BENEFITSPLUS

FLEXIBLE BENEFITS PLAN

AND

SUMMARY PLAN DESCRIPTION

Restated Effective January 1, 2017

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INTRODUCTION

The purpose of the Plan is to allow you to choose among different types of Benefits, and pay your share of the cost of those Benefits on a tax-favored basis. You may choose Benefits based on your own particular goals, desires, and needs. These plans are often called "cafeteria plans" because they offer a "menu" of benefit choices. This Plan, as reflected on the following pages, is restated effective January 1, 2017.

Example: Here's an example that shows how you enroll under the Plan, and explains why participating in this Plan is a good idea. Assume you and your family are covered under your Employer's health care plan, and that you pay $200 per month for this coverage. Also assume that your monthly pay is $2,000, and that 25% goes to pay state and federal income taxes and Social Security taxes.

Without the Plan, your premium payments are taken into account when calculating your taxes. In other words, without the Plan, you would pay $500 in taxes (.25 x $2,000) and have $1,300 in take home pay ($2,000 - $500 - $200). With the Plan, your taxes are calculated after deducting your premium payments from your income. In other words, with the Plan, you would pay $450 in taxes ([$2,000 - $200] x .25) and have $1,350 in take home pay ($2,000 - $450 - $200).

Important Note: Once you are eligible to participate and join the Plan, you cannot change your elections for the remainder of the Coverage Period, unless you meet certain requirements (these requirements are described in Article III).

ARTICLE I

BENEFITS AVAILABLE TO YOU

Benefit Options. When your Employer reduces your Compensation to pay for coverage offered through the Plan, the Employer takes each dollar it withholds from your Compensation and converts it to a Flexible Benefits Plan Dollar. These Flexible Benefits Plan Dollars are then credited to various accounts under this Plan, and used to provide the Benefits in which you have enrolled. The Employer may also choose to contribute its own dollars to the Plan on your behalf, in the form of discretionary, Employer-provided Flexible Benefits Plan Dollars.

You may choose to receive any or all of the following Benefits:

1. ***Pre-Tax Health and Welfare Plan Premium Payment***. You may choose to have Flexible Benefits Plan Dollars used to pay Premiums for coverage (on behalf of yourself, your Spouse and/or other Dependents, depending on whether they're eligible for the coverage) under the Employer's health and welfare benefit plan(s) listed below:

   - **Medical Plan**.
   - **Dental Plan**.
   - **Vision Plan**.

   The rules concerning eligibility under, and the benefits available from, the plans listed above, are contained in the documents and contracts that comprise those plans.

2. ***Health Savings Account.*** In addition, you may choose to have Flexible Benefits Plan Dollars used to make contributions to your health savings account ("HSA"), provided, however, that you are eligible to make contributions to an HSA and, if the Employer requires as much, you have certified to your eligibility in a manner acceptable to the Employer. The Employer may limit the amount and timing of your contributions to your HSA made through this Plan.

3. ***Health Care Reimbursement Program.*** You may elect coverage under the Health Care Reimbursement Program option. Appendix B describes the rules that apply to that Program.

4. ***Dependent Care Reimbursement Program.*** You may elect coverage under the Dependent Care Reimbursement Program option. The rules that apply to that Program are set forth in the appropriate Appendix.

Nondiscrimination Requirements. The following paragraphs describe technical requirements of the Code that apply to plans like this Flexible Benefits Plan.

This Plan is intended to provide Benefits that do not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate, or Highly Compensated Participants, with respect to contributions and benefits. In addition, it is the intent of this Plan not to provide

"qualified benefits" (as defined under Code Section 125(e)) to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan.

If the Administrator or its designee deems it necessary to avoid discrimination or possible taxation to Key Employees or Highly Compensated Individuals or Highly Compensated Participants, it may, but is not required to, reject any election or reduce contributions or nontaxable Benefits in order to assure that the rules in these paragraphs are not violated. Any act taken by the Administrator or its designee under these paragraphs will be carried out in a uniform and nondiscriminatory manner.

If the Administrator or its designee decides to reject any election or reduce contributions or nontaxable Benefits, it will be done in the following manner: the nontaxable Benefits of the affected Participant (either a Highly Compensated Individual or Participant, or a Key Employee, whichever is applicable) who has elected the *highest amount* of nontaxable Benefits for the Coverage Period will have his or her nontaxable Benefits reduced until:

1. the discrimination tests set forth in these paragraphs are satisfied, or

2. the amount of his or her nontaxable Benefits equals the nontaxable Benefits of the affected Participant who has elected the *second highest* amount of nontaxable Benefits.

This process will continue until the nondiscrimination tests described in these paragraphs are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to these paragraphs, the reduction will first be made proportionately among noninsured Benefits, and once all noninsured Benefits are expended, proportionately among insured Benefits.

ARTICLE II

PARTICIPATION

Becoming Eligible to Participate, and Beginning Your Participation. You must be an Eligible Employee and enroll for coverage under one or more of the Benefits offered through this Plan to actually *begin* your participation in this Plan.

Terminating Your Participation. Your participation in the Plan will end when one of the events listed below occurs (although in some cases described elsewhere in this Plan you and/or your Dependents might be eligible to *continue* your participation, at least for a while). The events are:

1. Termination of your employment.

2. The date you cease to be an Eligible Employee.

3. Your death.

4. The termination of this Plan itself.

5. The date you validly revoke your coverage under the Benefits.

COBRA Coverage. If you or one of your covered Dependents lose coverage under one or more of the Employer's health care plans (including dental and vision plans) under circumstances where you or the Dependent are entitled to continue coverage under the federal law known as COBRA,[1] and you or the Dependent would also lose coverage under the Health Care Reimbursement Program due to those same circumstances, you or the Dependent also have a right under COBRA to continue coverage for a short while under the Health Care Reimbursement Program. In this way, you or the Dependent may be able to obtain reimbursement for claims Incurred *after* coverage would otherwise have ended but for the continued coverage under COBRA. See the Health Care Reimbursement Program Appendix for more information.

USERRA Coverage. If you lose coverage under one or more of the Employer's health care plans (including dental and vision plans) or the Health Care Reimbursement Program because you commence a period of uniformed service to which the Uniformed Services Employment and Reemployment Rights Act applies, you may continue your coverage and, notwithstanding any other provision in this Plan to the contrary, your participation in this Plan (to the extent you have

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[1] This right to continue coverage applies, for example, where your coverage ends due to termination of your employment (for reasons other than gross misconduct) or reduction in work hours, or your death. Your covered family members might have the right to continue coverage where their coverage ends due to termination of your employment (for reasons other than gross misconduct) or reduction in work hours; your death; your divorce or legal separation; your entitlement to Medicare; or a covered child's ceasing to meet the definition of an eligible child under the plan. These events are known as "qualifying events" because they "qualify" you or the family member for COBRA coverage. Some family members, such as domestic partners and their children, may be not be eligible for COBRA coverage in some circumstances.

wages from the Employer) for the duration of your period of uniformed service or 24 months, whichever period is shorter.

Special Rules Concerning Reemployments. If you participate in the Plan during a Coverage Period, then terminate employment but are rehired during that same Coverage Period, you may be able to re-enroll for coverage for the remaining portion of the Coverage Period. You may do so if the termination of employment and the reemployment are *bona fide*. The termination and reemployment are deemed to be *bona fide* if there is at least a 30-day break in employment between the date of your termination and the date of your reemployment. If the break is for fewer than 30 days, you are considered to have resumed, upon your reemployment, the elections you had in effect at the time of your termination. See also the special rules described in Article III, in the section titled, *Mid-Year Changes to Elections*.

Special Rules Concerning Death. If you die your participation in the Plan will cease. Your beneficiaries or the representative of your estate, however, may submit claims for expenses that you Incurred through the termination date of your coverage. You may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Administrator or its designee may designate your Spouse, one of your other Dependents, or a representative of your estate. Claims Incurred by your Spouse or by other covered Dependents prior to termination of coverage may also be submitted for reimbursement.

ARTICLE III

BENEFIT ELECTIONS

Initial Benefit Elections. Once you meet the eligibility requirements described in Article II you can choose to participate in this Plan for the remainder of the Coverage Period, but to do so you must enroll for coverage within 30 days after you first become eligible. Your enrollment serves two purposes: (1) you elect the Benefits you wish to receive and (2) you authorize the Employer to reduce your salary in order to provide for contributions to participate in the Benefits you elect.

For example, assume that you first become eligible to participate in this Plan on March 1 of a given Coverage Period. Your initial Election Period will run from that March 1 to March 30. Your initial enrollment for coverage must be made within this Period, in order for you to receive any Benefits under this Plan for the remainder of that Coverage Period. If you fail to timely enroll for coverage, you must wait until the annual Election Period (described below) to enroll for coverage. However, you might be eligible for mid-year enrollment before the next annual Election Period if you meet the requirements for changing benefit elections described below, in the section titled, "*Mid-Year Changes to Elections.*"

Subsequent Annual Elections. During each annual Election Period (defined in Article VIII), you may choose which Benefits you wish to purchase for the next Coverage Period. Any election you make must be filed before the end of the annual Election Period and will apply for the following Coverage Period.

Choosing to Participate After Initially Declining to Participate. In addition, if you fail to enroll for coverage when you are first eligible, you can choose during an ensuing annual Election Period to participate in the Plan effective for the ensuing Coverage Period. Of course, in order to be able to do this you must still be eligible to participate in the Plan.

Terminating Participation in the Plan. If you want to *terminate* your participation in the Plan, you can do that by notifying the Administrator or its designee in writing (on a form the Employer will supply) during the annual Election Period that you do not want to participate in the Plan for the next Coverage Period. However, see the rules below titled, "Failure to Make a New Election."

If during the annual Election Period you choose not to participate for the next Coverage Period you will have to wait until the *next* annual Election Period before you will again have an opportunity to participate in the Plan. However, you might be eligible for mid-year enrollment before the next annual Election Period if you meet the requirements for changing benefit elections described below, in the section titled, "*Mid-Year Changes to Elections.*"

Failure to Make a New Election. With regard to coverage for which you must pay *Premiums* (such as coverage under a health care plan or disability insurance policy, etc.), you will be *deemed* to have made, for the ensuing Coverage Period, the *same* benefit elections that are then in effect for the current Coverage Period. You will also be deemed to have elected to have your Compensation reduced for the next Coverage Period in an amount necessary to purchase those Benefits.

With regard to Benefits for which you pay no Premiums, but *do* make contributions, you will be deemed to have elected *not* to receive any of those Benefits for the upcoming Coverage Period. These benefits include:

- Health Savings Account;
- Medical Care Reimbursement Program; and
- Dependent Care Reimbursement Program.

No further reductions from your Compensation will be made for the next Coverage Period in order to provide such Benefits to you.

Mid-Year Changes to Elections. As a general rule the Code does not allow you to change a benefit election after the start of a Coverage Period and make a new benefit election for the remainder of the Coverage Period. However, there are exceptions to this rule. The exceptions are described below, and the exception that applies to you depends on the Benefits that will be affected by your change. *If an exception applies to you, your new elections must be made (received by the Plan Administrator) within **30 days** after the date of the event that gives rise to your right to make the change*. However, in some cases as described below, you may have up to 60 days to make your change.

These rules are complex; if you have questions about them, contact the BenefitsPlus Solutions Center at 855.326.7870. In addition, please note that even if you are able to change elections under this Plan, the terms of the benefit plan or program under which you are purchasing coverage under this Plan may prohibit a mid-year change—in that case, the terms of the benefit plan or program control over the terms of this Plan.

In this section, the term "mid-year" means "mid-Coverage Period."

Public Health Marketplace Related Events Entitling You to Change Elections Concerning Payment of Medical Plan Premiums. You may prospectively cancel your coverage election with respect to the medical plan benefit in the following circumstances and in accordance with IRS Notice 2014-55 and any subsequent guidance related thereto:

- Reduction in Hours Not Causing Loss of Eligibility: You have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even though that reduction does not result in you ceasing to be eligible under the medical plan. Your revocation must correspond with the intended enrollment of you (and any related dependents who cease coverage due to your revocation) in another plan that provides minimum essential coverage with the new coverage being effective no later than the first day of the second month following the month that includes the date of your election was revoked.

