SPARROW
CAFETERIA PLAN

Restated Effective January 1, 2021

TABLE OF CONTENTS

Page

ARTICLE I

PREAMBLES

Section 1.01 Adoption of Plan. Sparrow Health System (the "Employer") adopted the Sparrow Cafeteria Plan originally effective January 1, 1980 (the "Plan).

Section 1.02 Amendment and Restatement of the Plan. The Employer hereby amends and restates the Plan effective January 1, 2021 to comply with recent changes in law and reflect plan design changes.

Section 1.03 Purpose. The purpose of the Plan is to provide Caregivers with the opportunity to select among various combinations of taxable and non-taxable Benefits and taxable compensation. Specifically, the Plan allows Participants to set aside "before-tax" dollars from their gross pay to be used by them for reimbursement for certain medical and dependent care expenses (see Article XII and XIII); and, to pay, on a pre-tax basis, their share of the premium payments under certain Benefit Plans; and to make or receive contributions, on a pre-tax basis, to a Health Savings Account, to the extent they qualify as an Eligible Individual. The Cafeteria Plan also may include an Opt-Out Cash Payment feature under which a Participant would be allowed to elect, in writing, to waive coverage under certain Benefit Plans and, in lieu thereof, receive a taxable Opt-Out Cash Payment.

Section 1.04 Adoption of Plan by Related Entities. The Employer, through Board resolution, may authorize the employees of other related entities of the Employer (within the meaning of Code Section 414(b), (c), (m) or (o)) to participate in the Plan. The Participating Employer shall be included within the meaning of the term "Employer" as defined in Article II. All provisions of the Plan shall apply to the Caregivers of the Participating Employer.

Section 1.05 Interpretation and Law. The Plan is intended to comply with Code Section 125. Where not governed by federal law, the Plan shall be administered and construed in accordance with Michigan law. The Plan is not intended to nor shall it be construed to be an amendment or interpretation of the provisions of any benefit plan maintained by the Employer, except to the extent that this Plan permits Caregivers who participate in this Plan to elect to participate in any such benefit plan. It is the intention of the Employer that the Plan be maintained for the exclusive benefit of eligible Caregivers.

ARTICLE II

DEFINITIONS

Throughout the Plan, various terms are used repeatedly. These terms have specific and definite meanings when capitalized in the text. For convenience, capitalized terms are collected and defined in this Article. Whenever capitalized terms appear in the Plan, they shall have the meanings specified in this Article. Where necessary or appropriate to the context, the masculine shall include the feminine, the singular shall include the plural and vice versa.

Section 2.01 **"Benefit"** means the Permitted Taxable Benefits (e.g. cash) and nontaxable Qualified Benefits made available to Participants from time to time under this Plan. Such Benefits shall be determined by the Plan Administrator each Plan Year and communicated to Participants during each Annual Enrollment Period and described in the Welfare Benefit Plan. The specific provisions of Qualified Benefits shall be set forth in Articles XII and XIII (for the Spending Account Plans) and in separate plan documents, agreements, or contracts for the remaining Benefit, all of which are incorporated by reference into this Plan (referred to as "**Benefit Plan(s)**").

Section 2.02 **"Claims Administrator"** means the third party administrator or other organization that has been engaged by the Plan Administrator to perform benefit claims processing and adjudication services or carry out other administrative responsibilities on behalf of the Plan. The Claims Administrator also could mean the Plan Administrator for those benefits self-administered by it.

Section 2.03 **"Code"** means the Internal Revenue Code of 1986, as amended, together with its related rules and regulations. References to any Section of the Code shall include any successor provision.

Section 2.04 **"Default Election Coverage"** means the Plan Administrator, at its discretion or as required by law, may automatically enroll a Participant in the Default Election Coverage for a Plan Year in the case the Participant fails to timely and affirmatively elect coverage options, which may include premium surcharges as set forth in the Welfare Benefit Plan. The Plan Administrator will communicate any Default Election Coverage to Participants during each annual enrollment periods, including a description of the Default Election Coverage, the amount by which a Participant's salary will be reduced to pay for such Default Election Coverage, procedures for exercising a Participant's right to decline coverage under the Plan (and thus have no salary reduction), the deadline for making any elections and the period for which such elections are effective. Notwithstanding the foregoing, a Participant must timely and affirmatively elect to make contributions to a Health and/or Dependent Care Spending Accounts for a Plan Year; no default coverage election will apply to such spending accounts.

Section 2.05 **"Dependent"** means any individual who is deemed a "Dependent" under the terms of the applicable Benefit Plan. However, a Participant can pay premiums on a pre-tax basis under this Plan only for the Participant's Spouse or for the Participant's Dependents who meet the Code Section 152 definition of "dependent" (without regard to the earnings limit under §152(d)(1)(B); the special exclusions under §152(b)(1) or (2); or the age or student status requirements under §152(c)(3), provided that such qualifying child is age 26 or under during the entire Plan Year), even if the Benefit Plan allows coverage for individuals who do not qualify as such. The term "Dependent" throughout this document shall include the Spouse and other eligible tax-dependents.

Section 2.06 **"Dependent Care Spending Account Plan"** means the dependent care spending account offered by the Employer and covered by this Plan, as described in Article XII below.

