by any Federal or State law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

6.6 Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third party administrative service provider, actuary, consultant, accountant, attorney, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, shall be paid by the Employer, provided, however that each Participant shall bear the monthly cost (if any) charged by a third party administrator for maintenance of his Benefit Account unless otherwise paid by the Employer.

6.7 Funding Policy

The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by, the Employer.

6.8 Source of Payments

The Employer shall cause the trustee to pay any non-insurance benefits to which a Participant is entitled under this Plan from the trust created herein.

6.9 Disbursement Reports

The Plan Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's general assets pursuant to the provisions of the Plan.

6.10 Timeliness of Payments

Payments shall be made as soon as administratively feasible after the required forms and documentation have been received by the Plan Administrator.

6.11 Requirement that Participants Substantiate Reimbursable Expenses

Each Participant must submit a written claim voucher to the Plan Administrator to receive reimbursements from the Plan on a form provided by the Plan Administrator, along with such evidence as the Plan Administrator reasonably may deem necessary to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed. Year-end expense reimbursement claims must be submitted to the Plan Administrator within 60 days of the close of the Plan Year during which any such expense was incurred, in order to be eligible for reimbursement. Likewise, if a Participant terminates participation in the Plan, such Participant shall be entitled to submit to the Plan Administrator any claims for reimbursement for reimbursable expenses incurred up to the date that coverage ceases at any time prior to the expiration of the earlier of: (1) 30 days following the date the Participant ceased their employment or eligibility; or (2) the end of the 60-day period following the close of the Plan Year in which the expense arose.

6.12 Periodic Account Statements

The Plan Administrator shall, on a periodic basis, provide each Participant with a statement of his medical expense reimbursement account balance, as well as provide a copy of such information to any Participant who makes a specific written request.

ARTICLE VII CLAIMS PROCEDURE

7.1 Method of Benefit Payment

(a) The Administrator shall make any and all payments or other reimbursements of Eligible Medical Expenses in the manner specified under Section 4.2, unless otherwise specified herein or as otherwise elected by the Employer (e.g., direct reimbursement by check, automatic deposit via automated clearing house (ACH), etc.).

(b) As an alternative to the method of Benefit payment referenced in Section 4.2 above, if an Eligible Employee agrees to the terms and conditions of any applicable cardholder agreement that provides for the payment of Eligible Medical Expenses through use of a debit or credit card, stored value card or other similar electronic media (hereinafter the "Debit Card"), payments under this Plan shall be made directly to the service provider, authorized merchant or other independent third party that provides products or services that are eligible for payment of Eligible Medical Expenses as otherwise set forth herein.

(i) Within the cardholder agreement, the Eligible Employee agrees that payment for Eligible Medical Expenses can only be made on behalf of the Employee, the Employee's spouse or other qualifying dependents and is otherwise limited to the maximum dollar amount of

coverage that is otherwise specified for that Benefit in accordance with the limitations set forth in the Employer's signed Adoption Agreement or as otherwise specified by the Employee's signed Election. The Employee also certifies that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. The Employee-cardholder also understands that the certification, which shall be printed on the back of the Debit Card, is reaffirmed each time the card is used. The Employee-cardholder also agrees to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate or as required by law. The Employee-cardholder also understands that the Debit Card is automatically cancelled at termination of employment or under such other situations that are otherwise set forth within the cardholder agreement itself.

(ii) Unless other more stringent procedures or requirements are implemented and communicated to the Employer and its Employees, the Administrator agrees that it shall adhere to the terms and conditions of any separate Employer cardholder servicing agreement, including but not limited to a requirement to maintain the program in compliance with applicable standards under the Internal Revenue Code and any mandates that payments for Eligible Medical Expenses only be made to authorized merchants and service providers. The Administrator also agrees that it shall establish and maintain procedures for substantiation of any payments after the card has been used, for Eligible Medical Expense payments that are in accordance with applicable provisions of the Code, any underlying Regulations and other applicable guidance thereunder.

(iii) If any claim reimbursement request is being submitted in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator may make a conditional payment of an allowable Eligible Medical Expense reimbursement item to the authorized service provider, merchant, or approved independent third party, but shall also require the Participant-cardholder to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which shall be subject to further review and substantiation.

(iv) If any conditional payment has been made but is subsequently not deemed to be an Eligible Medical Expenses reimbursement, the Administrator shall ensure that proper correction procedures are maintained with respect to the improper payment(s):

- (A) Upon identification of any improper payment, the Administrator shall require the Employee to pay back to the Plan an amount equal to the improper payment;
- (B) If the Employee does not immediately repay the Plan, the Administrator shall ensure that the proper amount is withheld from the Employee's wages or other compensation (with such amounts then being immediately remitted to the Plan by the Employer) to the extent consistent with applicable law;
- (C) To the extent that neither (A) nor (B) above are allowable or effective, the Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to the Employee-cardholder as part of his Employee cardholder agreement.

- (D) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the Debit Card until the indebtedness is repaid by the Employee. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or Employee cardholder agreement.
- (v) If a Participant attempts to utilize the Debit Card for any improper or non-allowable purpose, the Participant shall be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by the Participant.

7.2 Procedure if Benefits are Denied under the Plan

Any claim for Benefits shall be made to the Administrator. If the Administrator denies a claim or rescinds Benefits under the Plan, the Administrator may provide notice to the Participant or beneficiary, in writing, within 30 days after the claim is filed unless special circumstances require an extension of time for processing the claim. If the Administrator does not notify the Participant of the denial of the claim within the 30-day period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a culturally and linguistically appropriate manner calculated to be understood by the claimant and shall set forth:

- (a) Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- (b) The reason(s) for the denial;
- (c) Specific reference to the provisions of the Plan on which the denial was based;
- (d) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
- (e) A description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the Participant's right to bring a civil action under Section 502 of ERISA following a final appeal;
- (f) A statement of a Participant's right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
- (g) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon written request;
- (h) The availability of and contact information for an applicable office of health insurance

consumer assistance or ombudsman established under PHS Act Section 2793.