- Eligibility for Public Health Marketplace Coverage: You become eligible to enroll for coverage in a public health marketplace during a marketplace special or annual open enrollment period. Your revocation must correspond to the intended enrollment of you (and any related dependents who cease coverage due to your revocation) in a qualified health

plan through a public health marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Events Entitling You to Change Elections Concerning Payment of <u>Health Insurance Premiums</u>. For purposes of this section, the term "health insurance" includes medical, dental, vision and accidental death and dismemberment insurance, whether insured or self-insured by the Employer.

1. **HIPAA Special Enrollment**. You may cancel your coverage (and make a new election for the remainder of the Coverage Period) with respect to coverage under a group health care plan where the cancellation of the old coverage and election of the new coverage corresponds with a "special enrollment" right under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). ***If the "special enrollment event" is the birth, adoption or placement for adoption of an eligible child, and the health plan allows you to enroll the child retroactively (to the date of birth, adoption or placement for adoption), your election change may also be given retroactive effect.***

   Please note that notwithstanding the general rule that you must request the enrollment change within 30 days after the event giving rise to the special enrollment right, if you or your dependent (within the meaning of HIPAA) become eligible for a state-granted premium subsidy for the Employer's health coverage, you may request enrollment under the Employer's health coverage within 60 days after the date Medicaid or the Children's Health Insurance Program (CHIP) determine that you or the dependent qualify for the subsidy. Similarly, if you or your dependent lose coverage under Medicaid or CHIP, you may request enrollment under the Employer's health coverage, again within 60 days of the date you or the dependent lose such coverage.

2. **Court Decree**. You may cancel your coverage (and make a new election for the remainder of the Coverage Period) where a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody requires either you or your Spouse, former Spouse or other individual to provide health insurance coverage for your Dependent child. You may add coverage for the child if the court order requires you or the Employer's health care plan(s) to provide coverage for the child. You may drop coverage for the child if the court order requires your Spouse, former Spouse or other individual (or their employer's health care plan(s)) to provide coverage for the child, <u>*and*</u> your Spouse, former Spouse or other individual actually acquires coverage for the child. The Plan may make a *unilateral* change in your enrollment under these circumstances, to provide for coverage of your Dependent child under the Employer's health care plan(s), where the order is a qualified medical child support order and the order requires the plan(s) to provide coverage.

3. **Entitlement to Medicare or Medicaid**. You may cancel your coverage (and make a new election for the remainder of the Coverage Period) where you, your Spouse, or other Dependent becomes entitled to, or ceases to be entitled to, benefits under either Medicare or Medicaid. Where the individual becomes entitled to Medicare or Medicaid benefits you may modify your enrollment to drop coverage of the individual under your Employer's health care plan(s). Similarly, where the individual ceases to be entitled to Medicare or

Medicaid benefits you may modify your election to add coverage of the individual under your Employer's health care plan(s).

4. **Changes in Status**. You may cancel your enrollment (and make a new election for the remainder of the Coverage Period) where you experience a "change in status" and the change to your enrollment is "consistent with" that change in status. A "change in status" is:

- A change in your legal marital status, including your marriage, the death of your Spouse, the annulment of your marriage, or your divorce or legal separation;
- A change in the number of your Dependents, including the birth, adoption, placement for adoption, or death of a Dependent;
- A change in the employment status of you, your Spouse or other Dependent; a "change in employment status" includes:
    - Termination or commencement of employment (if commencement of employment follows a termination of employment with the same employer, no new election is permitted unless the commencement follows at least 30 days after the termination);
    - Strike or lockout;
    - Commencement of, or the return from, an unpaid leave of absence;
    - Change in work site;
    - Satisfying, or ceasing to satisfy, eligibility conditions due to a change in employment status (a switch between part-time and full-time employment, salaried and hourly positions, etc.);
- An event that causes your Dependent to satisfy or cease to satisfy the eligibility requirements for coverage whether due to the attainment of a specified age, student status, or any similar circumstance described in such plan(s); or
- A change in the place of residence or employment of you, your Spouse, or your other Dependent.

Your change in your enrollment is "consistent with" a change in status if and only if the change in status affects eligibility for coverage under an employer's plan, and the election change is on account of and corresponds with the change in status.

A change in status that affects eligibility for coverage includes a change in status that causes an increase or decrease in the number of your family members who may benefit from coverage under the plan. For example, let's say you wish to change your election to drop coverage under this Plan for you or your Spouse because, due to a marital status change or a change in your Spouse's employment status, you or your Spouse now qualify

for coverage under a plan provided by your Spouse's employer. You can make the election change so long as the person you wish to disenroll under this Plan acquires the newly available coverage under your Spouse's plan. We will allow the election change upon your certification that coverage has been or will be obtained under the other plan.

Notwithstanding this consistency rule, if you, your Spouse or other Dependent become eligible (under a health care plan maintained by the Employer) for COBRA, Public Health Service Act, or other applicable continuation coverage under any similar state health coverage continuation law, you may modify your enrollment in order to pay for that continuation coverage.

5. **Family and Medical Leave**. You may cancel your enrollment (and make a new election for the remainder of the Coverage Period) if you take a leave of absence pursuant to the Family and Medical Leave Act ("FMLA"). In addition,

- If you continue your participation during the period of FMLA leave, you will be entitled to change your election, in accordance with the rules described above, to the same extent as any other Participant who is not on FMLA leave;

- If you continue your participation during the period of FMLA leave the Employer may permit you, under procedures applied in a nondiscriminatory manner, to pay your share of the cost of coverage under one or more of the following methods (note, however, that where the period of FMLA leave is substituted paid leave, your method of paying your required contributions must be the same method normally used by Participants during paid leave):

    - ***Pre-pay option.*** You may, prior to beginning your FMLA leave, pre-pay on a pre-tax basis (from taxable Compensation payable to you, including the cashing out of unused sick days or vacation days) the contributions required on your behalf for the period of FMLA leave. But if the period of FMLA leave begins in one Coverage Period and ends in another Coverage Period, you may not pre-pay, on a pre-tax basis, for coverage during the period of FMLA leave that extends into the next Coverage Period. The cost of coverage for periods of FMLA leave in the next Coverage Period must be paid under the method described below.

    - ***Pay-as-you-go option.*** You may pay (on a pre-tax basis, from taxable Compensation otherwise payable to you, or on an after-tax basis) the contributions required on your behalf for the period of FMLA leave on the same schedule under which payments would be made if you were *not* on FMLA leave. For example, if while not on FMLA leave your contributions to the Plan were made bi-weekly, you may make your contributions bi-weekly while on FMLA leave. Alternatively, you may pay the required contributions on the same payment schedule that applies to payment for COBRA or PHSA continuation coverage under the Employer's group health care plan or dental plan (i.e., typically monthly, with a 30-day grace period for each monthly payment).

- ***Catch-up option.*** To the extent you and the Employer agree in advance, the Employer may continue your coverage(s) during a period of unpaid FMLA leave, and that you will not pay your share of the premiums until you return from leave. You and the Employer must agree in advance of the period of continued coverage that: (i) you elect to continue your coverage while on unpaid leave; (ii) the Employer assumes responsibility for advancing premium payments on your behalf during the FMLA leave; and (iii) these advance amounts are repaid by you after your return from FMLA leave. However, the Employer has the option of using this "catch up" feature unilaterally, where you intend but fail to make premium payments while on leave (that is, you utilize the pay-as-you-go option but fail to make premium payments). In that case, the Employer may unilaterally pay your share of the premium while you're on FMLA leave, and then recoup its advance from you after your return. No advance agreement is required in this latter case.

Upon your return from FMLA leave, your "catch-up" contributions may be made on a pre-tax basis from any taxable compensation to which you're entitled (including unused sick leave and vacation days). Premiums may also be paid from salary reductions on a pre-tax basis if the premiums were not paid under any other method while you were on leave. You may also make "catch-up" contributions on an after-tax basis.

- If your coverage under the Plan terminated while you were on FMLA leave (either because you cancelled your coverage, or because you failed to pay the required Premiums or other contributions), you may recommence participation after you return from FMLA leave by enrolling for coverage with the Administrator or its designee within 30 days of your return.

6. **Significant Changes in the Cost of Coverage**. If the cost of a benefit requiring contributions from you increases or decreases during the year, your enrollment will change automatically to keep pace with the change in required contributions. See the discussion about this automatic change, in Section IV.

You may cancel your enrollment where during a Coverage Period there is a significant increase *or* significant decrease in the cost of a benefit package option under the Employer's plan(s). (A "benefit package option" is a qualified benefit under Section 125(f) of the Code or an option for coverage under an underlying health care plan, such as an indemnity, HMO or PPO option.) In that case you may then make a new election to either (i) receive coverage under the option with the decrease in cost, (ii) revoke coverage under the option with an increase in cost and elect similar coverage under another benefit package option providing similar coverage or, if there is no other option with similar coverage available, drop coverage entirely. No automatic adjustment in your election, as described in Article IV, will be made under these circumstances.

For purposes of this rule, a "cost increase" or "cost decrease" refers to an increase or decrease in the amount of contributions you make under this Plan, whether due to actions taken by you (switching between part-time and full-time employment, etc.) or from an

action by your Employer (such as decreasing the cost of coverage for a classification of employees of which you're a member).

7. **Significant Changes in Coverage**. You may cancel your elections where during a Coverage Period your, your Spouse's or other Dependent's coverage under a plan of the Employer is significantly curtailed or ceases. Coverage is considered significantly "curtailed" if, among other things, there is a significant increase in the deductible, the copay, or out-of-pocket maximum amount under a health plan. In that event, you must then make a new election on a prospective basis for such person under another benefit package option providing similar coverage. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally.

   If there is a "loss" of coverage, you may elect coverage on a prospective basis for such person under another benefit package option providing similar coverage, or drop coverage if there is no other option providing similar coverage. A "loss" of coverage includes a complete loss of coverage (including the elimination of a benefit package option, an HMO ceasing to be available in the area where the person resides, the individual's attainment of an overall annual or lifetime benefit maximum under a plan, a substantial decrease in the number of medical providers available under the option (such as a major hospital ceasing to be a member of a managed care network, or a substantial decrease in the number of physicians participating in the network), a reduction in the benefits for a specific type of medical condition or treatment (where you, your Spouse or other Dependent is currently in a course of such treatment), or any other similar fundamental loss of coverage.

8. **Addition (or Improvement) of Benefit Package Option**. You may cancel your election where during a Coverage Period a plan of the Employer adds a new benefit package option or other coverage option (or significantly improves an existing benefit package option or other coverage option). In that case you may then make a new election to elect the newly-added or improved option prospectively.

9. **Loss of Coverage Under Certain Governmental or Educational Institution Plans**. You may cancel your election where during a Coverage Period you, your Spouse or other Dependent lose coverage under any group health plan sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government, the Indian Health Service or a tribal organization; a State health benefits pool; or a foreign government group health plan. You may then make a new election to provide coverage for such person on a prospective basis under a plan of the Employer.

10. **Change in Coverage Under Other Plan**. You may cancel your election, and file a new election for the remainder of the Coverage Period, where the change is on account of and corresponds with a change made under another plan maintained by your Employer or another employer if:

- That other plan permits participants to make an election change that would be permitted under the rules of this Article (disregarding this section concerning changes in coverage under another plan); or

- This Plan permits you to make an election for a period of coverage that is different from the period of coverage under the other plan.

Events Entitling You to Change Elections Concerning Contributions to the Health Care Reimbursement Program. The events and requirements under which you may make a mid-year change to your enrollment elections with respect to contributions to the Health Care Reimbursement Program are the same events and requirements described above (with respect to payment of health insurance premiums), with the following exceptions: the events described in the headings titled, **HIPAA Special Enrollment Events, Significant Changes in the Cost of Coverage, Significant Changes in Coverage, Addition (or Improvement) of Benefit Package Option, Loss of Coverage Under Certain Governmental or Educational Institution Plans, and Change in Coverage Under Other Plan** do not authorize changes to elections concerning the Health Care Reimbursement Program.

Note also that if you change your benefit elections as to the Health Care Reimbursement Program, you may not *reduce* the amount you elect to contribute to the Program for the Coverage Period below a certain amount. That amount is equal to the amount of Benefits paid to you by the Program during the Coverage Period and prior to the event justifying your change in Benefit Election.