Section 2.07 "Eligible Individual" means a Participant who can establish and make contributions to a Health Savings Account pursuant to Code Section 223 and related IRS regulations and guidance.

Section 2.08 "Caregiver" means any individual who is hired and designated by the Employer on its payroll as a common-law employee. Notwithstanding anything to the contrary in this document or any underlying Benefits Plan, the term "Caregiver" will **not** include any individual for whom the Employer designates as an independent contractor, leased employee, contract employee or worksite employee who is not treated as a common-law employee on the Employer's payroll.

These exclusions from the term "Caregiver" shall apply regardless of a finding by the Plan Administrator or any third party as to the common law employment status or reclassification of any such person.

Section 2.09 "Employer" means Sparrow Health System and any of its related entities (as defined under Code Section 414(b), (c), or (m)) who are authorized in writing to participate in the Plan by Sparrow Health System (in the aggregate referred to as "Employer"); provided, however, that whenever the Plan indicates that the Employer may or shall take any action under the Plan, Sparrow Health System shall have sole authority to take such action for itself and as agent for any such related entity. The Welfare Benefit Plan contains a current listing of Participating Employers.

Section 2.10 "ERISA" means the Caregiver Retirement Income Security Act of 1974, as presently enacted and as it may be amended from time to time, together with its related rules and regulations.

Section 2.11 "Health Care Spending Account Plan" means the health care spending account offered by the Employer and covered by this Plan as described in Article XIII below, which may, at the Plan Administrator's discretion, include General Purpose and/or Limited Purpose Health Care Spending Accounts as more fully described in the Welfare Benefit Plan.

Section 2.12 "Health Savings Account ("HSA")" means the health savings account established in accordance with Code Section 223 and related regulations and IRS guidance. For purposes of this Plan, the term "HSA" shall include only those HSAs that are linked to the Employer's High Deductible Plan(s) and provided through the trustee or custodian chosen by the Plan Administrator as identified in the Welfare Benefit Plan.

Section 2.13 "Opt-Out Cash Payment" means the taxable cash payment benefit available to a Participant if he or she declines and waives in writing coverage under certain Benefit Plans for a Plan Year. The Plan Administrator shall annually determine, in its sole discretion, which, if any, Benefit Plans will offer an Opt-Out Cash Payment and the amount of any such Opt-Out Cash Payment, which may be zero. A Participant is eligible for the Opt-Out Cash Payment only if he or she is eligible to actively participate in the particular Benefit Plan that offers such an Opt-Out Cash Payment. Participants will be informed of the availability and amount of any Opt-Out Cash Payment during their initial enrollment period or during the Annual Enrollment Period. Any Opt-Out Cash Payment shall cease on the date the Participant is no

longer covered as an active Participant under the Benefit Plan, including as of the date any COBRA coverage under the Benefit Plan begins.

Section 2.14 "Participant" means a Caregiver who has met the eligibility requirements specified in Article III, who has commenced participation in the Plan pursuant to Article IV, and whose active participation has not terminated under other applicable provisions of this Plan and the Welfare Benefit Plan documents.

Section 2.15 "Participating Employers" means any related entity (as defined by Code Section 414(b), (c), (m) or (o)) of the Employer that, with the approval of the Employer's board of directors, adopts the Plan by resolution of such related entity's board of directors. Participating employers are identified in the Welfare Benefit Plan.

Section 2.16 "Permitted Taxable Benefits" mean cash and certain other taxable benefits treated as cash for purposes of Code Section 125, including any Opt-Out Cash Payments and benefits attributable to Employer contributions that are currently taxable to the Caregiver upon receipt and benefits purchased with after-tax employee contributions.

Section 2.17 "Plan" means the Sparrow Cafeteria Plan as described in this document and any subsequent amendments (which includes Dependent Care and Health Care Spending Account Plans).

Section 2.18 "Plan Administrator" means the Employer or any other person(s) or organization(s) specifically delegated by the Employer's Board of Directors to administer the Plan.

Section 2.19 "Plan Year" means the 12-month period on which the plan records and elections are kept beginning and ending on the dates set forth in the Welfare Benefit Plan.

Section 2.20 "Qualified Benefit" means any benefit excluded from the Caregiver's taxable income pursuant to an express provision of the Code which is specifically recognized as a "qualified benefit" under Code Section 125 and related Treasury Regulations. Generally, qualified benefits include group term life insurance benefits (Code Section 79), accident and health plan benefits (Code Sections 105 and 106); premiums for COBRA continuation coverage under the Employer's group health plan or under a group health plan sponsored by a different employer; accidental death and dismemberment insurance benefits (Code Section 106); long-term or short-term disability benefits (Code Section 106); dependent care assistance benefits (Code Section 129); adoption assistance benefits (Code Section 137); qualified cash or deferred arrangement that is part of a qualified defined contribution (401(k)) plan; and contributions to a Health Savings Accounts.

Notwithstanding the foregoing, the following types of benefits do not constitute Qualified Benefits (and thus they cannot be offered under the Plan): scholarship benefits (Code Section 117); employer-provided meals and lodging benefits (Code Section 119); educational assistance benefits (Code Section 127); fringe benefits (Code Section 132); long-term care insurance benefits or services (Code section 106); group-term life insurance benefits on the life of any individual other than an employee; health reimbursement arrangement benefits; contributions to Archer MSA (Code Section 106(b) and 220); elective deferrals to a section 403(b) plan; or

group-term life insurance benefits that offer a permanent benefit, or any other benefits prohibited by treasury regulations or other IRS guidance.