7.3 Right to Request Hearing on Benefit Denial

When the Participant receives a denial, the Participant shall have 180 days following the receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

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

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

The Plan Administrator will provide a claimant with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

7.4 Disposition of Disputed Claims

Upon its receipt of notice of a request for review, the Plan Administrator shall make a prompt decision on the review. The decision on review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based. The decision on review shall be made not later

than sixty (60) days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than one hundred-twenty (120) days after receipt of a request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial sixty (60) day period. If notice of the decision on the review is not furnished in accordance with this Section, the claim shall be deemed denied and the claimant shall be permitted to exercise his right to legal remedy pursuant to Section 7.4.

7.5 External Claims Review

After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the Plan a request for an external review. A claimant may request from the Plan Administrator additional information describing the Plan's external review procedure.

7.6 Preservation of Other Remedies

After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article VII, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law.

ARTICLE VIII AMENDMENT OR TERMINATION OF PLAN

8.1 Permanency

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 8.2 and 8.3, below.

8.2 Employer's Right to Amend

The Employer reserves the right to amend the Plan at any time and from time-to-time, and retroactively if deemed necessary or appropriate to meet the requirements of Code Sec. 105, or any similar provisions of subsequent revenue or other laws, or the rules and regulations in effect under any of such laws or to conform with governmental regulations or other policies, to modify or amend in whole or in part any or all of the provisions of the Plan. Any amendment shall be effected by a written resolution adopted by a majority of the Board.

8.3 Employer's Right to Terminate

The Employer reserves the right to discontinue or terminate the Plan at any time without prejudice, provided that plan termination must be effected by a written resolution adopted by a majority of the Board. This Plan also shall terminate automatically if the Company (1) is legally

dissolved, (2) makes a general assignment for the benefit of its creditors, (3) files for liquidation under the Bankruptcy Code, (4) merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Company's successor in interest agrees to assume the liabilities under this Plan as to the Participants and Eligible Dependents.

ARTICLE IX GENERAL PROVISIONS

9.1 Relationship to a Cafeteria Plan

If an employer offers health care benefits under a cafeteria plan as provided under Section 125 of the Code, then an employee may also participate in this Plan as well. However, for purposes of funding the Plan, as provided in Section 3.2, the Employer shall bear the entire cost associated with the funding of the Plan. An arrangement which permits an employee to salary reduce to indirectly fund the Plan will disqualify such Plan and the arrangement will be subject to the provisions of Section 125.

9.2 Non-Discrimination Requirements

To the extent that the Plan is treated as a self-insured medical expense plan under Reg. Section 1.105-11, it must comply with the non-discrimination requirements as set forth under Section 105(h).

9.3 No Employment Rights Conferred

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

9.4 Payments to Beneficiary

Any benefits otherwise payable to a Participant following the date of death of such Participant shall be paid to his spouse, or, if there is no surviving spouse, to his estate, but only to the extent such benefits are related to Eligible Medical Expenses incurred by the Participant or his eligible dependents prior to his date of death.

9.5 Non-alienation of Benefits

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person. If any person entitled to benefits under the Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge any benefit under the Plan, or if any attempt is made to subject any such benefit to the debts, contracts, liabilities, engagements or torts of the person entitled to any such benefit, except as specifically provided in the Plan, then such benefit shall cease and terminate in the discretion of the Plan

Administrator, and he may hold or apply the same or any part thereof to the benefit of any dependent or beneficiary of such person, in such manner and proportion as he may deem proper.

9.6 Mental or Physical Incompetency

If the Plan Administrator determines that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, he may cause all payments thereafter becoming due to such person to be made to any other person for his benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Plan Administrator and the Employer.

9.7 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because he cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due shall be forfeited and returned to the Employer.

9.8 Requirement of Proper Forms

All communications in connection with the Plan made by a Participant shall become effective only when duly executed on forms provided by and filed with the Plan Administrator.

9.9 Source of Payments

The Employer shall be the sole source of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

9.10 Tax Effects

Neither the Company nor the Plan Administrator makes any warranty or other representation as to whether any payments received by a Participant hereunder will be treated as includible in gross income for federal or state income tax purposes.

9.11 Multiple Functions

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

9.12 Gender and Number

Masculine pronouns include the feminine as well as the gender neutral, and the singular shall include the plural, unless indicated otherwise by the context.

9.13 Headings

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

9.14 Applicable Laws

The provisions of the Plan shall be construed, administered and enforced according to applicable Federal law and the laws of the State as stated in the Employer Adoption Agreement.

9.15 Severability

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

ARTICLE X HIPAA PRIVACY

10.1 Definitions

In addition to the specific definitions set forth below, all other capitalized terms used that are not otherwise defined herein have the meanings ascribed in HIPAA:

- (a) “Designated Record Set” has the meaning in 45 CFR Section 164.501.
- (b) “Electronic Media” has the meaning in 45 CFR Section 160.103, which is:
 - 1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
 - 2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/ transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- (c) “Electronic Protected Health Care Information” (also known as “ePHI”) has the meaning in 45 CFR Section 160.103, and is limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of the Plan.

(d) “Plan Administration Functions” is defined as activities that would meet the definition of Payment or Health Care Operations by HIPAA as set forth in 45 C.F.R. Section 164.501, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administration includes quality assurance, claims processing, auditing, monitoring, and management of carve-out Plan (i.e., vision and dental). Plan administration does not include any employment-related functions or functions in connection with any other benefits or benefit Plan, and the Plan(s) may not disclose information for such purposes absent an authorization from an individual for whom the information pertains. In addition, enrollment functions performed by Company are not considered as Plan Administration Functions.