In addition, and notwithstanding any other provision in this Plan to the contrary (except the provisions concerning contributions and coverage during a period of FMLA leave), if after making a benefit election concerning the Health Care Reimbursement Program your Compensation is reduced (for example, due to an unpaid leave of absence) such that there is insufficient Compensation for the Employer to make salary reductions in the amount elected, the Employer may treat you as ineligible to continue your participation in the Program due to nonpayment of premiums, and may permit you to cancel your election and make a new election for no coverage under the Health Care Reimbursement Program. Alternatively the Employer may unilaterally cancel your participation in the Program due to nonpayment of premium. However, otherwise covered claims incurred prior to the termination of your participation, and timely submitted for reimbursement, will still be considered for payment notwithstanding the subsequent termination of coverage.

Events Entitling You to Change Elections Concerning Contributions to the Dependent Care Reimbursement Program. The events and requirements under which you may make a mid-year change to your benefit elections with respect to contributions to the Dependent Care Reimbursement Program are the same events and requirements described above (with respect to payment of health insurance premiums), with the following exceptions:

1. The events described in the headings titled, **HIPAA Special Enrollment Events, Court Decree, Family and Medical Leave, Loss of Coverage Under Certain Governmental or Educational Institution Plans**, and **Entitlement to Medicare or Medicaid** do not apply.

2. The Change in Status rules described above (with respect to payment of health insurance premiums) apply; in order for an election change to be considered "consistent with" the change in status, the election change must affect eligibility for coverage under an employer's plan, and the election change must be on account of and correspond with the change in status. An election change meets this consistency requirement if the election change is on account of and corresponds with a change in status that affects Employment-Related Dependent Care Expenses described in the appropriate Appendix. For purposes of the "change in status" rules as they apply to the Dependent Care Reimbursement Program, the term "Dependent" means your Qualifying Dependent as described in the appropriate Appendix. Thus, for example, a "change in status" occurs when your Dependent child attains age 13 and is therefore no longer a "Dependent" for purposes of the Dependent Care Reimbursement Program.

3. The events described in the headings titled, **Significant Changes in the Cost of Coverage, Significant Changes in Coverage, Addition (or Improvement) of Benefit Package Option, and Change in Coverage Under Other Plan** apply; however:

   - The term "Dependent" means your Qualifying Dependent as described in the appropriate Appendix; and

   - The rules concerning Changes in Cost of Coverage apply only if the cost change is imposed by a dependent care provider who is not your relative. For this purpose, a "relative" is a child (including a stepchild) or grandchild, a brother or sister (or stepbrother or stepsister), parent (including a stepparent), grandparent or great-grandparent, a niece or nephew, uncle or aunt, or mother- or father-in-law, brother- or sister-in-law, or son- or daughter-in-law. A child includes a foster child and a child adopted by or placed for adoption with you. A sister or brother includes a sister or brother by half-blood.

Changes to Elections Concerning Health Savings Account Contributions. You may change your election concerning the amount of your pre-tax contributions to a health savings account at least monthly, but the change may be effective prospective only, and will take effect as soon as the Employer's payroll department is able to effectuate the change. Please note that if the Employer has pre-funded your HSA account with all or a portion of the amount you elected to contribute for the year, and is entitled to be reimbursed the "advance" from deductions from your pay, you may not modify your HSA contribution election so that the total amount you elect to contribute for the year is less than the amount of the Employer's advance. The intent of this rule is to ensure that the Employer is allowed to recoup the amount of its advance, as long as you are still entitled to pay from the Employer.

The Employer may limit the amount and timing of your pre-tax contributions to your HSA, and such restrictions may affect your ability to change your election.

In addition to the rules described above, you may make changes to your Benefit elections (and file a new enrollment election for the remainder of the Coverage Period) to the extent consistent with the requirements of the Uniformed Services Employment and Reemployment Rights Act, when

you commence or return from a period of uniformed service under circumstances protected by the provisions of that Act.

ARTICLE IV

YOUR CONTRIBUTIONS TO THE PLAN

Salary Reductions – General Rules. Recall that, in order to participate in this Flexible Benefits Plan, you must both choose the Benefits you want to receive and agree to reduce your salary to pay for the Benefits you choose. You agree to reduce your salary by filing your enrollment elections discussed in Article III.

> ***NOTE***: If you elect to enroll in an Employer health and welfare plan, you will be deemed to have elected to pay for your share of the employee contributions otherwise due under such program by salary reduction under this Plan. You may not pay for your share of any contributions under an employer health and welfare plan on an after-tax basis, except in the case of dependent coverage which cannot be paid for with pre-tax dollars under federal tax laws, or as otherwise permitted by your Employer in a nondiscriminatory manner.

Your Employer will administer its payroll program to allow you to agree to reduce your Compensation during a Coverage Period by the amount necessary to purchase the Benefits you choose (note, however, that the Code might impose limits on your selections). You indicate in your enrollment elections how much you will contribute under the Plan for the year. Your enrollment elections will apply for the entire Coverage Period and can't be changed except as provided under the special rules in Article III concerning *Mid-Year Changes to Elections*.

As a general rule, the amounts you agree to contribute to the Plan will be contributed on a *pro rata* basis for each pay period during the Coverage Period (that is, the same amount will be subtracted from your Compensation each pay period). However, the Employer may also allow you to make your contributions to the Plan in advance (for example, in a single sum at the beginning of the Coverage Period). Each dollar contributed to the Plan will be "converted" into what the Plan calls a "Flexible Benefits Plan Dollar" and allocated to the appropriate funds or accounts under the Plan, to pay for the Benefits you chose.

Changing Your Enrollment Elections. Except as described in Article III, you may generally not change your salary reductions during the Coverage Period. Note, however, your salary reductions will *automatically* change to the extent necessary to conform to any increase or decrease in the cost of coverage of any of the Employer's health and welfare plans under which you are enrolled.

For example, assume that you choose coverage under the Employer's group health care plan, and choose to have your cost of coverage paid under this Plan. Assume your monthly cost of coverage under the health care plan, at the beginning of the year, is $100.

If your cost of coverage increases or decreases during the course of the year, then as a general rule your elections will *automatically* change to correspond to the adjusted Premium amount. The rules in Article III concerning mid-year changes to benefit elections describe situations where, due to a change in the cost of some coverages, you might be entitled to cancel your benefit elections and make a new election.

What Your Employer Does with the Reductions From Your Compensation. As soon as practicable after each pay period your Employer will take the amount by which you agreed to have your Compensation reduced and convert those dollars into Flexible Benefits Plan Dollars. It will then apply those Flexible Benefits Plan Dollars to provide the Benefits you chose.

Employer Discretionary Contributions on Your Behalf. Your Employer may choose to make its own contributions of Flexible Benefits Plan Dollars to the Plan on your behalf, which you may then use to purchase one or more of the various Benefits offered under the Plan. Whether the Employer makes such contributions, and the amounts and timing of any such contributions, shall be determined by the Employer in its discretion, subject only to applicable nondiscrimination requirements.

ARTICLE V

CLAIMS AND APPEALS

Submitting Your Claims for Benefits. Any claim for Benefits provided under an Insurance Contract issued by an insurance company must be filed with that Insurer. If the Insurer denies any claim, you or your beneficiary must follow the Insurer's claims review procedure. A claim for Benefits under any self-insured Benefit program sponsored by the Employer should be submitted to the claims administrator for that program. See the following paragraphs below, and the applicable Appendix describing the rules concerning claims under each program.

Benefit Plan Surplus. Any forfeited amounts credited to the Benefit Plan Surplus (because you did not Incur a reimbursable expense or did not timely make a claim for reimbursement) may be separately accounted for after the end of the Coverage Period (or after a later time specified in this Plan for the filing of claims) in which the forfeitures arose. Except as otherwise described in an Appendix, such forfeited amounts will not be carried over to the next Coverage Period, to reimburse you for expenses Incurred during such next Coverage Period, nor will amounts you forfeited be made available to you in any other form or manner, except as may be permitted by Treasury regulations and this Plan. Forfeited amounts credited to the Benefit Plan Surplus will be used to defray any administrative costs and experience losses, or otherwise used in a manner consistent with the Code and, as applicable, ERISA.

Review of Reimbursement Claims. The Claims Administrator will review and decide a claim (appropriately filed with it) for reimbursement within 90 days after it is timely filed. If the Claims Administrator denies a claim, the Claims Administrator will provide notice to you or your beneficiary, in writing, within 90 days after the claim is filed, unless special circumstances require an extension of time for processing the claim. No extension will be for more than 90 days after the end of the initial 90-day period.

If an extension of time for processing is required, written notice of the extension will be furnished to you or your beneficiary before the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which a final decision will be rendered. You will be informed in writing of the time limits set forth in this paragraph. If the Claims Administrator does not notify you of the denial of the claim within the period specified above, then the claim will be deemed denied.

If a claim appropriately filed with the Claim Administrator is wholly or partially denied, you or your beneficiary will be furnished a written notice setting forth in a manner calculated to be understood:

1. The specific reason or reasons for the denial;

2. Specific references to the pertinent Plan provisions on which the denial is based;

3. A description of any additional material or information necessary for you or your beneficiary to perfect the claim and an explanation as to why such information is necessary; and

4. An explanation of the Plan's claim procedure, including the steps to be taken if you or your beneficiary wishes to appeal the claim, the period within which the appeal must be filed, and the period within which it will be decided.

Appealing a Denied Claim. Within 60 days after receipt of the above material, you or your beneficiary will have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. You or your beneficiary or your (or the beneficiary's) duly authorized representative may:

a. Request a review upon written notice to the Administrator;

b. Review pertinent documents; and

c. Submit issues and comments in writing.

Decision on Review. A decision on the review by the Administrator will be made not later than 60 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 that case a decision will be rendered as soon as possible, but not later than 120 days after receipt. If such an extension of time for deciding the appeal is required, written notice of the extension will be furnished to you or your beneficiary prior to the commencement of the extension. The decision of the Administrator will be written and will include specific reasons for the decision, written in a manner calculated to be understood by you or your beneficiary, with specific references to the pertinent Plan provisions on which the decision is based.

Conformity with Patient Protection and Affordable Care Act of 2010. Notwithstanding the foregoing, to the extent the Health Care Reimbursement Program is or becomes subject to the Patient Protection and Affordable Care Act of 2010, as amended (and regulations thereunder), the claims and appeals rules applicable to that Program shall be construed and applied in a manner consistent with applicable requirements of such Act and regulations.

ARTICLE VI

ADMINISTRATION

Plan Administration. With respect to the Healthcare Reimbursement Program and Dependent Care Reimbursement Program, the operation of the Plan will be conducted by the Claims Administrator under the supervision of the Administrator. In all other respects, the operation of the Plan will be conducted by the Administrator or its designee. It will 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 will have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code.

The Administrator has the greatest permissible discretion to construe the terms of the Plan and to determine all questions concerning eligibility, participation and benefits. Any such decision made by the Administrator will be binding on all Employees, Participants, and beneficiaries, and is intended to be subject to the most deferential standard of judicial review. Such standard of review is not to be affected by any real or alleged conflict of interest on the part of the Administrator. The Administrator's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

1. To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

2. To interpret the Plan, the Administrator's interpretations thereof to be final and conclusive on all persons claiming benefits under the Plan;

3. To decide all questions (including questions of fact) concerning or related to the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;

4. To reject enrollment elections or to limit contributions or Benefits for certain Highly Compensated Employees, Individuals or Participants, or Key Employees, if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

5. To provide Employees with a reasonable notification of their Benefits available under the Plan;

6. To approve reimbursement requests, if any, and to authorize the payment of Benefits; and

7. To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation, or construction taken by the Administrator will be done in a nondiscriminatory manner based upon uniform principles consistently applied, and will be consistent with the intent that the Plan comply with Section 125 of the Code and the regulations issued under that Section.

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

General Fiduciary Responsibilities. The Administrator and any other fiduciaries under ERISA will discharge their duties with respect to this Plan solely in the interest of you and your beneficiaries and:

1. For the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

2. 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

3. In accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

Nonassignability of Rights. Your right to receive any reimbursement under the Plan cannot be assigned by you, and will not be made subject to the rights of your creditors. Any attempt to cause such right to be subjected to your creditors will not be recognized, except to such extent required by law.