Section 2.21 **"Spouse"** means an Caregiver's husband or wife to whom the Caregiver is legally married as recognized by the laws of the State or foreign jurisdiction in which the marriage was validly performed; provided, however, that the term "Spouse" shall not include common law marriages, even if common-law marriages are recognized under the laws of the Participant's State of domicile. The legal married status between the Caregiver and Spouse must have existed at the time that the expense was incurred for which reimbursement is claimed, but shall not include an individual who is legally separated from the Caregiver under a decree of divorce, legal separation or of separate maintenance.

Section 2.22 **"Welfare Benefit Plan"** means the "Sparrow Health System Group Benefit Plan – Legal Wrap Plan Document and Summary Plan Description which includes and incorporates Supplemental Plan Documents. The relevant provisions of the Welfare Benefit Plan that are specifically cross referenced in this Plan document are incorporated by reference herein.

ARTICLE III

ELIGIBILITY

A Caregiver who is eligible to participate in a Benefit Plan (i.e., an Eligible Caregiver as defined and as set forth in the Welfare Benefit Plan document) shall be eligible to participate under this Plan.

ARTICLE IV

PARTICIPATION

Section 4.01 **Commencement of Participation**. A Caregiver who has met the eligibility requirements of Article III above shall commence participation in the Plan on the date that he or she becomes eligible for coverage under one or more of the applicable Benefit Plan, identified in the Welfare Benefit Plan. Notwithstanding anything to the contrary in this Plan, a Caregiver must properly and timely complete (or be deemed to have completed) the enrollment process as established by the Plan Administrator and as set forth in Article VI before his or her participation in the Plan shall become effective.

Section 4.02 **Meaning of Participation**. Participation entitles a Participant to elect among the Benefits made available by the Plan Administrator under the Plan for each Plan Year. Each of the Benefit Plans incorporated in this Plan may have its own eligibility requirements for participation which differ from those set forth in this Plan. The eligibility and participation requirements set forth in this Plan relate only to participation in this Plan and shall have no effect on any eligibility or participation requirements set forth under the applicable Benefit Plan.

Section 4.03 **Dependents**. The Participant's Dependents may not participate actively in the Plan (i.e., a Dependent may not be given the opportunity to select or purchase Benefits offered under the Plan), but the Participant's Dependent may benefit from the Participant's

election of Benefits. Further, upon the death of a Participant, no rights under the Plan will inure to a Dependent, except as provided under a specific Benefit Plan.

ARTICLE V

TERMINATION OF PARTICIPATION

Section 5.01 Termination of Participation. Except as provided in Section 5.02 (COBRA Coverage), Article XI (Leave of Absence), Articles XII and XIII (regarding Spending Accounts) or otherwise provided under the terms of the Welfare Benefit Plan, participation in the Plan shall terminate upon the earliest of termination of the Plan or termination of a Participant's employment with the Employer (or the date of the Participant's final regular payroll from the Employer if later). A Participant's employment shall be deemed to terminate in any of the following situations:

(a) voluntary or involuntary termination of employment;

(b) death;

(c) retirement;

(d) leave of absence, including for disability (except as otherwise provided under the terms of the Welfare Benefit Plan); or

(e) failure to meet the eligibility requirements of Article III.

A Participant who terminates active participation in the Plan may continue coverage under a Benefit Plan to the extent that the terms and conditions of such Benefit permit continued coverage.

Section 5.02 COBRA Continuation Coverage. Notwithstanding the provisions of Section 5.01, continuation coverage under any Benefit Plan which is a "group health plan" as that term is defined in Code Section 5000 shall be provided under the group health plan to Participants, their covered Spouses and dependents to the extent required under ERISA Sections 601 through 608, and Code Section 4980B ("COBRA"). The terms of such COBRA continuation coverage, if any, shall be described in the Welfare Benefit Plan document. If a Participant elects COBRA coverage under an applicable Benefit Plan, the Participant may continue participation under this Plan to pay for required contributions under such Benefit Plan to the extent he or she is still receiving compensation from the Employer.

ARTICLE VI

ELECTION OF BENEFITS

Section 6.01 Available Benefits. Prior to the beginning of each Plan Year, the Plan Administrator will designate the type and amount of Benefits that are available for Participant election under the Plan for the following Plan Year and the cost to Participants of each such Benefit. The Plan Administrator may impose such conditions on allowing a Participant to accept

or decline Benefits coverage as it determines are appropriate, in its discretion; including, but not limited to, requiring that a Participant provide proof of other, comparable coverage that is then in effect with respect to the Participant (e.g., through a Spouse's employer, etc.).

Section 6.02 Notification. Prior to the beginning of each Plan Year, the Plan Administrator will notify (electronically or otherwise) each Caregiver who is eligible pursuant to Article III for participation in the Plan for the following Plan Year of the Benefits available for selection under the Plan for such following Plan Year. Participants are responsible to timely notify the Plan Administrator of any changes to their mailing addresses. The notice generally may include:

(a) A description of each Benefit available under the Plan for the Plan Year including whether the Benefit is taxable or non-taxable;

(b) The maximum amount of salary reduction that a Participant may direct to be used on his or her behalf to provide Benefits;

(c) The available minimum and maximum levels of coverage under each Benefit; and

(d) The amount available or cost to the Participant for each Benefit provided under the Plan for the Plan Year.