(e) “PHI” is defined as Protected Health Information, as set forth in 45 C.F.R. Section 164.501. It is information that is created or received by a health plan, employer, health care provider, or health care clearing house and includes information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. In addition, the information either identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. This information may be maintained or transmitted either electronically or in any other form or medium.

f) “Secretary” means the Secretary of the Department of Health and Human Services or designee.

g) “Security Incident” has the meaning in 45 CFR Section 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(h) “Summary Health Information” is defined by HIPAA as set forth in 45 C.F.R. Section 164.504 as information that may be PHI, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom Company has provided health benefits under the Plan; and from which the following information has been deleted, except that the geographic information described in (2) below need only be aggregated to the level of a five digit zip code.

(1) Names;

(2) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(A) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(B) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

- (3) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
- (4) Telephone numbers;
- (5) Fax numbers;
- (6) Electronic mail addresses;
- (7) Social security numbers;
- (8) Medical record numbers;
- (9) Health plan beneficiary numbers;
- (10) Account numbers;
- (11) Certificate/license numbers;
- (12) Vehicle identifiers and serial numbers, including license plate numbers;
- (13) Device identifiers and serial numbers;
- (14) Web Universal Resource Locators (URLs);
- (15) Biometric identifiers, including finger and voice prints;
- (16) Full face photographic images and any comparable images; and
- (17) Any other unique identifying number, characteristic, or code.

10.2 Disclosure of Summary Health Information

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to Company, if Company requests the Summary Health Information for the purpose of:

- (a) Obtaining premium bids from health Plan for providing health insurance coverage under the Plan; or
- (b) Modifying, amending, or terminating the Plan.

10.3 Disclosure of PHI

The Plan may release PHI to the Company, so long as the Company agrees to do the following:

- (a) Company shall not use or further disclose the PHI other than as permitted or required by the Plan's documents or as required by law;
- (b) Company shall ensure that any agents, including a subcontractor, to whom it provides PHI shall agree to the same restrictions and conditions that apply to Company with respect to such PHI;
- (c) Company shall not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Company;
- (d) Company agrees to report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures providing herein, if and when Company becomes aware of such inconsistent use or disclosure;
- (e) Company, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with Company Privacy Policy, has authorized the Plan to make PHI available to individuals;
- (f) Company, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with Company Privacy Policy, has authorized the Plan to make PHI available to individuals for amendment and to incorporate such amendments of PHI;
- (g) Company, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.528 and consistent with Company Privacy Policy, has authorized the Plan to make available the information required to provide an accounting of disclosures;
- (h) Company, agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for purposes of determining the Plan's compliance with HIPAA; and
- (i) If feasible, Company shall return or destroy all PHI that Company received from the Plan and which Company no longer needs for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, Company shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
- (j) Company agrees to use appropriate safeguards to prevent unauthorized use or disclosure of PHI, and have reasonable and appropriate safeguards in place to protect the confidentiality, integrity and availability of ePHI;
- (k) Company agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement;
- (l) Company agrees to report to the Plan, any use or disclosure of PHI of which it becomes aware that is not permitted or required by HIPAA; and

- m) Company agrees to report to the Plan any Security Incident of ePHI of which it becomes aware.

10.4 Adequate Separations

The Company shall ensure that the following adequate separations are established:

- (a) Company shall designate specific people who shall use and disclose PHI on behalf of the Plan for purposes of Plan Administration Functions. The Plan shall use and/or disclose (as proscribed in Section 10.5) PHI to the following people:
 - (i) Plan Administrator
 - (ii) HIPAA Privacy Official
 - (iii) Other Personnel, specifically designated by the Plan's Privacy Official
- (b) Access and use of PHI by the Group shall be limited to Plan Administration Functions that Company performs on behalf of the Plan;
- (c) Any issues of non-compliance by the Group shall result in disciplinary measures specified in Company Privacy Policy.

10.5 Uses and Disclosures.

The Plan may:

- (a) Disclose PHI to Company in order for Company to carry out Plan Administration Functions consistent with the provisions of Subsections (a) through (m) of Section 10.4 above;
- (b) Permit an insurance plan, insurance service, insurance organization, or HMO to disclose PHI to Company, so long as the disclosure is made to a person listed in the Group, and the disclosure is only for the purpose described in this Section 10.5;
- (c) Not disclose or permit an insurance, insurance service, insurance organization, or HMO to disclose PHI to Company unless Company's privacy notice contains a provision which permits such disclosure; and
- (d) Not disclose PHI to Company for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Company.

Summary Plan Description

**For: Village of Sugar Grove
Health Reimbursement Arrangement**

HEALTH REIMBURSEMENT ARRANGEMENT

Summary Plan Description

INTRODUCTION

We are pleased to announce that we have established a medical expense reimbursement program for you and other eligible employees. Under this program, you will be able to receive reimbursement for the cost of eligible medical deductible expenses without taxation to you individually. The purpose of this Summary Plan Description is to briefly describe the expenses that qualify for reimbursement, as well as provide an outline of other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

However, one of the most important features of our Plan is that the cost of all benefits being offered to you within this Plan are entirely paid for by us, the Employer, at no additional cost to you or your family.

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a participant. You should direct any questions you have to the Administrator. There is a Plan document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan document, the Plan document will control. Also, to the extent there are any type of insurance contracts that exist to provide any portion of benefits under this Plan, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract would control.

**PART A
ADOPTION AGREEMENT
GENERAL INFORMATION ABOUT OUR PLAN**

This Section contains certain general information, which you may need to know about the Plan.