Examination of Records. The Administrator will make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, any records that pertain to his or her interest under the Plan.

Payment of Expenses. The Employer will pay any reasonable administrative expenses, unless the Employer decides that administrative costs will be paid by Participants under the Plan or by any Trust Fund that may be established in connection with the Plan. The Administrator and/or its designee may impose reasonable conditions for payments, but such conditions will not discriminate in favor of Highly Compensated Employees.

Insurance Contracts May Control Over Terms of this Plan. If there is a conflict between the terms of this Plan and the terms of an Insurance Contract of a particular Insurer whose product is being used in conjunction with this Plan, the terms of the Insurance Contract will control with respect to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract will 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.

Indemnification of Claims Administrator and Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law the Claims Administrator and 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 the following: all liabilities, damages, costs and expenses (including reasonable attorneys' fees and amounts paid in settlement of any claims approved by the

Employer) caused by or resulting from any act of, or omission to act by, the Claims Administrator or any such Employee) in connection with the Plan, if such act or omission is in good faith.

ARTICLE VII

AMENDMENT OR TERMINATION OF PLAN

Amendment. The Employer may at any time amend any provisions of the Plan without the consent of any other Affiliated Employer, Participating Employer, Employee, or Participant. No amendment will have the effect of modifying any enrollment election of any Participant in effect at the time of the amendment, unless the amendment is made to comply with Federal, state or local laws, statutes or regulations. Where a Participating Employer is added, amended or removed, the Employer may, without resorting to the formalities of a formal amendment, replace the Schedule of Participating Employers attached hereto with a Schedule of Participating Employers reflecting the updated Participating Employer information.

Termination. The Employer has established 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 will be made. Benefits under any Insurance Contract will be paid in accordance with the terms of the Insurance Contract.

Upon termination, no further additions will be made to your Reimbursement Accounts described in the Appendices. However, all payments from your Reimbursement Accounts will continue to be made, according to the benefit elections Forms in effect, until the earlier of two dates. The two dates are: (1) the end of the Coverage Period in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims), and (2) the date on which the balances of all Reimbursement Accounts have been reduced to zero. Any amounts remaining in any such Reimbursement Accounts as of the end of the Coverage Period in which Plan termination occurs will be forfeited and deposited in the Benefit Plan Surplus after the expiration of the claim filing period.

ARTICLE VIII

DEFINITIONS

"Administrator" the individual(s) or corporation responsible for carrying out or overseeing the administration of the Plan. The Employer will be deemed to be the Administrator unless it formally designates an employee or committee to serve in that capacity.

"Affiliated Employer" means with respect to the Plan Sponsor, any corporation that is a member of a controlled group of corporations (as defined in Code Section 414(b)) or any organization (whether or not incorporated) that is a member of an affiliated service group (as defined in Code Section 414(m)) that includes, and any trade or business (whether or not incorporated) that is under common control (as defined in Code Section 414(c)), or any other entity required by Code Section 414(o) to be aggregated, with, the Plan Sponsor.

"Benefit" means any of the benefits available under the Plan. These benefits are described in Article I.

"Benefit Plan Surplus" means amounts you forfeit and that are credited to such surplus as described in Appendices A and B, as applicable.

"Claims Administrator" means the person or entity designated by the Employer to administer claims.

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

"Compensation" means the total cash compensation you receive from the Employer during a Coverage Period, prior to any reductions under your benefit elections authorized under this Plan. "Compensation" includes overtime, commissions and bonuses.

"Coverage Period" means the period for which certain Benefits are provided to you under the Plan. The Coverage Period will be no less than 12 months, except that the Plan's first Coverage Period may, if it is commensurate with the Plan's fiscal year, be a short Coverage Period, and except where the Plan changes its fiscal year. In the event your participation begins during a Coverage Period, your initial Coverage Period is the portion of the Coverage Period remaining, beginning on the date your participation begins, and ending on the last day of that Coverage Period. The Plan may have different Coverage Periods for different Benefits, and a Coverage Period may be different than the Plan's fiscal year.

The Coverage Period is as follows:

Premium Conversion: January 1 to December 31

Health Care Reimbursement Program: January 1 to December 31

Dependent Care Reimbursement Program: January 1 to December 31

"Dependent" means any individual who, with respect to you, is a "qualifying child" or "qualifying relative" for the taxable year under Section 152 of the Code as determined without regard to subsections 152(b)(1), (b)(2) or (d)(1)(B). Generally, this requires the individual to (i) be your child, parent, or other relative described in that Section, and (ii) rely upon you for over half of his or her support during the taxable year (special support rules apply in the case of a child of divorced or legally separated parents). In the case of a non-spouse Dependent who is not a child or relative described in Section 152, generally the individual must rely upon you for over half of his or her support, have the same principal place of abode as you, and reside with you as a member of your household in a manner that is not in violation of local law.

Notwithstanding anything in the preceding paragraph to the contrary, however, for purposes of your ability to (1) make pre-tax payment of Premiums under this Plan for health care coverage on behalf of a child and (2) obtain, under the Health Care Reimbursement Program, reimbursement of Medical Expenses on behalf of a child, "Dependent" shall also include any child of yours defined in Code Section 152(f)(1) (generally, your natural, step, foster and adopted child, or child placed with you for adoption) through the end of the calendar year in which the child attains age 26. This rule does not mean that a child described in Code Section 152(f)(1) is necessarily *eligible* for health care coverage to the end of such calendar year under a health care plan or program (other than the Health Care Reimbursement Program) funded through this Plan; the eligibility of a child for a benefit shall be determined by the specific terms of the health care plans or programs funded through this Plan.

"Dependent Care Reimbursement Account" means your account under the Dependent Care Reimbursement Program, to which Flexible Benefits Plan Dollars may be credited on your behalf, in accordance with your benefit election, and from which this Plan will pay eligible dependent care expenses Incurred by you, as described in the appropriate Appendix.

"Dependent Care Reimbursement Program" means the program, under this Flexible Benefits Plan, under which Flexible Benefits Plan Dollars, contributed to your Dependent Care Reimbursement Account pursuant to your benefit election, are used to pay eligible dependent care expenses Incurred by you. The Program is described in detail in the appropriate Appendix.

"Effective Date" means the date set forth in the "Introduction" section of this Plan.

"Election Period" means the annual period that precedes the beginning of a Coverage Period, and during which you may elect the Benefits you want to receive under this Plan during that Coverage Period. The annual Election Period under this Plan will be separately communicated to you prior to each Coverage Period.

"Eligible Employee" means any Employee who has satisfied the following eligibility rules:

- Pre-Tax Health and Welfare Plan Premium Payment: An Employee is eligible on the date he becomes eligible to participate in a health and welfare plan sponsored by the Employer, as described in Article I. The eligibility rules of the health and welfare plan(s) are described in the plan(s), and are hereby incorporated into this Plan by reference.

- Health Care Reimbursement Program: An Employee is eligible on the date he or she become eligible to participate in major medical plan coverage through the Employer**.**

- Dependent Care Reimbursement Program: An Employee is eligible on the date he or she become eligible to participate in major medical plan coverage through the Employer.

- Health Savings Account: See Appendix A.

"Employee" means any person who is employed by an Employer, but excluding the following persons (if any):

1. Any individual who at any time during the Employer's taxable year is a ***more than 2% shareholder*** in the Employer, if the Employer is a subchapter S corporation; and any individual who is the spouse, child, parent or grandparent of the more than 2% shareholder

2. Temporary Employees

3. Interns

"Employer" means **Aegis Media Americas, Inc.** (also referred to as the "Plan Sponsor"), any Affiliated Employer that adopts this Plan, any other Participating Employer that adopts this Plan, any successor that maintains this Plan, and any predecessor that has maintained this Plan, with respect to their Eligible Employees.

Notwithstanding the foregoing, for purposes of the authority to amend or terminate the Plan, and for performing other settlor-type functions, the term "Employer" is limited to the Plan Sponsor.

Affiliated and Participating Employers that have adopted this Plan are listed in the Schedule of Affiliated and Participating Employers attached hereto.

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

"Flexible Benefits Plan Dollars" means the amount available to you, pursuant to your benefit election described in Article IV, to purchase Benefits. Each dollar contributed to this Plan equals one Flexible Benefits Plan Dollar.

"Health Care Reimbursement Account" means your account under the Health Care Reimbursement Program of this Plan, to which Flexible Benefits Plan Dollars may be allocated on your behalf, pursuant to your benefit elections, and from which this Plan will pay eligible Medical Expenses Incurred by you, your Spouse or other Dependents, as described in Appendix B.

"Health Care Reimbursement Program" means the program, under this Flexible Benefits Plan, under which Flexible Benefits Plan Dollars are contributed to your Health Care Reimbursement Account pursuant to your benefit elections, and used to pay eligible Medical Expenses Incurred by you, your Spouse or other Dependents. The Program is described in detail in Appendix B.

"Highly Compensated Employee" means an Employee described in Code Section 414(q) and the Treasury regulations issued under that Section.

"Highly Compensated Individual" means a person described in Code Section 125(e)(2) and the Treasury regulations issued under that Section.

"Highly Compensated Participant" means a person described in Code Section 125(e)(1) and the Treasury regulations issued under that Section.

"Insurance Contract" means any contract issued by an Insurer.

"Insurer" means any insurance company that underwrites a Benefit.

"Key Employee" means an Employee described in Code Section 416(i)(1) and the Treasury regulations issued under that Section.

"Participant" means any Eligible Employee who chooses to become a Participant under Article II and has not, for any reason, become ineligible to participate further in the Plan.

"Participating Employer" means an Employer that is not an Affiliated Employer and participates in this Plan for the benefit of its Eligible Employees, pursuant to the approval of such participation by the Plan Sponsor. Participating Employers must execute a written Participation Agreement provided by the Plan Sponsor, in order to become a Participating Employer. Participating Employers are listed in the Schedule of Participating Employers attached hereto.

"Plan" means this document, including all amendments to this document.

"Premiums" mean the cost of your (and, where applicable, your Dependents') coverage under any or all of the health and welfare plans described in Article I under which you chose to be covered.

"Pre-Tax Health and Welfare Premium Account" means your account under this Plan to which Flexible Benefits Plan Dollars may be credited on your behalf, under your benefit election, and from which this Plan will pay Premiums for your (and, where applicable, your Spouse's and/or your other Dependents') coverage under one or more of the health and welfare benefit plans described in Article II. If you elect coverage under more than one benefit plan, a sub-account will be established for each such plan.

"Qualifying High Deductible Health Plan" means a high deductible health plan described in and meeting the requirements of Code Section 223 and regulations issued under that Section.

"Spouse" means your legal spouse (regardless of gender). Your spouse will cease to be considered your Spouse" under this Plan upon the entry of a decree of divorce.

"You" means an Employee.

ARTICLE IX

MISCELLANEOUS

Plan Interpretation. All provisions of this Plan will be interpreted and applied in a uniform, nondiscriminatory manner by the Administrator, as described in Article VI. This Plan will be read in its entirety and not severed, except as described below, in the section titled, *Severability*.

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

Written Document. This Plan, in conjunction with any separate written document that may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any regulations promulgated thereunder relating to cafeteria plans.

Exclusive Benefit. This Plan will be maintained for the exclusive benefit of the Employees who participate in the Plan.

Participants' Rights. This Plan is not an employment contract between the Employer and any Participant or Employee, nor is it consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan will 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 which such discharge will have upon him as a Participant of this Plan.

Action by the Employer. Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act, it will be done and performed by a person duly authorized by the Employer.

Employer's Protective Clauses. Upon the failure of either you or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), your Benefits will be limited to the amounts described in the following sentence. The amounts described in this sentence are: (1) the insurance premium, if any, that remained unpaid for the period in question; and (2) the actual insurance proceeds, if any, received by the Employer or you as a result of your claim.

The Employer's liability to you will only extend—and be limited to—any payment actually received by the Employer from the Insurer. If the full insurance Benefit is not received by the Employer within a reasonable time after submission of a claim, the Employer will have no legal obligation whatsoever (except to execute any document called for by a settlement reached by you). You will be free to settle, compromise or refuse to pursue the claim as you, in your sole discretion, will see fit.