Section 6.03 Minimum Benefits. The Plan Administrator may require Caregivers to elect, with respect to a specified Benefit, a minimum level of such Benefit for the Plan Year. Minimum benefits shall be determined by the Plan Administrator from the Benefits available under the Plan for the Plan Year, and each Caregiver shall be notified in writing of the identity and amount of minimum benefits for the Plan Year. Such notification shall be in conjunction with the notification of available Benefits pursuant to Section 6.02 and shall be given prior to the beginning of the Plan Year or participation. If a Participant fails to elect at least the minimum amount of a specified Benefit, he or she will not be permitted to elect that Benefit or will be deemed to have elected the minimum Default Election Coverage outlined in Section 6.04 below.

Section 6.04 Election Process, Including Automatic Enrollment Process. In conjunction with the distribution of the written notice as provided in Section 6.02 above, the Plan Administrator shall inform eligible Caregivers of the enrollment process (which may be electronic) for participation in the Plan for the following Plan Year. A Participant may not revoke or modify any election made under this Plan for the Plan Year, except as provided in Section 6.05.

(a) Annual Enrollment. Before the beginning of each Plan Year, the Plan Administrator will hold an Annual Enrollment Period during which a Participant may elect the type of benefits and amount he or she wants to contribute to the Plan for the upcoming Plan Year. The enrollment period will begin and end on dates determined by the Plan Administrator. These dates always will be prior to the beginning of the next Plan Year. Participants must make their elections before the start of the new Plan Year. Coverage for each benefit elected becomes effective on the first day of the Plan Year following each enrollment period and the coverage continues until the last day of such Plan Year. If a Participant fails to timely complete the enrollment process, he or she

generally will not be covered under any of the Benefits under the Plan (except as otherwise provided in subparagraph (c) below).

(b) Enrollment for New Caregivers. New employees will be enrolled in the Plan upon becoming eligible to participate in any of the Benefits provided under the Plan and timely and accurately completing the enrollment process established by the Plan Administrator as set forth in the Welfare Benefit Plan. Coverage in the Plan as elected by new Caregivers will become effective upon enrollment for the remainder of the Plan Year. If a Participant fails to timely complete the enrollment process, he or she generally may not receive any Benefits under the Plan for the remainder of that Plan Year (except as otherwise provided in subparagraph (c) below). A Participant then may elect to participate for a subsequent Plan Year by making timely elections during the Annual Enrollment Period (as defined in the Welfare Benefit Plan).

(c) Default Elections. The Plan Administrator, at its sole discretion, may establish Default Election Coverage under which a Participant may be deemed to have elected one or more Benefit options for a Plan Year (or reminder thereof) as set forth in the Welfare Benefit Plan. For example, the Plan Administrator may establish default election coverage, which may include deemed premium surcharges, for existing Participants providing that they will be deemed to have elected the same elections in effect for the prior Plan Year with respect to all Benefits under the Plan, other than the Dependent Care Spending Account Plan and/or Health Care Spending Account Plan (which requires an affirmative election to participate each and every Plan Year). If the Plan Administrator decides to implement such a default election coverage (e.g. for newly hired Eligible Caregivers and/or existing Participants), the Plan Administrator will notify Participants in writing (e.g. in the initial or open enrollment materials) of such default election coverage, including a description of the default elections, the amount of the salary reduction, the period of time for which the election is effective, the procedures to decline coverage and the deadline for making elections.

Section 6.05 Involuntary Election Modifications. At any time prior to or during the Plan Year, the Plan Administrator may require some or all Participants to modify their Benefit elections under the Plan if the Plan Administrator determines to its satisfaction that such modifications are necessary in order to preserve the tax-preferred status of this Plan under Code Section 125 or of any Benefit available under the Plan under any other applicable provision of the Code. Specifically, such modifications may be required in order to enable the Plan or any Benefit available under the Plan to satisfy the nondiscrimination requirements of applicable provisions of the Code. The Plan Administrator shall adopt and follow uniform and nondiscriminatory rules for purposes of this section and its decisions regarding involuntary election modifications shall be final and binding. The Plan Administrator reserves the discretion to disaggregate the Plan for different employee groups for non-discrimination testing purposes to the extent permitted under a good faith interpretation of the Code.

Section 6.06 Voluntary Election Modifications. Under the circumstances specified below, the Plan Administrator may permit or require a Participant to revoke a Benefit election under the Plan during a Plan Year, and, in some cases, to make a new election with respect to the remainder of the Plan Year provided that the new election is consistent with the reason that such

change is permitted, subject, however, to any restrictions set forth under the Welfare Benefit Plan.

(a) **Cost or Coverage Changes**. This Section 6.06(a)(1) through (4) explains the circumstances under which a Participant's election may be modified as a result of certain cost or coverage changes to a Benefit or a benefit package option available under the applicable Benefit Plan. Notwithstanding anything to the contrary in this Section 6.06(a), a Participant's election with respect to the Health Care Spending Account Plan may **not** be changed under the circumstances described in this Section 6.06(a)(1) through (4).