1. General Plan Information. Village of Sugar Grove (employer name) Health Reimbursement Arrangement is the name of the Plan.
2. The provisions of your Plan became effective on 1/1/2013, which is called the Effective Date of the Plan. The provisions of the amended Plan became effective on 1/1/2013.
3. Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The initial and future Plans begin on 01/01 and ends on 12/31.
4. Your Employer has assigned Plan Number 505 to your Plan, unless your employer already had a prior plan that was assigned Plan Number 505.
5. Employer Information

Your Employer's name, address and identification number are:

Village of Sugar Grove
10 S. Municipal Drive
Sugar Grove, IL
60554

EIN: 366009121

6. The Plan shall be governed under the laws of the State of IL.
7. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator (also referred to as the "Administrator") is:

Village of Sugar Grove
10 S. Municipal Drive
Sugar Grove, IL
60554

Phone: 630-466-4507

The Administrator keeps the records for the Plan and is responsible for the Plan. The administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

8. Service of Legal Process

The Administrator is the Plan's agent for service of legal process.

9. Type of Administration

The type of Administration is Employer Administration.

10. Eligibility Requirements.

All Employees are considered eligible to participate in this Plan except:

Self-employed person(s), within the meaning of Code Section 401(c), including independent contractors, a greater than 2% shareholder in a Subchapter S corporation, a partner in a partnership, or any owner or member of a limited liability company that is treated like a partnership for tax purposes AND

A relative, within the meaning of IRC Section 318, of one of the above self-employed person(s)
AND:

- Employees not eligible under Employer's group medical plan.
- Employees not electing Employer group medical plan.
- Part-time Employees expected to work at less than hours per week.
- Commissioned Employees
- Union Employees (which shall include any Employee of the Employer who is included in a unit of employees covered by an agreement which the Secretary of Labor finds to be a collective bargaining agreement between employee representatives and one or more employers), unless the collective bargaining agreement requires the employee to be included within the Plan.
- Temporary or seasonal Employees (working for the Employer less than 6 months of the year)
- Leased Employees, as well as any independent contractor, or other "statutory employee" who is not treated as a common law employee of the Employer for payroll purposes, regardless of any other court or administrative agency determination.
- Nonresident Aliens

For purposes of determining continued eligibility under the Plan, Retirees shall not be eligible to continue participation in the Plan.

11. Entry Date. The Entry Date for eligible Employees shall be:

Same as Employer's group Medical Plan.

12. Benefits. The Plan shall reimburse Eligible Employees for the cost of Eligible Medical Expenses (as defined under Internal Revenue Code Sections 105 and 213 (without regard to the limitations contained in Code Sec. 213(a)), and any accompanying regulations or other applicable Treasury guidance information and as further described below), subject to the

Annual Limit. (None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred).

Types of Eligible Medical Expenses. The following types of Medical Expenses qualify for reimbursement under the Plan:

Deductible Medical Expenses

Note: If the Employer also sponsors a Section 223, Health Savings Account, qualifying Medical Expenses shall be limited in accordance with the Benefit ordering rules discussed below.

Eligible Medical Expenses. The following categories of expenses qualify for reimbursement under the Plan:

Bridge: Only those expenses that are covered under insurance, but subject to a deductible.

Employee Only Coverage: Plan Deductible: \$2,500. Village of Sugar Grove reimburses 90% of the \$2,500 or a maximum of \$2,250 reimbursed by Village of Sugar Grove You are responsible for the 10% or \$250.00 and remainder of the out-of-pocket limit once you meet your deductible. Please review your plan highlight sheet for these limits. TOTAL REIMBURSEMENT = \$2,250.00

Family Coverage: Plan Deductible: \$5,000. Village of Sugar Grove reimburses 90% of the \$5,000 or a maximum of \$4,500 reimbursed by Village of Sugar Grove You are responsible for the 10% portion or \$500.00 and remainder of the out-of-pocket limit once you meet your deductible. Please review your plan highlight sheet for these limits. TOTAL REIMBURSEMENT = \$4,500.00

Benefits under this Plan shall be paid BEFORE the employee is responsible for his portion of the deductible limit.

13. Annual Limit.
Health Reimbursement Arrangement is subject to an annual limit of \$2,250 (Single) and \$4,500 (Family).

Description	Annual Limit
Family	\$4,500
Employee +1	\$Not Applicable
Individual	\$2,250

Newly-eligible participants may have access to the Annual Limit at the time of plan entry.

14. Access to Benefits. Other than for Retiree/COBRA continuees, the employer shall make all contributions for this Plan. The employer shall make access to benefits under the plan in the following manner: On an annual basis at the beginning of the Plan Year.

15. Order of Benefit Payments. If the Employer sponsors a Section 125 Flexible Spending Arrangement, in addition to this Plan: Eligible Medical Expenses must be paid under the Section 125 Plan after this Plan.

Note: If the Employer also sponsors a Section 223, Health Savings Account (“HSA”) program for eligible employees, this Plan shall suspend payment of all Eligible Medical Expenses until all HSA deductible limits have been satisfied (and subject to the ordering rules with the applicable Section 125 Flexible Spending Arrangement as set forth above).

16. Carry over amounts. There are no carry over HRA amounts under this plan.
17. Claims. Outstanding claims may not be considered for the next plan year.
18. Rollovers to HSA Accounts. Rollovers to HSA accounts will not be allowed.
19. COBRA Continuation: Qualified employees must be required to elect COBRA continuation for Employer sponsored medical insurance before being eligible to elect COBRA continuation for the Health Reimbursement Arrangement.
20. Run-Out Date: 4/30/

21. **Authorized Signatures:**

Date _____
Employer

By _____
Authorized Signature

Date _____
Witness

By _____
Authorized Signature

PART B
QUESTIONS & ANSWERS

I-1. What is the purpose of the Plan?

The purpose of the Plan is to provide a source of funds to reimburse you or your dependents that are covered under the Plan for some or all of the uninsured medical expenses you incur in the course of each year while you are employed with the Company and the Plan remains in effect.