The Employer will not be responsible for the validity of any Insurance Contract issued under this Plan or with respect to which you purchase coverage under this Plan. Similarly, the Employer will

not be responsible for the Insurer's failure to make payments called for under any Insurance Contract, or for the action of any person that might delay or render null and void or unenforceable, in whole or in part, an Insurance Contract. With regard to this paragraph, the following will apply:

1. Once insurance is applied for or obtained, the Employer will not be liable for any loss that might result from the failure to pay Premiums, where the Employer does not receive Premium notices.

2. Where the Employer receives Premium notices, its liability for the payment of such Premiums will be limited to the amount of such Premiums and will not include liability for any other loss that may result from failure to pay such Premiums.

3. The Employer will not be liable for the payment of any insurance Premium—or any loss that may result from the failure to pay an insurance Premium—if the Benefits available under this Plan are insufficient to provide for the amount of such Premium cost at the time it is due. In these circumstances you will be responsible for and see to the payment of such Premiums. The Employer will attempt to notify you if available Benefits under this Plan are insufficient to provide for payment of an insurance Premium but will not be liable for any failure to make such notification.

No Guarantee of Tax Consequences. The Administrator and the Employer make no guarantee that any amounts paid to you or for your benefit under the Plan will be excludable from your gross income for federal or state income tax purposes. In addition, the Administrator and the Employer make no guarantee that any other federal or state tax treatment will apply to or be available to you. It will be your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes, and to notify the Employer if you have reason to believe that any such payment is not so excludable.

Indemnification of Employer by Participants. If you receive one or more payments or reimbursements under the Plan that are not for a permitted Benefit, or if the Employer incurs any liability on account of your having made excess contributions to a health savings account, you will 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 will not exceed the amount of additional federal and state income tax (plus any penalties) that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your 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 you.

Funding. The Plan is funded through salary reductions made by Participants. Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but will instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing in this Plan will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for your benefit, and neither you nor any other person will 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.

Other Salary-Related Plans. It is intended that any other salary-related employee benefit plans that are maintained or sponsored by the Employer will not be affected by this Plan. Any contributions or benefits under the other plans with respect to you will be based on your total compensation from the Employer, *including* any amounts by which your salary or wages may be reduced under Article IV. However, this rule will not apply to the extent not permitted by law or not otherwise provided for in such other plans.

Governing Law. The Code and the Treasury regulations issued under the Code (as they might be amended from time to time) govern this Plan. The Employer does not guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan will be construed, enforced and administered according to the laws of the State of **New York**.

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

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 will affect the Plan or the construction of any provision thereof.

Continuation of Coverage. In the event any Benefit under this Plan is subject to the continuation coverage requirement of Code Section 4980B or 42 U.S.C. § 300bb-1 (Public Health Service Act) and becomes unavailable, each Participant will be entitled to continuation coverage but only to the extent required in Code Section 4980B or 42 U.S.C. § 300bb-1, and regulations issued under the appropriate Section. In the event any Benefit under this Plan is subject to the continuation coverage requirement of the Uniformed Services Employment and Reemployment Rights Act and becomes unavailable on account of a Participant's uniformed service to which such Act applies, such Participant will be entitled to continuation coverage but only to the extent required in that Act and regulations issued under that Act.

Plan Records and Plan Numbers. Plan records are maintained on the basis of the Plan's fiscal year. The Health Care Reimbursement Program is a component of the BenefitsPlus Flexible Benefits Plan (ERISA plan #502).

Plan's Fiscal Year. The Plan's fiscal year is: January 1 to December 31.

Employer's Information. The Employer's Tax Identification Number is: **13-3906970**.

Administrator's Address and Telephone Number. The Administrator's address and telephone number are:

32 Avenue of the Americas, 16th Floor
New York, NY 10013
(212) 591-9100

Agent for Service of Process. Service for the Plan may be made upon the Employer.

Not in Place of Workers' Compensation. This Plan is not in place of and does not affect any requirement for coverage by Workers' Compensation insurance.

PLAN SPONSOR ADOPTION PAGE

The undersigned, on behalf of **Aegis Media Americas, Inc.** hereby adopts the amended and restated **BenefitsPlus** Flexible Benefits Plan and Summary Plan Description, in the form attached hereto, effective as of January 1, 2017.

AEGIS MEDIA AMERICAS, INC.

By: _____

Title: VP, Director of Benefits

Date: May 31, 2018

APPENDIX A

HEALTH SAVINGS ACCOUNT

The Plan is also designed to allow HSA Eligible Employees (defined below) to elect to make pre-tax contributions to their health savings accounts ("HSA") established and maintained with an outside custodian or trustee. If you choose to make HSA contributions through the Plan, the Employer will forward your contributions to be deposited in your HSA. The Employer may select a single trustee/custodian to receive such contributions or allow HSA Eligible Employees to direct contributions to a trustee/custodian of their choosing.

HSA Eligible Employees. An Employee is eligible to make HSA contributions for a given month on a pre-tax basis through this Plan, if he is considered an "eligible individual" under Code Section 223 with respect to that month. Generally, this requires the Employee to be enrolled as of the first day of that month in the Employer's qualifying high deductible health plan ("HDHP") (as defined under Code Section 223) and not enrolled as of the first day of that month in other health coverage that is not a qualifying HDHP, unless such other coverage is permitted insurance as defined in Section 223 of the Code. Permitted insurance includes insurance for a specified disease or illness, and insurance paying a fixed amount per day (or other period) of hospitalization), or coverage for accidents, disabilities, dental care, vision care, preventive care, long-term care.

Section 223 of the Code, however, includes special "deeming" rules that may apply to allow an Employee to be considered an "eligible individual" with respect to months with respect to which the Employee was not enrolled in qualifying coverage as of the first day of the month. The Employer is permitted to rely upon the Employee's representation regarding the absence of such disqualifying coverage, unless the Employee is enrolled in such disqualifying coverage sponsored by the Employer.

Changes to Elections Concerning Health Savings Account Contributions. You may change your election concerning the amount of your pre-tax contributions to your HSA at least monthly, but the change may be effective prospective only, and will take effect as soon as the Employer's payroll department is able to implement your new election. However, if the Employer has pre-funded your HSA account with all or a portion of the amount you elected to contribute for the year, and is entitled to be reimbursed the "advance" from deductions from your pay, you may not modify your HSA contribution election so that the total amount you elect to contribute for the year is less than the amount of the Employer's advance. The intent of this rule is to ensure that the Employer is allowed to recoup the amount of its advance, as long as you are still entitled to pay from the Employer.

The Employer may limit the amount and timing of your pre-tax contributions to your HSA, and those restrictions may affect your ability to change your election.

Limit on Health Savings Account Contributions. The Employer has no authority or control over the funds deposited in your HSA and your HSA is not considered part of the Plan. However, the Employer may limit your pre-tax contributions made through this Plan to your HSA to your theoretical maximum HSA contribution after taking into account factors such as the number of months during the Coverage Period during which you were an HSA Eligible Employee (or, pursuant to

Section 223 of the Code, *deemed* to be an Eligible Employee) with respect to pre-tax HSA contributions, your age (for purposes of HSA "catch-up contributions"), the amount of Employer contributions made to your HSA, and other factors prescribed by law or within the Employer's discretion. The Employer may also confine your ability to make pre-tax HSA contributions through this Plan to months with respect to which you are an HSA Eligible Employee (or, pursuant to Section 223 of the Code, *deemed* to be an HSA Eligible Employee) with respect to HSA contributions, and may limit your pre-tax contribution in such a month to your "monthly limit" for such month, as that term is defined in Code Section 223 or regulations issued thereunder.

In addition to your own pre-tax contributions, the Employer may choose to make non-salary reduction contributions through this Plan directly to the HSAs of Eligible Employees. The amount and timing of, and eligibility for, these contributions will be determined by the Employer in its sole discretion. For example, the Employer may determine to make HSA contributions to the HSA of just those Employees who complete a health risk assessment, or to make HSA contributions to the HSAs of just those Eligible Employees who are enrolled in the Employer's qualifying HDHP, or to make "matching" HSA contributions to the HSAs of Eligible Employees who make their own contributions to their respective HSAs.

The Employer will communicate to Employees the terms and conditions, if any, under which such contributions may be made, and such communications will be considered part of this Plan. However, such contributions, if made, will be made in compliance with Internal Revenue Service requirements, and any such requirements are hereby incorporated into this Plan by reference.

Trust/Custodial Agreement; HSA Not Intended to be an ERISA Plan. HSA Benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims and appeals procedures, use of debit and credit cards, and investments) will be provided by and are set forth in the trust/custodial agreement, not this Plan.

The HSA is not an Employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Section 223(d)(2) of the Code. Even though this Plan may allow pre-tax salary reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

Neither the Administrator nor Employer guarantee the non-taxability of your or the Employer's (on your behalf) contributions to a health savings account, as the taxability of such contributions may turn, in some cases, on issues outside the Employer's knowledge or control or both.

Where the Employer allows you to make pre-tax contributions to an HSA, the Employer's obligation with respect to such contributions is limited to determining whether you are enrolled under the Employer's qualified HDHP, the deductible under such plan, the then extant statutory monthly and annual limit for HSA contributions, your age (for purposes of calculating the potential HSA "catch up" contribution, if any, under Code Section 223), the amount of any non-salary reduction Employer contributions made to your HSA for the Coverage Period, and whether you are enrolled under any other health care program of the Employer that disqualifies you from making HSA contributions.

Submitting Claims for Benefits under your HSA. Any claim for benefits under your HSA must be submitted to your HSA custodian or trustee.

APPENDIX B

HEALTH CARE REIMBURSEMENT PROGRAM

Establishment of Program. This Health Care Reimbursement Program is intended to qualify as a medical reimbursement plan under Code Section 105. It will be interpreted in a manner consistent with that Code Section and the Treasury regulations issued under that Section. If you choose to participate in the Health Care Reimbursement Program you may submit claims for the reimbursement of "Medical Expenses" (as defined below). All amounts reimbursed under this Health Care Reimbursement Program will be paid from amounts credited to your Health Care Reimbursement Account in accordance with your benefit elections. Except as otherwise provided in this Appendix, for a Medical Expense to be reimbursed from the benefit you elected for a Coverage Period, the Medical Expense must be Incurred within the Coverage Period.

Definitions. For the purposes of this Appendix and the Flexible Benefits Plan:

> ***"Medical Expenses"*** means expenses for medical care that meet the following requirements. First, the expense must fall within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213 (and the rulings and Treasury regulations issued under that Section). Second, you may not deduct the expense from your gross income for purposes of determining your income tax. Medical Expenses do not include a medicine or drug unless such medicine or drug is a prescribed drug (but note the prescribed medicine or drug may be an over-the-counter medicine or drug if obtained with a valid prescription) or is insulin. ***This Program will not reimburse you for the cost of other health coverage, such as premiums paid under plans maintained by your Spouse's or other Dependent's employer or individual policies maintained by you or your Spouse or other Dependent.***
>
> ***"Incur" or "Incurred"*** with respect to an expense means the following: An expense is Incurred at the time the service giving rise to the expense is furnished, and not when the individual is formally billed for, is charged for, or pays for the service. Special rules may apply with respect to a course of treatment such as orthodontic care, where payment is required in advance.

The definitions of Article VIII are incorporated into this Appendix to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Program.

Limited Coverage for Health Savings Account Participants. If you have enrolled in the Employer's Qualifying High Deductible Health Plan, such that you are eligible to make contributions to a health savings account ("HSA"), your participation in the Health Care Reimbursement Program creates some issues for you. Coverage under the Health Care Reimbursement Program, which provides reimbursement for "medical care" as defined in the Tax Code, generally disqualifies you from eligibility to make HSA contributions (and disqualifies the Employer from making any discretionary HSA contributions on your behalf). Similarly, because as a general rule your Spouse is also covered under the Health Care Reimbursement Program if you are enrolled, that coverage would also disqualify your Spouse from making HSA contributions to his or her own HSA.

As a result, if you are enrolled in the Employer's Qualifying High Deductible Health Plan you are not able to participate in the Health Care Reimbursement Program.