(1) *Cost Changes*. In the event that the cost of a Benefit increases or decreases during a Plan Year, the Plan automatically may increase or decrease, as applicable, all affected Participants' salary reduction contributions for such Benefits on a reasonable and consistent basis.

If the cost charged to a Caregiver for a Benefit significantly increases or decreases during the Plan Year, the Participant may make a corresponding change in his or her salary reduction contributions under the Plan. Changes that may be made include electing to participate in the Plan with respect to the Benefit with the decreased cost or in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving similar coverage or dropping coverage if no other benefit package option providing similar coverage is available. The Plan Administrator in its sole discretion shall determine if the increase or decrease is significant.

A cost increase or decrease refers to an increase or decrease in the amount of salary contributions under the Plan, whether the increase or decrease results from an action taken by the employee (such as switching from full-time to part-time) or from action taken by the Plan Administrator (such as increasing or decreasing the amount of employer contributions for Caregivers).

The cost changes allowed under this sub-paragraph (1) applies to the Dependent Care Spending Account Plan only if the cost change is imposed by a dependent care provider who is not a relative (as defined by Code Section 152) of the Caregiver.

(2) *Coverage Changes*. If an Caregiver (or his or her dependents) has a significant curtailment of coverage (i.e. an overall reduction in coverage) under a Benefit which does not result in a loss of coverage (as defined below) (e.g. a significant increase in the deductible, co-pay or out-of-pocket cost sharing limit), an Caregiver receiving such coverage may revoke his or her election for such coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option with respect to the applicable Benefit which provides similar coverage. The Plan Administrator in its sole discretion shall determine if the curtailment is significant.

If an Caregiver (or his or her dependents) has a significant curtailment of coverage under a Benefit that is a loss of coverage, the Caregiver may revoke his or her election for such coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option with respect to the applicable Benefit

which provides similar coverage or completely drop coverage if no other benefit package option providing similar coverage is available. A loss of coverage means a complete loss of coverage under the benefit package option with respect to a Benefit, a substantial decrease in medical providers available under a benefit package option or a reduction in benefits for a specific type of medical condition or treatment with respect to which the Caregiver (or his or her dependents) is currently in a course of treatment.

If the Plan adds a new Benefit Plan or benefit package option, or an existing benefit package option is significantly improved during the Plan Year, an Caregiver may revoke his or her election under the Plan and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved Benefit or benefit package option.

(3) *Change In Coverage Under Another Employer Plan*. An Caregiver may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer), if the other employer plan permits participants to make an election change under the same circumstances described under this Section 6.06 or this Plan permits Participants to make an election for a period of coverage (Plan Year) that is different from the period of coverage under the other cafeteria plan or other employer plan.

(4) *Loss Of Coverage Under Another Group Health Plan*. If an Caregiver (or his or her Dependents) loses coverage under any group health coverage sponsored by a governmental or educational institution, the Caregiver may make a corresponding election change under this Plan to add coverage for himself or herself (or for his or her Dependents), on a prospective basis, under the applicable Benefit Plan.

(b) **Special Enrollment Events of HIPAA**. If the Benefit is a "group health plan" subject to the Health Insurance Portability and Accountability Act ("HIPAA") (as codified under Code Section 9801 and related regulations) and to the extent permitted by the applicable plan document or insurance policy for such Benefit, a Participant may revoke an election during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f) and related regulations.

Under Code Section 9801(f) and related regulations, special enrollment rights allow a Caregiver to enroll in group health plan coverage, upon the occurrence of an "Enrollment Event." For example, an Caregiver and/or his or her Dependent will have an Enrollment Event if, when the Caregiver declined coverage under the applicable group health plan, he or she certified that he or she was covered by another group health plan or health coverage and he or she (his or her Spouse or child) loses eligibility for coverage under that other health plan for reasons such as legal separation, divorce, annulment of marriage, death, termination of employment, reduction in number of hours of employment (e.g., leave of absence, transfer from full-time to part-time status, strike), change in place of residence or work, failure to elect COBRA coverage on termination of employment, cessation of the other employer's contributions for health coverage, or exhaustion of COBRA coverage. The Caregiver will not be considered to have lost coverage under this provision if he or she failed to pay the required premiums for such other coverage, or such other coverage was terminated for cause. A

Caregiver and/or his Dependent also may experience an Enrollment Event if he or she loses coverage under Medicaid or a State's Child Health Insurance Program (CHIP). Finally, a Caregiver may experience an Enrollment Event under HIPAA upon acquiring a new Dependent through marriage, birth or adoption.

(c) **Change in Status**. Except as otherwise provided under the Welfare Benefit Plan, an Caregiver may revoke a benefit election during a Plan Year and make a new election with respect to the remainder of the Plan Year provided that both the revocation and new election are on account of and correspond with a change in status that affects eligibility for coverage under a Benefit. The following events are "changes in status" for purposes of this subsection:

(1) *Legal Marital Status*. Events that change a Caregiver's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment.

(2) *Number of Dependents*. Events that change a Caregiver's number of Dependents, including birth, adoption, placement for adoption (as defined in regulations under Code Section 9801), or death of a Dependent.