I-2. When did the Plan take effect?

Please refer to Part A, "General Information About Our Plan," subsection (2), of this document for a description of the "effective date" for our Plan.

I-3. Who can participate in the Plan?

You will be eligible to join the Plan once you have satisfied the conditions for eligibility. If you are not eligible to participate in this Plan on the Effective Date of the Plan, you will be eligible to join the Plan once you have satisfied the Eligibility Requirements under this Plan. Please refer to Part A, "General Information About Our Plan," subsection (10), of this document for a description of our eligibility requirements.

I-4 Who shall make all of the contributions to the Plan?

As your employer, we will make all of the contributions necessary to fund the Plan. Please refer to Part A. "General Information About Your Plan" of this document for a description of our contribution schedule.

I-5. How much of my uninsured medical expenses may be reimbursed each year?

Please refer to Part A, "General Information About Our Plan," subsection (13), of this document for a description of the "Annual Limit" for our Plan. To the extent provided for in Part A, all or a portion of any unused amounts remaining at the end of the calendar year may be carried over for use in future periods in which you remain eligible under the Plan.

I-6. How do I become a Participant?

Before you become a member or a “participant” in the Plan, there are certain rules which you must satisfy. First, you must meet the “eligibility requirements.” Please refer to Part A, “General Information About Our Plan” of this document for a description of our eligibility requirements.

Once you have met the eligibility requirements, Please refer to Part A, “General Information About Our Plan” of this document for a description of our Entry Date.

I-7. How do I receive my benefits under the Plan?

When you incur an eligible medical expense, you must submit a claim reimbursement request to the Plan's Administrator within the time frames specified under Part C, Section 2 set forth below. If the Plan Administrator determines that your claim is valid, you will be reimbursed for your eligible expenses as soon as is administratively feasible after it has been submitted. You may submit a claim for any eligible medical expense arising during the Plan Year at any time during the period that begins when the expense is incurred. Remember, though, you can't be reimbursed for any total expenses above the annual amount of benefit the Company has provided plus any unused carryover amounts from the previous calendar year. If your claim arises while you have COBRA continuation coverage (see Answer I-17), all required premiums for the coverage (subject to a 30-day grace period for late payment of premiums) also must have been received by the Company prior to the request for reimbursement of otherwise allowable expenses.

To have your claims processed as soon as possible, please read the *Claims Instructions* that have been furnished to you by the Plan Administrator. Please note that it is *not* necessary that you have actually paid an amount due for an eligible medical expense—only that you have *incurred* the expense, and that it is not being paid for or reimbursed from any other source. For purposes of the Plan, you are considered to have “incurred” an expense when the health care services are rendered for which you are seeking a reimbursement, and not when you have actually paid the bill.

I-8. What is an “eligible expense?”

An “eligible expense” means any expense identified as an Eligible Medical Expense that is further described under subsection 12 of Part A, “General Information About our Plan” described above. However, you may not submit a claim for an amount that has been deducted on your prior year’s personal tax return or that was incurred prior to the time that you became a participant under the Plan, nor shall you be entitled to submit a claim for any other expenses that have been paid through any other health insurance plan, Section 125 “cafeteria” plan, or other similar medical expense reimbursement arrangement. In addition, you may not submit a claim for medical expenses related to any over-the-counter (OTC) medicine or drug that is not prescribed or is not insulin. Please review the list of any other eligible medical expenses included with the *Claims Instructions* for assistance in determining what is generally accepted as an “eligible expense.”

I-9. When must the expenses be incurred that I may be reimbursed for?

Eligible expenses must have been incurred after the date the Plan became effective. You may not be reimbursed for any expenses arising before the Plan became effective, or prior to the time you became covered under the Plan, if later.

I-10. Does the Plan also provide benefits for my family?

The Plan provides reimbursement for expenses incurred for you, your spouse, and any other person you could claim as a dependent on your federal income tax return.

I-11. What happens if my claim for benefits is denied?

You will be notified in writing by the Plan's Administrator within 30 days of the date you submitted your claim if the claim is denied. If you do not receive notification of the denial of a claim within the 30 day period, then if the claim is not otherwise paid, it will be deemed denied. The notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 180-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review. See Part C, subsection (4), below for more information regarding your rights to appeal any adverse claim determination.

I-12. Does my coverage under this Plan end when my employment terminates?

Generally yes. Your normal participation will cease at the end of the last day before your employment with the Company terminates. However, you may still receive reimbursement of any eligible expenses, as otherwise provided for under the Plan, as long as such reimbursement requests are made prior to the expiration of the earlier of: (1) 30 days following the date that you ceased your employment or eligibility; or (2) the end of the 60-day period following the close of the Plan Year in which the expense arose. In addition, you and your family will also have the opportunity to continue to be covered under the Plan under the terms of the Continuation Coverage provisions described in Answer I-17, below. Under all circumstances, coverage ends upon the earlier of your death or the date the Plan terminates.

I-13. Will my coverage end if I go on a family or medical leave under the FMLA?

Subject to certain conditions, the Family and Medical Leave Act ("FMLA") entitles you to take unpaid leaves of absence totaling 12 weeks per year for specific personal or family health and child care needs. Your coverage under the Plan will continue while you are on an FMLA leave as long as you opt to continue your coverage under the Plan and continue to make any applicable premium contributions that would otherwise be paid by your employer. Upon your return you will be permitted to re-enter the Plan on the same basis that you were participating in prior to taking FMLA leave. However, you will lose coverage when you fail to return to work at the end of the leave or give earlier notice that you will not be returning to active employment.

I-14. Does my coverage continue while I am absent on duty in the uniformed services?