Forfeitures. The amount in your Health Care Reimbursement Account as of the end of any Coverage Period (and after the processing of all claims for that Coverage Period pursuant to rules described below) will be forfeited and credited to the Benefit Plan Surplus. In that case, you will have no further individual claim to such amount for any reason. Forfeited amounts may include amounts credited to your Account and with respect to which checks were issued by the Health Care Reimbursement Program administrator but which remain uncashed after a reasonable period of time, as determined by the Employer or administrator in its sole discretion.

You may carry over unused amounts of up to $500 remaining in your Health Care Reimbursement Account at the end of a Coverage Period to the immediately following Coverage Period. The amounts carried over may be used during the following Coverage Period to pay for qualifying Medical Expenses incurred by your or your Dependents in such Coverage Period. Amounts carried over do not affect the maximum amount of Flexible Benefit Plan Dollars, if any, your Employer will credit to your Health Care Reimbursement Account for the Coverage Period to which they are carried over. Amounts in excess of $500.00 may not be carried over and will be forfeited. The Plan will treat claims as being paid first from carryover amounts and then from the current year amounts.

For purposes of the above, the amount remaining unused as of the end of the Coverage Period is the amount unused after Medical Expenses have been reimbursed at the end of the Plan's run-out period for the Coverage Period (i.e., the period immediately following the end of the Coverage Period during which a Participant may submit a claim for reimbursement of expenses).

If you are enrolled in your Employer's Qualifying High Deductible Health Plan, then any unused amounts in your Health Care Reimbursement Account that are carried over to the next Coverage Period will be converted to a limited purpose Health Care Reimbursement. This restriction is in place to allow you to make HSA contributions.

As required by the IRS, any grace period following the close of the Coverage Period shall not be available concurrently with this carryover provision.

Qualified Reservist Distributions. If during the Coverage Period for the Health Care Reimbursement Program an Employee participating in the Program is called, as a member of a reserve component defined in Section 101 of Title 37 of the United States Code, to active duty for a period of at least 180 days (or for an indefinite period), the Plan shall, upon written request of such Employee on a form or in such manner as the Employer may direct, make to the Employee a distribution of the balance then credited, as of the date of such distribution, to such Employee's Health Care Reimbursement Account under the Program, subject to the following requirements:

1. The Employee's balance on the date of the distribution must exceed zero; the balance on the date of the distribution is the sum of the contributions credited to the Employee's Health Care Reimbursement Account for the Coverage Period, as of the date of the distribution, less the amount of claims paid under the Program, as of the date of distribution, to the Employee for Medical Expenses Incurred during the Coverage Period;

2. The Employee requests the distribution prior to the end of the Coverage Period, or the grace period, if any, applicable to such coverage period; and

3. The Employer is able to make the distribution within 60 days after a valid request for the distribution is received.

Upon the payment of the distribution, the Employee's participation in the Health Care Reimbursement Program shall terminate, and any claims (with respect to the Coverage Period) Incurred but unpaid as of the date of the distribution or Incurred after that date shall not be payable; provided, however, that covered claims incurred during the Coverage Period and prior to the Plan's receipt of the request for the qualified reservist distribution shall be paid to the extent of (a) minus (b), where (a) is the Benefit elected by the Employee for the Coverage Period, and (b) is the sum of covered claims paid to the Employee, for the Coverage Period, as of the date of the qualified reservist distribution, and the amount of such distribution.

The amount of the distribution shall be treated as taxable income to the Employee and subject to employment taxes, except to the extent the Employee's distribution includes after-tax contributions from the Employee (*e.g.*, COBRA premium payments).

The terms and conditions of this special rule shall be construed and applied in a manner consistent with applicable federal law.

Limitation on Allocations. The maximum and minimum amount of Medical Expenses that may be reimbursed under this Plan during any Coverage Period will be determined by the Administrator in its discretion and will be communicated to you prior to be beginning of the Coverage Period. The maximum salary reduction election you may make cannot exceed $2,500, as indexed for inflation pursuant to Code Section 125(i)(2). Further, in no event will maximum amount of reimbursable Medical Expenses for any Coverage Period exceed two times your salary reduction election for the Coverage Period (or, if greater, $500 plus the amount of your salary reduction election). This $2,500 limit (as adjusted for inflation) shall be applied by treating all Health Care Reimbursement Programs maintained within a controlled group of corporations, trades or businesses (as defined in Code Sections 414(b), (c) and (m)) as a single Program.

Health Care Reimbursement Program Claims. Medical Expenses that you, your Spouse or other Dependents Incur may be reimbursed even though the submission of the claim occurs after your participation under the Plan ends. However, the Medical Expenses must have been Incurred while you were a Participant, and the claims must be filed with the Claims Administrator within the time described in below.

Generally, the claim will include a written statement (*e.g.*, a receipt) from an independent third party (such as the health care provider that provided the service) stating that the Medical Expense has been Incurred and the amount of such expense. Furthermore, you must provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health care plan coverage and, if reimbursed from the Health Care Reimbursement Account, such amount will not be claimed as a tax deduction. *However, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Health Care*

Reimbursement Program Claims Administrator. The Claims Administrator will retain a file of all such claim forms.

The Claims Administrator will direct the reimbursement to you of all allowable Medical Expenses, up to a maximum equal to the amount of Flexible Benefits Plan Dollars you chose—in your benefit elections—to have the Employer contribute to your Health Care Reimbursement Account for the Coverage Period. ***Reimbursements will be made available to you throughout the Coverage Period without regard to the amount of Flexible Benefits Plan Dollars that have been credited to your Account at any given point in time***.

Example: Assume you choose in your benefit elections to contribute $1,200 to the Health Care Reimbursement Program for the Coverage Period, in increments of $100 per month. The Coverage Period is the calendar year. During January, the Employer reduces your Compensation by $100, converts those dollars into Flexible Benefits Plan Dollars and credits them to your Health Care Reimbursement Account. In that same month, you Incur an expense of $500 that is reimbursable under the Program. The claim is properly payable, even though at the time the claim is submitted you have only 100 Flexible Benefits Plan Dollars credited to your Account.

In addition, you will be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan that may be sponsored by the Employer, any governmental agency or any other plan covering you and/or you Spouse or other Dependents.

Claim Filing Deadline. A claim for the reimbursement of Medical Expenses Incurred in any Coverage Period will be decided within a reasonable time after it is received. However, if you fail to submit a properly executed claim before the end of the claim filing deadline, the claim will not be accepted. The claim filing deadline is: **90 days** after the close of the Coverage Period.

A claim will be deemed submitted when the Claims Administrator receives the completed claim form. However, if a claim form is filed by U.S. Postal Service, it will be deemed to have been submitted on the date of the United States postmark stamped on the envelope in which the claim form is mailed. Claims will be decided in accordance with Article V.

Notwithstanding the foregoing, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Health Care Reimbursement Program Claims Administrator.

Claim Payments Are Made to You. Except where this Program provides for your use of a debit or credit card to obtain services and supplies that would otherwise have been reimbursable under the Program had you paid cash for them, reimbursements under this Program will be made directly to you. In the event a payment from this Plan is made by check and such check is not negotiated by the payee within a reasonable time, the Plan Administrator may direct that such payment be forfeited, escheated to the State, or otherwise dealt with in such manner as the Employer may decide.

Review of Health Care Reimbursement Claims. The Claims Administrator will review and decide a claim (appropriately filed with it) for reimbursement under the Health Care Reimbursement Program within 30 days after receipt of the claim. The Claims Administrator may

extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Claims Administrator will notify the claimant within the initial 30-day timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan cannot render a decision within 30 days because the claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim. The claimant will have at least 45 days from receipt of the notice to provide the required information. The Plan will then have 15 days from the date of receiving the claimant's information to render its decision. The claimant may agree to extend these deadlines.

Form and Content of Notice of Adverse Determination on Health Care Reimbursement Claims. If a claim is denied in whole or in part, notice of such adverse determination will be provided to the claimant. Notice will be written or electronic. The notice will include the following:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the determination is based;

3. If applicable, a description of any additional information needed for the claimant to perfect the claim and an explanation of why such information is needed;

4. A description of the Plan's review procedures, including the claimant's right to bring a civil action under Section 502(a) of ERISA;

5. A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;

6. If the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or a statement that this will be provided without charge upon request; and

7. In the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

Right to Appeal Decision on Health Care Reimbursement Claims. Any claimant who has had a claim for benefits denied in whole or in part by the Claims Administrator, or is otherwise adversely affected by action of the Claims Administrator, has the right to request review by the Administrator. Such request must be in writing, and must be made within 180 days after the claimant is advised of the Claim Administrator's action. If written request for review is not made within such 180-day period, the claimant will forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all pertinent documents and submit issues and comments in writing. The Administrator or its designee may prescribe a reasonable procedure under which a claimant may designate an authorized representative.

Action on Appeal of Health Care Reimbursement Claim. The Administrator or its designee will then review the claim. The person or entity that reviews the claim will be a fiduciary under the Plan, and will not be the same person, or a person subordinate to the person, who initially decided the claim. If the adverse benefit determination was based on medical judgment, the person handling the appeal will consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional will not be the same professional who was consulted with respect to the initial action on the claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and shall issue a written or electronically disseminated decision reaffirming, modifying or setting aside the initial decision on the claim. The decision on appeal will be made within 60 days; the time period begins to run on the date the appeal is received by the Plan or its designee. The claimant may agree to further extend these deadlines.

A copy of the decision will be furnished to the claimant. The decision shall set forth:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific plan provisions on which the determination is based;

3. a statement that the claimant is entitled to receive without charge reasonable access to any document: (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;

4. A statement of any voluntary appeals procedures and the claimant's right to receive information about the procedures as well as the claimant's right to bring a civil action under Section 502(a) of ERISA;

5. A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request; and

6. If the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the claimant's medical circumstances, or a statement that this will be provided without charge upon request.

The decision will be final and binding upon the claimant and all other persons involved.

Conformity with Patient Protection and Affordable Care Act of 2010. To the extent the Health Care Reimbursement Program is or becomes subject to the Patient Protection and Affordable Care Act of 2010, as amended (and regulations thereunder), the claims and appeals rules applicable to that Program shall be construed and applied in a manner consistent with applicable requirements of such Act and regulations.

The Status of Your Plan Accounts Pending Appeal. Any balance remaining in a Reimbursement Account described in one or more Appendices (as applicable) at of the end of a Coverage Period will be forfeited and credited to the Employer's Benefit Plan Surplus as described in the appropriate Appendices, as applicable. However, if you had made a claim for such Coverage Period, in writing, which was denied or is pending, the amount of the claim will be held in your Account until the claim appeal procedures described 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 Coverage Period will be forfeited and credited to the Benefit Plan Surplus.

Debit or Credit Card Usage for Obtaining Covered Services and Supplies. The Employer may contract with the Claims Administrator to allow you to use a debit or credit card to access your Health Care Reimbursement Account. This allows you, where you obtain a service or supply from a provider that is willing to accept such debit or credit card transactions, to avoid having to pay cash for the service or supply, and then seek reimbursement from the Claims Administrator. However, your use of a debit or credit card is subject to specific and mandatory requirements imposed by the Claims Administrator, including (among other things), "after-the-fact" documentation or substantiation of the expense in some cases. If you fail to provide adequate after-the-fact documentation or substantiation of an expense paid via a debit card, you agree that the Employer may deduct the amount of the expenses paid via the debit card from your wages, or set-off the amount you owe the Employer or the Program against future covered claims for Medical Expenses Incurred during the same Coverage Period.

COBRA Continuation Coverage. If you and/or your Spouse and/or other Dependent loses coverage under the Health Care Reimbursement Program due to a "qualifying event," you and/or your Spouse and/or Dependent, as the case may be, might be entitled to continue coverage for a period of time after the qualifying event, in accordance with the COBRA provisions of Article II and this Appendix.

"Qualifying events" include:

1. Termination of your employment for any reason (including death), except for gross misconduct;

2. Your termination of eligibility due to reduced work hours;

3. Your eligibility for Medicare;

4. Your divorce or legal separation; and

5. A Dependent child's ceasing to satisfy the definition of "Dependent."

Under the law, you or the affected Spouse or Dependent has the responsibility to inform the Administrator of a qualifying event that is a divorce, legal separation, or a child losing Dependent status under this Plan within 60 days of the date of the later of the event or the date on which coverage would end under the Plan because of the event. The notice may be provided by contacting the BenefitsPlus Solutions Center at **855.326.7870**.