(3) *Employment Status*. A termination or commencement of employment by the Caregiver, Spouse, or Dependent.

(4) *Work Schedule*. A reduction or increase in hours of employment by the Caregiver, Spouse, or Dependent, including a switch between part-time and full-time employment, a strike or lockout, or commencement or return from an unpaid leave of absence.

(5) *Dependent Satisfies or Ceases to Satisfy the Requirements for Unmarried Dependents*. An event that causes a Caregiver's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstance as provided under the Welfare Benefit Plan.

(6) *Residence or Worksite*. A change in the place of residence or work of the Caregiver, Spouse or Dependent resulting in his or her becoming covered under another plan which provides the applicable Benefit.

(d) **QMCSO**. If a Qualified Medical Child Support Order requires coverage for a child under the applicable Benefit Plan, the Caregiver's election under the Plan may be revised to provide coverage to such child. If a Qualified Medical Child Support Order requires a former Spouse to provide coverage and such coverage is in fact provided, the Caregiver's election may be revised to cancel coverage for the child.

(e) **Entitlement to Medicare or Medicaid**. If an Caregiver (or his or her Dependent) is enrolled in a Benefit which is a group health plan and he or she becomes enrolled in coverage under Part A or B of Medicare or Medicaid (other than a program for distribution of pediatric vaccines), the Caregiver may make a prospective election change to cancel or reduce coverage of that Caregiver (or Dependent) under such Benefit Plan. In addition, if an Caregiver (or Dependent) who has been entitled to such Medicare or Medicaid coverage loses eligibility for

such coverage, the Caregiver may make a prospective election to commence or increase coverage of that Caregiver (or Dependent) under the Benefit which is a group health plan.

(f) **Automatic Termination of Election**. Except as provided in Section 5.02 or the Welfare Benefit Plan, a Participant's elections under this Plan shall automatically terminate on the date the Participant ceases to be a Participant in this Plan or in each one of the corresponding Benefit Plans.

If the Participant is reemployed by the Employer within 30 days after his termination of employment and within the same Plan Year, then such Participant automatically shall resume participation in the Plan without any change in his or her prior elections under the Plan for such Plan Year. If a Participant is reemployed by the Employer more than 30 days after termination of employment or in a subsequent Plan Year, then, to the extent eligible for Benefits, the terms of the Welfare Benefit Plan shall govern reenrollment.

(g) **Failure to Make Contribution**. In the event a Participant fails to make the required contributions with respect to Benefits elected under the Plan, then, at the Plan Administrator's election in accordance with applicable law, such Participant's receipt of Benefits under the Plan for the remainder of the Plan Year shall be terminated and he or she shall not be permitted to make a new benefit election under the Plan during the remainder of that Plan Year.

(h) **Election Changes for HSA Contributions**. With respect to a Participant who is an Eligible Individual (within the meaning of Code Section 223) making pre-tax contributions to his or her Health Savings Account, such Participant may prospectively elect to increase, decrease or completely revoke the amount of his or her salary reduction election for such HSA contribution with respect only to salary that has not become currently available to the Participant.

(i) **Election Changes under Notice 2014-55 Regarding Marketplace Coverage**. A Participant may prospectively revoke an election of coverage under the Employer's group health plan that is providing minimum essential coverage (within the meaning ascribed under Code Section 5000A(f) and related regulations or guidance) ("Employer's plan") under the circumstances described in IRS Notice 2014-55 or any subsequent guidance. Under these circumstances, a Participant may prospectively revoke coverage under the Employer's plan, when:

(1) *Reduction of Hours*. A Participant has been in an employment status that is reasonably expected to average at least 30 hours of service a week, there is a change in that employment status where the Participant reasonably will be expected to average less than 30 hours of service per week and the Participant represents to the Plan Administrator that he or she intends to enroll in other minimum essential coverage effective no later than the first day of the second month following the month that includes the date the Participant revokes coverage under the Employer's plan. This change is status event may apply even though the Participant's reduction in hours below the 30-hour threshold does not result in a loss of eligibility under the Employer's plan.

(2) *Enrollment in a Qualified Health Plan*. A Participant represents to the Plan Administrator that he or she is eligible and intends to enroll during a Special

Enrollment Period or the annual enrollment period in a qualified health plan purchased through the Health Insurance Marketplace (pursuant to guidance issued by the Department of Health and Human Services), effective beginning no later than the day immediately following the last day of coverage under the Employer's plan.

The Plan Administrator and Plan may rely on the reasonable written representations of a Participant that he or she is revoking coverage under the Employer's plan due to the Participant's intended enrollment into other minimum essential coverage or a Qualified Health Plan through the Marketplace under the circumstances described above. Notwithstanding anything to the contrary, a Participant shall not be permitted to elect to revoke coverage under the Employer's plan on a retroactive basis; all revocations of coverage under the Employer's plan must be on a prospective basis after the Plan Administrator approves the Participant's request to revoke such coverage.

(j) **In General**. Any change in election permitted under Section 6.06(a), (b), (c) and (e) above must be made no later than the last business day falling on or before 30 days (or within 60 days for Medicaid or CHIP circumstances) following the date on which one of the events described in such paragraph occurs.