The Plan will continue to reimburse you or your family for eligible medical expenses (except for any illness or injury suffered by you in connection with duty in the uniformed services) for the first 30 days of your absence. However, coverage after that period will be suspended while you are on approved military service leave, unless you opt to continue coverage under the Plan in accordance with the procedures set forth in Answer I-17. No re-entry requirements will be imposed if you return to active employment within 30 days of taking leave of employment for duty in the uniformed services.

The “uniformed services” are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

I-15 Which Plan pays first if I am already enrolled in a Flexible Spending Account?

Please refer to Part A, “General Information About Our Plan” subsection (15) of this document to determine the Order of Benefit Payments option, if we provide the capability for you to participate in a Section 125 “Cafeteria” Flexible Spending Arrangement, in addition to this Plan.

If your Employer offers an HSA Program, with the exception of “limited benefits” that may be paid concurrently, any qualifying medical expense amounts that can be paid under the HSA Program must be exhausted before reimbursements can be made from the Health Reimbursement Arrangement. The Health Reimbursement Arrangement may then also reimburse employees for those costs that are not otherwise covered by the HSA or other provisions of the Plan.

I-16 Can I use my unused account balance for my Health Savings Account?

Yes, if elected under Part A, “General Information About Our Plan” subsection (18). In that case, the Company allows you to request a one-time Qualified HSA Distribution of amounts remaining in your account under this Plan as of the last day of the Plan Year, subject a maximum distribution that is the lesser of the amount in your account as of September 21, 2006, or the end of the Plan Year for which the distribution is being requested. Upon receipt of a qualifying election from you requesting an otherwise allowable amount from this Plan, we will distribute these amounts directly to the HSA trustee or custodian on your behalf. However, you should note that after such a distribution is made, your remaining account balance, if any, under this Plan shall be considered as being a zero balance for that Plan Year and no further claims may be submitted or paid as of that date under the Plan for that period regardless of whether such claims were submitted or incurred, received or otherwise under review prior to that date.

I-17. What is “Continuation Coverage,” and how does it work?

“Continuation Coverage” means your right, or your spouse and dependents' right, to continue to be covered under this Plan if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a “Qualifying Event.” A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours below what is required for participation under this Plan.
- your death.
- divorce or legal separation from your spouse.
- your becoming eligible to receive Medicare benefits.
- when a dependent of yours ceases to be a dependent.

It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs. The notice of these rights that you will receive will explain all the rest of the terms and conditions of the continued coverage.

If you or any of your Eligible Dependents elect to continue coverage under the Plan, you or they will be required to pay premiums for the coverage. The Plan Administrator will inform you of the cost of continued coverage and the schedule for premium payments in the notice that will be sent to you and your Dependents after a Qualifying Event has occurred.

I-18. How long will the Plan remain in effect?

Although the Company expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time.

This Plan may be amended or terminated by a written resolution adopted by a majority of the Company's Board of Directors. The Plan will also automatically terminate if the Company (1) is legally dissolved, (2) makes a general assignment for the benefit of its creditors, (3) files for liquidation under the Bankruptcy Code, (4) merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Company's successor in interest agrees to assume the liabilities under this Plan as to the Participants and Eligible Dependents. If the Plan is terminated, credits to your Accounts will be used to provide benefits through the end of the Plan Year in which termination occurs. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

PART C ADDITIONAL PLAN INFORMATION

1. Plan Accounting

The Plan Administrator shall periodically furnish you with a statement of your medical expense reimbursement account for you to use in determining how much additional benefits remain in your

account prior to the end of the Plan Year, which will also assist in budgeting for expense reimbursement needs in future Plan Years. You may also make a written request to receive a copy of your medical expense reimbursement account from the Plan Administrator at any time.

2. Claims Instructions

No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits to the Plan Administrator on a form specified by the Plan Administrator, or as otherwise set out below. Upon receipt of a properly documented claim, the Plan Administrator shall pay the Participant the benefits provided under this Plan as soon as is administratively feasible. A Participant may submit a claim for reimbursement for an Eligible Medical Expense arising during the Plan Year at any time during the period that begins when the expense is incurred.

The Participant may not submit a claim that is attributable any prior taxable year or any claim that was incurred before the individual became eligible for coverage under this Plan, or which has already been paid through any other health insurance plan, Section 125 “cafeteria” plan (including the Primary Care Holding Company Cafeteria Plan), or other similar medical expense reimbursement arrangement.

Two types of documentation are usually acceptable to the Plan Administrator as substantiation of any claim request:

First, you must submit your claims under any insurance plan under which the person receiving the medical service is covered - your own, your spouse’s, and/or your dependent’s health plan. This will result in the insurer sending an Explanation of Benefits (EOB). You may send the EOB as documentation of an unreimbursed out-of-pocket medical expense. Second, for unreimbursed out-of-pocket medical expense not covered by insurance and not documented by an EOB, you may submit a provider statement of the expenses, including: name of the recipient of the service; date of the service; description of the service; cost of the service; and name, address of the provider. You must also fill out a form provided to you by the Plan Administrator.

- a) The Plan Administrator will process your claim, deduct the money from your Account, and send you a check in payment of your claim. The Plan Administrator issues checks as soon as reasonably practicable, but no less than monthly. If your claim request is denied, you will be notified of this denial under procedures further discussed and set forth below.
- b) As an alternative to the method of payment referenced in subsection a) above, if an Eligible Employee agrees to the terms and conditions of any applicable cardholder agreement that provides for the payment of Eligible Medical expenses through use of a debit card, credit card, other stored value card or other similar electronic media (hereinafter the “Debit Card”), payments under this Plan shall be made directly to the service provider, authorized merchant or other independent third party that provides products or services that are eligible for payment of Eligible Medical expenses as otherwise set forth herein.