When the Administrator is notified that one of these events has happened, the Administrator will in turn notify the person entitled to COBRA coverage ("qualified beneficiary") of his or her COBRA rights. Under the law, qualified beneficiaries have at least 60 days from the date coverage would be lost because of one of the events described above to inform the administrator that they want continuation coverage.

Special COBRA rights might apply if you lose coverage as a result of termination or reduction of hours and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. You may be entitled to a second opportunity to elect COBRA coverage for yourself and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which you begin receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begin receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after your group health plan coverage ended.

The duration for which a qualified beneficiary may purchase COBRA coverage depends on a number of factors. If (1) you are eligible for major medical coverage through your employer, and (2) the maximum amount of Benefits available to you under the Health Care Reimbursement Program does not exceed two times your salary reduction contribution for the year or, if greater, your salary reduction contribution plus $500, your COBRA coverage rights are limited. COBRA coverage is not available beyond the end of the Coverage Period in which the qualifying event occurred; in addition, if at the time of the qualifying event the amount available for reimbursement for the remainder of the Coverage Period is *less* than the amount of contributions the COBRA qualified beneficiary would be required to pay for the remainder of that Coverage Period, then the qualified beneficiary is not eligible for COBRA coverage under the Health Care Reimbursement Program. These rules are described in additional detail in Article II.

However, if (1) you are *not* eligible for major medical coverage through your Employer, or (2) the maximum amount of Benefits available to you under the Health Care Reimbursement Program exceeds two times your salary reduction contribution for the year or, if greater, your salary reduction contribution plus $500, COBRA coverage can continue for 18 months (for qualifying events that are a termination of employment (for reasons other than death) or reduction in work hours) or 36 months (for other qualifying events). If a qualified beneficiary is disabled (within the meaning of the Social Security Act) at the time of a qualifying event that is a termination of employment (for reasons other than death) or reduction in hours, or is so disabled during the first 60 days of COBRA coverage following such a qualifying event, COBRA coverage for that beneficiary—and any other qualified beneficiary affected by the same qualifying event—can continue for up to 29 months. Where there are multiple qualifying events the 18- or 29-month limit may be extended to 36 months.

You must pay for the COBRA coverage you elect, typically on an after-tax basis, in monthly amounts. For the remainder of the Coverage Period in which the qualifying event occurs the monthly amount is equal to the monthly amount you chose (in your benefit elections) to pay during the Coverage Period, plus two percent. If COBRA coverage can be continued into a subsequent Coverage Period the monthly amount is equal to the $1/12^{th}$ of the total Benefits you elected to have

available under the Program for that Coverage Period, plus two percent. Where a disabled qualified beneficiary continues COBRA coverage for the additional 11-month period described above, the surcharge per month is fifty percent rather than two percent during the 11-month extension.

A qualified beneficiary's continuation coverage may be cut short for any of the following three reasons:

1. The Employer no longer provides group health coverage to any of its employees;

2. The premium for continuation coverage is not paid on time; or

3. The beneficiary becomes covered, after the date of the election of COBRA coverage, under Medicare or under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition he or she may have.

Payments are due monthly. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

For additional questions about continuation coverage, please contact the Administrator.

Continuation of Coverage Under USERRA. When an Eligible Employee participating in the Health Care Reimbursement Program commences a period of uniformed service to which the Uniformed Services Employment and Re-employment Rights Act applies, he or she may continue coverage under the Program, on a self-pay basis, for up to 24 months or, if shorter, the duration of the period of uniformed service. The Employer may prescribe reasonable procedures under which the Eligible Employee must elect and pay for this continued coverage, if the Eligible Employee chooses to continue the coverage.

Statement of ERISA Rights. As a participant in the Health Care Reimbursement Program under this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Administrator's office and at other specified locations, such as worksites 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 Employee Benefits Security Administration.

1. Obtain, upon written request to the 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.

2. Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Program as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a 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 or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a benefit under the Program 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 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 administrator. If you have a claim for benefits which 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.

Assistance with Your Questions. If you have any questions about your Plan, you should contact the 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 Administrator, 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Nondiscrimination Under Section 105(h). The Administrator may designate portions of the Health Care Reimbursement Program as separate plans for purposes of satisfying nondiscrimination testing under Section 105(h) of the Internal Revenue Code. In addition, where this Plan is included as a component program in a comprehensive health and welfare benefit plan that includes other health care benefits subject to Section 105(h), the Health Care Reimbursement

Program may be designated as a separate testing plan, that is, it may be tested separately from other component health care programs included in such plan. Where the Administrator makes such a separate testing plan designation it shall disclose the separate testing plans to the Participants, to the extent required by applicable law or regulations.

Notwithstanding any other language in this Plan to the contrary, each Participating Employer's participation in the Health Care Reimbursement Program shall, to the extent the Participating Employer's participation, be considered a separate welfare benefit plan. No contributions made by any Participating Employer or an Eligible Employee of such Participating Employer shall be used to pay Health Care Reimbursement Program claims incurred by an Eligible Employee of any other Participating Employer.

APPENDIX C

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 PRIVACY AND SECURITY REQUIREMENTS

Introduction. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to covered persons remains confidential, subject to limited exceptions in which PHI may be disclosed. PHI also includes electronic or "ePHI". "Protected Health Information" means health information (including oral information) that:

1. is created or received by health care providers, health plans, or health care clearinghouses;

2. relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and

3. identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

Electronic Protected Health Information or "ePHI" is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103.

Disclosures Of PHI By The Plan To The Employer. Provided that the Plan (or the Employer on behalf of the Plan) provides to covered person a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose PHI (relating to a covered person) to the Employer, as further described below, without the consent or authorization of the covered person. In no event may the Plan disclose PHI to the Employer, without the consent or authorization of the covered person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

The Plan may disclose PHI to the Employer, without the consent or authorization of the covered person, subject to the Employer's obligations described below (in the section titled, *Employer Obligations with Respect to PHI Obtained from the Plan*) for Plan administrative functions such as quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of PHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information to the Employer, without the consent or authorization of the covered person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers,

including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information to the Employer without the consent or authorization of the covered person.

Employer Obligations With Respect To PHI Obtained From The Plan. As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

1. not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the covered person to whom the PHI relates;

2. ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;

3. not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the covered person to whom the PHI relates;

4. report to the Plan any improper uses or disclosures of the PHI;

5. provide covered persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide covered persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);

6. make available to appropriate federal authorities the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan; and

7. return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

Use And Disclosure Of PHI By The Employer; Dispute Resolution. When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to the human resources or employee benefits department of the Employer, and may also be provided to the Employer's payroll department (for purposes of processing payroll deductions for payment of premium) and chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the covered person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in section above titled, *Disclosures of PHI by the Plan to the Employer*. The Employer may also disclose PHI relating to a covered person, without the consent or authorization of the covered person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the covered person, to law enforcement, public health, and judicial agencies in certain circumstances. PHI pertaining to a minor covered person may, to the extent permitted by local law, be disclosed to the covered person's parent or guardian without the consent or

authorization of the minor. There are other situations in which PHI may be disclosed without the covered person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a covered person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the human resources or employee benefits department for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which you should have already received (an additional copy is available from the employee benefits department). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.

Employer Obligations With Respect To ePHI Obtained From The Plan. In addition to the rules discussed above with respect to all PHI, as a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

1. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that the adequate separation, between the ePHI and persons who have no legitimate need to access such ePHI, as required by 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
4. Report to the Plan any security incident of which it becomes aware.

APPENDIX D

DEPENDENT CARE REIMBURSEMENT PROGRAM

Establishment of Program. This Dependent Care Reimbursement Program is intended to qualify as a program under Code Section 129. It will be interpreted in a manner consistent with that Code Section and the Treasury regulations issued under that Section. If you choose to participate in this Program you may submit claims for the reimbursement of Employment-Related Dependent Care Expenses (defined below). All amounts reimbursed under this Dependent Care Reimbursement Program will be paid from amounts credited to your Account under this Program. **See the section at the end of this Appendix for information about whether the Dependent Care Reimbursement Program is more beneficial to you than the tax credit for dependent care expenses available to you under the Code.** Except as otherwise provided in this Appendix, for an Employment-Related Dependent Care Expense to be reimbursed from the benefit you elected for a Coverage Period, the Employment-Related Dependent Care Expense must be Incurred within the Coverage Period.

Definitions. For the purposes of this Appendix and the Flexible Benefits Plan, the terms below will have the following meaning:

> ***"Earned Income"*** means earned income as defined under Code Section 32(c)(2) (generally wages and salaries, plus net earnings from self-employment) but excluding amounts paid or Incurred by the Employer for dependent care assistance to you or on your behalf.
>
> ***"Employment-Related Dependent Care Expenses"*** means expenses Incurred by you for those services that, if paid by you, would be considered employment-related expenses under Code Section 21(b)(2). Generally, they include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are Incurred to enable you to be gainfully employed for any period for which you have at least one Qualifying Dependent. Whether an amount qualifies as an Employment-Related Dependent Care Expense will be decided under the following rules:
>
> - If the amounts are paid for expenses Incurred outside your household, they will constitute Employment-Related Dependent Care Expenses only if Incurred for a Qualifying Dependent as defined below (if the Qualifying Dependent is not a Dependent child under the age of 13, the Qualifying Dependent must also regularly spend at least 8 hours each day in your household);
>
> - If the expense is Incurred outside your 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
>
> - Your Employment-Related Dependent Care Expenses will not include amounts paid or Incurred for service performed by a person who is your child (as defined in Code Section 151(c)(3)) and who is under the age of 19, or to an individual who is

claimed as a Dependent by your or your Spouse (that is, an individual with respect to whom a personal exemption is claimed on your or your Spouse's federal income tax return).

- Expenses for "household services" means expenses paid for the performance in your home of ordinary and usual services necessary to the maintenance of your household. The expenses must also be attributable to the care of a Qualifying Dependent.

"Incur" or "Incurred" with respect to an expense means the following: An expense is Incurred at the time the service giving rise to the expense is furnished, and not when the individual is formally billed for, is charged for, or pays for the service. Thus, with respect to Employment-Related Dependent Care Expenses, for example, services rendered for the month of June are not fully Incurred until June 30th and cannot be reimbursed in full until then.

"Qualifying Dependent" means, for purposes of this Dependent Care Reimbursement Program:

- Your Dependent (as defined in Section 152(a)(1) of the Code (*e.g.*, a "qualifying child") who is under the age of 13;

- Your Spouse or other Dependent who is physically or mentally incapable of caring for himself or herself, and who has the same principal place of abode as you, for over half the taxable year, and whose relationship with you is not in violation of local law at any time during the year; or

- Any other Dependent who is deemed to be a Qualifying Dependent described in one of the preceding two paragraphs, whichever is appropriate, pursuant to Code Section 21(e)(5) (dealing with special rules for establishing dependency in the case of divorced parents).

The definitions of Article VIII are incorporated into this Appendix to the extent necessary to interpret and apply the provisions of this Dependent Care Reimbursement Program.

Your Account Under this Program. The Claims Administrator will establish an Account under this Program for you when you choose to apply Flexible Benefits Plan Dollars to Dependent Care Reimbursement Program Benefits.

Increases and Decreases in Dependent Care Reimbursement Accounts. Your account under this Program will be *increased* each pay period by the portion of Flexible Benefits Plan Dollars that you chose to apply toward your account under this Program pursuant to your benefit elections.

Your account under this Program will be *reduced* by the amount of any Employment-Related Dependent Care Expense reimbursements paid or Incurred on your behalf, as described below in the section titled, *Dependent Care Reimbursement Program Claims.*

Allowable Dependent Care Reimbursement. Subject to (1) limitations reflected below, in the section titled, *Limitations on Payments*, and (2) the extent of the amount credited to your account under this Program, if you Incur Employment-Related Dependent Care Expenses you will be entitled to receive from the Program full reimbursement for the entire amount of such expenses Incurred during the Coverage Period (or portion of the Coverage Period) during which you are a Participant.