Notwithstanding the foregoing, a Participant shall not revoke an election and make a new election that would cause him or her to maintain less than the minimum benefits, if any, required with respect to any Benefit for a Plan Year. The Plan Administrator shall adopt and follow uniform and nondiscriminatory rules for purposes of this Section and its decisions regarding voluntary election modifications shall be final and binding.

ARTICLE VII

SALARY REDUCTION CONTRIBUTIONS

Section 7.01 Salary Reduction. By enrolling for Benefits under this Plan, a Participant automatically directs the Plan Administrator to reduce his or her compensation each pay period over the Plan Year in an amount equal to the cost of his or her selected Benefits, which shall constitute a salary reduction agreement between the Participant and the Plan Administrator/Employer. The amount of salary reduction available to a Participant under the Plan for a Plan Year shall be equal to a percentage of the cost necessary for the Plan Administrator to purchase the elected Benefit. Such amount shall be determined by the Plan Administrator prior to the beginning of each Plan Year. In the event of increases or decreases in the cost of providing Benefits during a Plan Year, a Participant's salary reduction amount shall be automatically adjusted to reflect such increase or decrease.

Section 7.02 Payments to Insurer. The Plan Administrator shall maintain separate bookkeeping records of a Participant's salary reduction amounts and shall apply such amounts on behalf of a Participant for the sole purpose of paying premiums or reimbursements to the appropriate party in accordance with a Participant's Benefit elections.

Section 7.03 Funding Benefits. All Participant salary reduction amounts contributed to the Plan shall be used to provide Benefits in accordance with Participants' Benefit elections

pursuant to Section 6.03. Benefits shall be funded from the general assets of the Employer or, alternatively, through the direct payment of insurance premiums to an insurer from the general assets of the Employer. The Plan shall not utilize a trust fund or other separately maintained fund for accumulation of Plan assets or the provisions of other benefits, unless required by law.

ARTICLE VIII

CLAIMS FOR BENEFITS

The Welfare Benefit Plan describes the claims review and appeal procedures that apply to disputes involving a Participant's elections or claims under this Plan.

ARTICLE IX

PROVISIONS RELATING TO ADMINISTRATION AND FIDUCIARIES

Section 9.01 Plan Administration. The Employer (or such person or entity as it shall designate) shall be the Plan Administrator and shall administer the Plan in accordance with its terms. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions under the Plan, including, but not limited to the following:

(a) Construction. To have full discretionary and binding authority to construe and interpret the Plan and decide all questions of eligibility to participate in and for benefit under the Plan;

(b) Forms. To require Participants (1) to complete and file with it such forms as the Plan Administrator finds necessary or desirable for the administration of the Plan, and (2) to furnish all pertinent information requested by the Plan Administrator, and to rely upon all such forms and information furnished, including each Participant's mailing address;

(c) Procedures. To prescribe procedures to be followed by Participants in electing Benefits and filing claims for Benefits;

(d) Rules. To promulgate uniform rules and regulations whenever in the opinion of the Plan Administrator such rules and regulations are required by the terms of the Plan or would facilitate the effective operation of the Plan;

(e) Information. To prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan, and to receive from Participants such information as shall be necessary for the proper administration of the Plan;

(f) Annual Reports. To prepare, furnish, and file such annual reports with respect to the administration of the Plan as are required by law or as are reasonable and appropriate;

(g) Insurers. To appoint and remove insurance carriers;

(h) Records. To prepare, receive, review, and keep on file (as it deems convenient and proper) records of benefit payments and disbursements for expenses; and

(i) Appointments. To appoint and remove fiduciaries, fix their compensation, if any, and exercise general supervisory authority over them.

Notwithstanding any provision of this Plan to the contrary, the Plan Administrator in its sole discretion may enroll Participants in the Plan over the telephone, may furnish notices and other disclosures via electronic transmission and may otherwise administer the Plan in a paperless manner.

Section 9.02 Finality of Decisions. All determinations of the Plan Administrator or the Employer under Section 9.01, or any of its delegates under Section 9.03, shall be final and binding on all persons except as otherwise expressly provided herein.

Section 9.03 Fiduciaries. The Employer shall be a "named fiduciary" of this Plan and of any Benefit Plan available under the Plan only to the extent they are considered "employee benefit plans" as those terms are described in ERISA. The Employer shall have only those duties, responsibilities, and obligations (referred to collectively as "fiduciary duties") as specifically are given it under the Plan, under any Benefit Plan available under the Plan, or as otherwise are imposed by applicable law. The Employer shall have the sole responsibility for making contributions or purchasing insurance in order to provide the Benefits available under the Plan. The Employer may allocate or delegate its fiduciary duties under the Plan to other Plan fiduciaries by written agreement between the Employer and such other fiduciaries.

Section 9.04 Employment of Advisers. The Employer shall have the authority to employ such legal, accounting, and financial counsel and advisers as it shall deem necessary in connection with the performance of its duties under the Plan, and to act in accordance with the advice of such counsel and advisers. In administering the Plan and to the extent permitted by law, the Employer may rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Employer.