- (i) Within the cardholder agreement, the Eligible Employee agrees that payment for Eligible Medical expenses can only be made on behalf of the Employee, the Employee's spouse or other qualifying dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth in the Employer's signed Adoption Agreement or as otherwise specified by the Employee's signed Election. The Employee also certifies that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. The cardholder also understands that the certification, which shall be printed on the back of the Debit Card, is reaffirmed each time the card is used. The cardholder also agrees to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate or as required by law. The cardholder also understands that the Debit Card is automatically cancelled at termination of employment or under such other situations that are otherwise set forth within the cardholder agreement itself.
- (ii) Unless other more stringent procedures or requirements are implemented and communicated to the Employer and its Employees, the Administrator agrees that it shall adhere to the terms and conditions of any separate Employer cardholder servicing agreement, including but not limited to a requirement to maintain the program in compliance with applicable standards under the Internal Revenue Code and any mandates that payments for Eligible Medical expenses only be made to authorized merchants and service providers. The Administrator also agrees that it shall establish and maintain procedures for substantiation of any payments after the card has been used for Eligible Medical Expense payments that are in accordance with applicable provisions of the Code, any underlying Regulations and other applicable guidance thereunder.
- (iii) If any claim reimbursement request is being submitted in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator may make a conditional payment of an allowable Eligible Medical Expense reimbursement item to the authorized service provider, merchant, or approved independent third party, but shall also require the cardholder to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which shall be subject to further review and substantiation.
- (iv) If any conditional payment has been made but is subsequently deemed not to be an Eligible Medical expenses reimbursement, the Administrator shall ensure that proper correction procedures are maintained with respect to the improper payment(s):
 - (A) Upon identification of any improper payment, the Administrator shall require the Employee to pay back to the Plan an amount equal to the improper payment;

- (B) If the Employee does not immediately repay the Plan, the Administrator shall ensure that the proper amount is withheld from the Employee's wages or other compensation (with such amounts then being immediately remitted to the Plan by the Employer) to the extent consistent with applicable law;
 - (C) To the extent that neither (A) or (B) above are allowable or effective, the Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to the Employee-cardholder as part of his Employee cardholder agreement.
 - (D) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the debit or credit card until the indebtedness is repaid by the Employee. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or Employee cardholder agreement.
- (v) If a cardholder attempts to utilize the Debit Card for any improper or non-allowable purpose, the Participant/cardholder shall be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by the Participant/cardholder.

3. Your Rights under ERISA

As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of this Plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have an affirmative duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or

otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the Plan or exercising your rights under ERISA.

If your claim for a benefit under this Plan is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration, (800) 998-7542.

4. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than 60 days after the end of a Plan Year. For a terminated employee or any Participant who is no longer eligible under the terms of this Plan, claims will still be reimbursed but only if such reimbursement requests are made by the earlier of 1) 30 days following the date that you ceased your employment or eligibility; or (2) the end of the 60-day period following the close of the Plan Year in which the expense arose. Any claims submitted after that time will not be considered. Claims for benefits that are insured will be received in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

- a) Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- b) The reasons for the denial;
- c) Reference to the specific provisions of the Plan on which the denial was based;
- d) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
- e) A description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
- f) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
- g) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request;
- h) The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

You or your beneficiary shall have 180 days following the receipt of any notification of Claim denial to appeal the decision, making a written request for reconsideration to the Administrator. Documents, comments, records or any other information in support of your appeal should be submitted in writing and accompany any such request. You or your beneficiary may review pertinent documents and receive copies of all documents and records, free of charge. You will be provided any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial of your Claim. You will have a reasonable opportunity to respond to such new evidence or rationale.

The Administrator will review the Claim, without deference to the initial denial and after taking into account all comments, information, documents, records and other information submitted as part of the appeal. Unless a 15-day written extension is utilized to review further information, the Administrator will provide a written response to the appeal within 30 days from the date of receipt of any appeal request. In this response, the Administrator will explain the reason for the decision, with reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to review and interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding.

In the event you receive notice of an adverse benefit determination, you may file with the Plan a request for an external review of your Claim. Please contact the Plan Administrator for additional information about external claims procedures.

5. Non-Discrimination Requirements

To the extent that the Plan is treated as a self-insured medical expense Plan under Reg. Section 1.105-11, it must comply with the non-discrimination requirements as set forth under Section 105(h).

6. Highly Compensated Employees

Under the Internal Revenue Code, if you are deemed to be a “highly compensated employee”, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Your own circumstances will dictate whether contribution limitations on “highly compensated employees” will apply. You will be notified of these limitations if you are affected.

7. No Employment Rights Conferred

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

8. HIPAA Privacy

Title II of the Health Insurance Portability and Accountability Act of 1996 and the regulations at 45 CFR Parts 160 through 164 (“HIPAA”), contain provisions governing the use and disclosure of Protected Health Information by health plans, and provide privacy rights to participants in those plans. HIPAA applies to this Plan.

Protected Health Information or “PHI” is health information that is created or received by the Plan. PHI relates to your physical or mental health or condition, the provision of health care to you, or the payment for the provision of health care to you. Typically, the information identifies you, your diagnosis, and treatment or supplies used in the course of your treatment. Electronic Protected Health Information (also known as “ePHI”) is PHI stored in any electronic media, including any memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card or the transmission or exchange of information through usage of the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/ transportable electronic storage media, but does not include facsimile or voice transmissions and is limited to the information created, maintained, transmitted or received by or on behalf of the Plan.

The Plan may disclose PHI to the Employer only for limited purposes as described in the Plan’s documents. The Employer agrees to use and disclose PHI only as permitted or required by the Plan’s documents or as required by HIPAA. PHI or ePHI may be used or disclosed for plan administration functions that the Employer performs on behalf of the Plan. Such functions include:

- Enrollment of eligible employees and their eligible dependents
- Eligibility determinations
- Payment for coverage
- Claim payment activities
- Coordination of benefits
- Claim appeals

In order to perform these functions, the Plan will use and disclose PHI only to the following individuals:

- Human Resources Director

- HIPAA Privacy Official
- Other Personnel, specifically designated by the Plan's Privacy Official

The Plan shall maintain policies and procedures that govern the Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the above individuals and only for the functions listed above. The Plan's policies and procedures also include a mechanism for resolving issues of noncompliance. A notice has been provided to you summarizing the Plan's policies and procedures.