Annual Statement of Benefits. If you participate in this Program during a Coverage Period, then on or before January 31 of the ensuing Coverage Period the Employer will furnish to you a statement of all Benefits paid to you or on your behalf under this Program during the preceding Coverage Period.

Forfeitures. The amount credited to your account under this Program as of the end of any Coverage Period (and after the processing of all claims for such Coverage Period pursuant to the section below titled, *Coordination with Flexible Benefits Plan*) will be forfeited and credited to the Benefit Plan Surplus. In that case, you will have no further claim to such amount for any reason. Forfeited amounts may include amounts credited to your Account and with respect to which checks were issued by the Dependent Care Reimbursement Program administrator but which remain uncashed after a reasonable period of time, as determined by the Employer or administrator in its sole discretion.

Notwithstanding any other provision in this Appendix to the contrary, a special rule applies where, you maintain a positive balance with respect to your Dependent Care Reimbursement Account as of the last day of the Coverage Period and are covered by the Dependent Care Reimbursement Program on such day. In that event, such positive balance may be applied to reimburse you for allowable Employment-Related Dependent Care Expenses incurred by you either in such Coverage Period, or within 2-1/2 months after the end of such Coverage Period (the "grace period"), provided the Claims Administrator has agreed to administer such a grace period, and a proper claim for reimbursement is properly submitted for reimbursement within the time prescribed below.

To the extent the Claims Administrator agrees to do so, reimbursable Employment-Related Dependent Care Expenses incurred during the grace period will be reimbursed first from the positive balance remaining as of the close of the last day of the prior Coverage Period, and then from benefits you elected for the current Coverage Period. Where a claim is so reimbursed, exhausting the prior year's Dependent Care Reimbursement Account balance, and thereafter you timely submit additional claims incurred during such prior Coverage Period (or a previously denied claim is approved, for expenses incurred during such prior Coverage Period), a special rule applies.

In such event, the Claims Administrator may, in its discretion, (i) recharacterize the previously paid "grace period" claims as claims payable from the benefits you elected for the current Coverage Period, (ii) restore the balance remaining as of the close of the prior Coverage Period, and (iii) apply such balance to pay the additional claims incurred in the prior Coverage Period (or, as the case may be, the previously denied claims where an appeal of the denial is sustained).

Your continued coverage under the grace period shall continue to the end of the grace period notwithstanding your termination of employment (on or before the last day of the grace period) that would otherwise have operated to make you ineligible.

Limitation on Payments. Amounts paid from your account under this Program, in or on account of any single taxable year, will not exceed:

1. the Earned Income limitation described in Code Section 129(b), or

2. $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)), whichever is *less*.

Dependent Care Reimbursement Program Claims. You are required to file a claim with the Claims Administrator in order to receive Benefits from this Program. The claim must be in a form satisfactory to the Claims Administrator, and must include a statement from an independent third party (for example, the caregiver) as proof that the expense has been Incurred, and the amount of such expense. In addition, the Claims Administrator may require that the claim include a statement containing the following information:

1. The name and age of each Dependent for whom the services were performed.

2. The nature and dates of the services that were performed.

3. Your acknowledgment that you will include on your federal income tax return the name, address, and (except in the case of a tax-exempt provider) the taxpayer identification number of the provider (or will exercise due diligence in attempting to obtain such information).

4. The relationship, if any, of the person performing the services for you.

5. If another of your Dependents performed the services, the age of the other Dependent.

6. Where the services were performed.

7. If any of the services were performed outside your home, whether the Dependent for whom such services were performed regularly spends at least 8 hours each day in your household.

8. If the services were performed in a day care center that provides care for more than six individuals (other than individuals residing at the center) and receives a fee, payment, or grant for providing any of such care:

    - Whether the day care center complies with all applicable state and local laws and regulations of the state of residence, and

    - The amount of the fee, payment, or grant paid to the provider.

9. If you are married:

- Whether you and your Spouse plan to file a joint return or separate returns of federal income taxes; and

- The amount, if any, of nontaxable dependent care assistance benefits received from any other employer by you or your Spouse for the Coverage Period.

Claim Payments Are Made to You. The Claims Administrator will pay Benefits under this Program directly to you or, in the Claims Administrator's discretion, directly to the service provider. In the event a payment from this Plan is made by check and such check is not negotiated by the payee within a reasonable time, the Plan Administrator may direct that such payment be forfeited, escheated to the State, or otherwise dealt with in such manner as the Employer may decide.

A claim for the reimbursement of Employment-Related Dependent Care Expenses Incurred in any Coverage Period will be decided within a reasonable time after it is received. However, if a Participant fails to submit a properly executed claim form within the claim filing deadline, the Claims Administrator will not consider the claim. The claim filing deadline is: **90 days** after the close of the Coverage Period.

Notwithstanding the foregoing, Employment-Related Dependent Care Expenses incurred by you during a Coverage Period (or within 2-1/2 months after the close of the Coverage Period) may be considered by the Dependent Care Reimbursement Program for payment from your Dependent Care Reimbursement Account for such Coverage Period, provided a proper claim therefore is made not later than **90 days** after the close of such 2-1/2 month period.

The Claims Administrator will deem a claim to have been submitted when the Claims Administrator receives the claim form. However, if a claim form is filed by U.S. Postal Service, the Claims Administrator will deem it to have been submitted on the date of the United States postmark stamped on the envelope in which the claim form is mailed. Claims will be decided in accordance with the rules in Article V.

Review of Dependent Care Reimbursement Claims. The Claims Administrator will review and decide a claim (appropriately filed with it) for reimbursement under the Dependent Care Reimbursement Program within 90 days after it is timely filed. If the Claims Administrator denies a claim, the Claims Administrator will provide notice to you or your beneficiary, in writing, within 90 days after the claim is filed, unless special circumstances require an extension of time for processing the claim. No extension will be for more than 90 days after the end of the initial 90-day period.

If an extension of time for processing is required, written notice of the extension will be furnished to you or your beneficiary before the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which a final decision will be rendered. You will be informed in writing of the time limits set forth in this paragraph. If the Claims Administrator does not notify you of the denial of the claim within the period specified above, then the claim will be deemed denied.

Form and Content of Notice of Adverse Determination on Dependent Care Reimbursement Claims. If a claim appropriately filed with the Claim Administrator is wholly or partially denied, you or your beneficiary will be furnished a written notice setting forth in a manner calculated to be understood:

1. The specific reason or reasons for the denial;

2. Specific references to the pertinent Plan provisions on which the denial is based;

3. A description of any additional material or information necessary for you or your beneficiary to perfect the claim and an explanation as to why such information is necessary; and

4. An explanation of the Plan's claim procedure, including the steps to be taken if you or your beneficiary wishes to appeal the claim, the period within which the appeal must be filed, and the period within which it will be decided.

Right to Appeal Decision on Dependent Care Reimbursement Claim. Within 60 days after receipt of the above material, you or your beneficiary will have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. You or your beneficiary or your (or the beneficiary's) 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.

Action on Appeal of Dependent Care Reimbursement Claim. A decision on the review by the Administrator will be made not later than 60 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 that case a decision will be rendered as soon as possible, but not later than 120 days after receipt. If such an extension of time for deciding the appeal is required, written notice of the extension will be furnished to you or your beneficiary prior to the commencement of the extension. The decision of the Administrator will be written and will include specific reasons for the decision, written in a manner calculated to be understood by you or your beneficiary, with specific references to the pertinent Plan provisions on which the decision is based.

The Status of Your Plan Accounts Pending Appeal. Any balance remaining in a Reimbursement Account described in one or more Appendices (as applicable) at of the end of a Coverage Period will be forfeited and credited to the Employer's Benefit Plan Surplus as described in the appropriate Appendices, as applicable. However, if you had made a claim for such Coverage Period, in writing, which was denied or is pending, the amount of the claim will be held in your Account until the claim appeal procedures described 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 Coverage Period will be forfeited and credited to the Benefit Plan Surplus.

Nondiscrimination Requirements. It is the intent of this Dependent Care Reimbursement Program that:

1. Contributions or Benefits not discriminate in favor of Highly Compensated Employees or their Dependents, as prohibited by Code Section 129(d), and

2. Not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Coverage Period 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 Coverage Period) owns more than 5 percent of the stock or the capital or profits interest in the Employer.

If the Claims Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Employees (as defined under Article VIII) or to principal shareholders or owners as described above, it may reject any benefit elections or reduce contributions or nontaxable benefits in order to assure compliance with these rules. Any act taken by the Claims Administrator under these rules will be carried out in a uniform and nondiscriminatory manner. If the Claims Administrator decides to reject any benefit election or reduce contributions or Benefits, it will be done in the following manner. First, the Benefits designated for the account under this Program of the Highly Compensated Employee that elected to contribute the highest amount to such account for the Coverage Period will be reduced until the nondiscrimination tests set forth in these rules 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 an account under this Program for the Coverage Period. This process will continue until the nondiscrimination tests described above are satisfied.

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

What You Should Know — Comparison of the Dependent Care Reimbursement Program and the Dependent Care Tax Credit. Many people find it necessary to pay for the care of their children or other dependents so that they can work outside of the home. If that is your situation, you may be eligible for certain tax benefits provided in the Code. This subsection describes two of those benefits, so that you can judge which would be best suited to your own circumstances.

The Code helps you to pay for dependent care expenses in two different ways. First, it may be possible to exclude from your taxable income a portion of the dependent care expenses you Incur. Second, you may receive a credit against your taxes equal to a portion of such expenses. Although the exclusion and credit are calculated in entirely different ways, they are both subject to essentially the same eligibility requirements. Moreover, the dependent care expenses to which each applies are limited to the earned income of you or your Spouse, *whichever is smaller*. These requirements and limitations are described in earlier sections of this Appendix. The remainder of this discussion will assume that you are eligible for at least a certain level of both such benefits.

Dependent Care Exclusion. You will note that the dependent care exclusion is described in earlier sections of this Appendix. The exclusion works like this. You elect to have the Employer withhold a portion of your Compensation each month and contribute that amount to your account under this Plan's Dependent Care Reimbursement Program. Those amounts, up to the maximum set forth in this Appendix, may be used to pay for the expenses of dependent care, and are then excluded from the amount of compensation reported on your Form W-2. In other words, this would not be a deduction (which you would have to itemize on your income tax return), but would simply never be considered a part of your income.

The actual benefit of such a dependent care exclusion would depend on your income tax bracket. For example, if you were in a 15% tax bracket, the monetary benefit of $5,000 dependent care exclusion would be 15% of that amount, or *$750.* If you were in a 28% bracket would receive a $1,400 benefit from the full $5,000 exclusion.

Dependent Care Credit. The dependent care credit is entirely different from the exclusion described above. A credit is applied directly against the amount of taxes you would otherwise pay at the end of the year. To calculate the estimated credit, you must know your tax bracket, your adjusted gross income, how much you spend on daycare & how many qualified dependents you have.

For additional assistance in deciding whether to elect to participate in the Plan's Dependent Care Assistance Benefit, to claim the Dependent Care Credit, or both, please consult your tax advisor.

SCHEDULE OF AFFILIATED AND PARTICIPATING EMPLOYERS

Affiliated Employers

Amplifi Inc.
Copernicus Marketing Inv
Posterscope USA Inc.
AMNET GROUP INC
ICUC iPROSPECT MODERATION SERV
Data2Decisions, Inc
Aegis DMN, LLC
Carat USA Inc.
Team Epic, LLC
iProspect Inc
Covario, Inc
Vizeum Inc
Aegis Media Innov8, LLC
Aegis Media Innov8 Search, LLC
Aegis Media Innov8 OOH, LLC
Aegis Media Innov8 Content, LLC
Isobar, Inc
Aegis Media Deep Blue Inc.
Mitchell Communications Group
Fetch
John Brown (iProspect)
Aegis Media Americas, Inc.
Dentsu Attik, LLC
Dentsu America
Dentsu Entertainment, USA, Inc.
Dentsu Holdings USA, Inc.
Dentsu Sports
Firstborn Multimedia Corporation
360i
McGarry Bowen Freelance
McGarry Bowen, LLC
MKTG, Inc
US Concepts LLC
iSi- Dentsu of America

Participating Employers

None