PART D SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our goal with the Plan is to allow you to have a greater portion of your allowable medical expense costs reimbursed to you without increasing the amount of taxes you pay; thereby increasing the amount of money you keep at the end of each pay period. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Attachment A

*** VERY IMPORTANT NOTICE ***
(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES)
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

INTRODUCTION

A federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

CONTINUATION COVERAGE FOR EMPLOYEE (COBRA)

If your employer is subject to COBRA, you, as an employee of that employer, have the right to continue coverage under your current Plan if your coverage is lost due to any of the following qualifying events:

1.1 QUALIFYING EVENTS

1. Termination of employment (for reasons other than gross misconduct.)
2. Involuntary termination of employee.
3. Reduction in hours of employment.

CONTINUATION COVERAGE FOR SPOUSE OF EMPLOYEE

As a spouse of a covered employee, you have the right to continue coverage under your current health plan(s) if your coverage is lost due to any of the following qualifying events:

1.2 QUALIFYING EVENTS

1. A termination of your spouse's employment (for reasons other than gross misconduct).
2. Reduction in your spouse's hours of employment.
3. The death of your spouse.
4. Divorce or legal separation from your spouse.
5. Your spouse becomes entitled to Medicare.

CONTINUATION COVERAGE FOR DEPENDENT OF EMPLOYEE

As a dependent child of a covered employee, you have the right to continue your current coverage if your coverage is lost due to any of the following qualifying events:

1.3 QUALIFYING EVENTS

1. The termination of an employee parent's employment (for reasons other than gross misconduct).
2. Reduction in an employee parent's hours of employment with his/her current employer.
3. The death of your employee parent.
4. Parent's divorce or legal separation.
5. Employee parent becoming entitled to Medicare.

You cease to be a "dependent child" under the current health plan(s).

1.4 NOTIFICATION AND PREMIUMS

Under this law, it is your responsibility to inform us of a divorce, legal separation, or a child losing dependent status under the plan(s) within 60 days of the occurrence of the event. You must also notify us within 60 days of receiving a disability determination letter from the Social Security Administration. Upon the occurrence of a qualifying event, you will be notified of your right to continue coverage under your current health plan(s). If you elect continuation coverage you must do so, in writing, within 60 days from the later of the notice or the date of the qualifying event/loss of coverage.

The recipient of coverage may have to pay part or all of the cost of coverage, which cannot exceed 102 percent of the cost under the group plan. If, during the continuation period, rates change for the employer group, persons under COBRA are subject to that increase.

You will have a 45-day period from the date you elect continuation coverage to pay the initial premium. This premium must include the entire amount due from the date you would have lost coverage to the date of the election. Thereafter, you will be given a grace period of not less than 30 days to pay premiums.

If you choose continuation coverage, your employer is required to give you coverage that is identical to the coverage provided under the plan to similarly situated employees or family members.

You do not have to show that you are insurable to choose continuation coverage.

If you do not choose continuation coverage, your group health coverage will end as of the date of the qualifying event.

If a qualified beneficiary dies or becomes incapacitated during the election period, he or she may not be able to elect coverage timely. A legally appointed guardian can make the election and act for the qualified beneficiary. However, there may not be adequate time during the 60-day election period. Therefore, the election period can be extended until a legally appointed guardian is designated. This extension of the time period is referred to as “tolling”.

1.5 TERMINATION OF RIGHTS

If you do choose continuation coverage, the law provides that coverage may be terminated for any of the following reasons:

1. Your employer terminates all group health coverage provided to its employees.
2. The premium for your continuation coverage is not paid in full the time prescribed under the Notifications and Premiums section of this notice.
3. You are or become covered under another group health plan other than the plan of the employer providing continuation as long as no exclusionary period will be imposed on a preexisting condition.
4. You are or become entitled to Medicare. However, if it is determined that Medicare is to be the secondary payor, your continuation coverage under your current health plan(s) is primary until Medicare becomes primary, or continuation coverage is otherwise terminated, whichever is earlier.

1.6 ADDITIONAL INFORMATION

If you have questions about your right to continue coverage under your current health plan(s), please contact your Plan Administrator.

If you change your address, marital status, or become entitled to Medicare or another group health plan while you are covered under the plan, please notify your Plan Administrator.

1.7.1 QUALIFIED BENEFICIARIES

The term Qualified Beneficiary (Q.B.) refers to individuals who are covered under the employee’s group health plan the day before a COBRA qualifying event takes place. According to the COBRA statutes, a Qualified Beneficiary is the covered employee, covered spouse of the employee, covered dependent child of the employee **OR** any child born to, or placed for adoption with the covered employee during the period of continuation coverage.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Purpose.

This notice is intended to inform you of the privacy practices followed by your employer and other affiliated entities (the "Employer"), which provide a group health plan to eligible employees under the Health Reimbursement Arrangement (the "Health Plan" or "Plan"). It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group health plan.

As a plan sponsor, your employer may need access to health information in order to perform plan administrator functions. We want to assure the plan participants covered under our group health plan that we comply with federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information comply with the privacy practices outlined below.

Uses and Disclosures of Health Information.

Health Care Operations. We use and disclose health information about you in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as *permitted by law*. We are *permitted by law* to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g. preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as an merger, sale, or acquisition. We will also disclose health information about you when *required by law*, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you \$0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, health care operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Requirements. We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, or if you have any questions or complaints, please contact your plan administrator.

Filing a Complaint. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information.