Section 9.05 Delegation to Officers or Caregivers. The Employer shall have the power to delegate its fiduciary duties under the Plan or under any Benefit available under the Plan to officers or employees of the Employer and to other persons, all of whom, if employees of the Employer, shall serve without compensation other than their regular remuneration from the Employer. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any delegated employee or officer against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer), occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

Section 9.06 Fees and Expenses. All expenses incurred in the operation and administration of the Plan, including the fees and expenses of counsel and other advisors and the compensation, if any, of the fiduciaries, agents, and administrators shall be paid or reimbursed by the Employer unless the Employer shall determine that such fees and expenses shall be paid in whole or in part by the Plan or by Participants.

ARTICLE X

GENERAL

Section 10.01 Amendment and Termination. The Plan and all Benefits available under the Plan shall be subject to alteration, amendment, or termination in whole or in part, at any time by action by the board of directors of the Employer (which power may be delegated, through resolutions of the Board of Directors, to another person or organization selected by the Employer). In the event of Plan termination, a Participant may submit claims for reimbursement of Medical Care Expenses and/or Dependent Care Expenses incurred prior to such termination for up to a maximum of 60 days following the effective date of Plan termination.

Section 10.02 Non-Alienation of Benefits. No right or benefit provided for under the Plan or under any Benefit available under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge the same shall be void.

Section 10.03 Employer's Rights. While the Employer believes in the benefits, policies and procedures described in the Plan, the language used in the Plan is not intended to create, nor is it to be construed to constitute, a contract of employment between the Employer and any of its Caregivers. The Employer retains all of its rights to discipline or discharge Caregivers or to exercise its rights as to incidents and tenure of employment. Caregivers retain the right to terminate their employment at any time and for any reason, and the Employer retains a similar right.

Section 10.04 Construction. Whenever any words are used in the Plan in the masculine gender, they shall be construed as though they are also used in the feminine gender, where applicable. Similarly, words used in the single form shall be construed as though they are also in the plural form, where applicable. Headings of sections and paragraphs of this document are inserted for convenience of reference. They constitute no part of the Plan and are not to be considered in the construction of the Plan.

Section 10.05 Tax Consequences. Neither the Employer nor the Plan makes any representations or warranties regarding the federal, state, local or other tax treatment of benefits provided pursuant to the Plan and a Participant shall have no rights against the Employer or the Plan if any tax consequences contemplated by any Participant are not achieved.

Section 10.06 Law Governing. This Plan is made pursuant to, and shall be governed by, construed under and enforced in accordance with federal law and the laws of the State indicated in the Welfare Benefit Plan.

Section 10.07 Exclusive Benefit. All contributions made under this Plan and all benefits received shall inure to the exclusive benefit of the Participants and their beneficiaries, and such contributions and benefits shall not be used for nor diverted to purposes other than for the exclusive benefit of the Participant and their beneficiaries (including the costs of maintaining and administering the Plan).

ARTICLE XI

LEAVE OF ABSENCE

The Welfare Benefit Plan describes what happens to a Participant's elections under this Plan during certain leaves.

ARTICLE XII

DEPENDENT CARE SPENDING ACCOUNT PLAN

Section 12.01 Dependent Care Spending Account Plan Authority. The Employer has established a Dependent Care Spending Account Plan as described in this Article XII, which is intended to qualify as a separate, nontaxable employee benefit plan under Code Section 129 which provides dependent care assistance benefits to Participants and is to be interpreted in a manner consistent with the requirements of Code Section 129.

Section 12.02 Definitions. The following definitions shall apply for purposes of this Article XII:

(a) **"Dependent"** means any individual who would be a "qualifying individual" within the meaning of Section 21(b)(1) of the Code, including:

(1) A Participant's dependent who is a qualifying child within the meaning of Code Section 152 who has not attained age 13; or

(2) A Participant's dependent (as defined under Code Section 152, without regard to 152(b)(1) and (2) or 152(d)(1)(B)) or Spouse, if such dependent or Spouse is physically or mentally incapable of self-care and has the same principal place of abode as the Participant for more than one-half of the taxable year.

(b) **"Dependent Care Center"** means a Dependent Care Center as defined in Code Section 21. Generally, a Dependent Care Center is any facility which:

(1) provides care for more than 6 individuals (other than individuals who reside at the facility); and

(2) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

(c) **"Dependent Care Expenses"** means amounts which if paid for by the Participant would constitute "employment-related expenses" within the meaning of Code Section 21(b)(2). Generally, Dependent Care Expenses are those expenses incurred for the care of a Dependent or for household services with respect to the care of a Dependent that are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to such Participant.

(d) **"Dependent Care Spending Account"** means an account described in Section 12.12 below.

(e) **"Earned Income"** means:

(1) with respect to a Participant, all income derived from wages, salaries, tips, self-employment (with regard to the deduction allowed under Code Section 164(f)), and other Caregiver compensation as defined in Code Section 32(c)(2), but excluding amounts paid or incurred by the Employer for dependent care assistance to the Participant;

(2) with respect to a Participant's Spouse, all wages, salaries, tips, and other employee compensation, plus the amount of net earnings from self-employment; provided, however, in the case of a Spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such Spouse shall be deemed to have Earned Income of not less than $200 per month if the Participant has 1 Dependent and $400 per month if the Participant has 2 or more Dependents.

Section 12.03 Eligibility. To be eligible to participate in the Dependent Care Spending Account Plan during any Plan Year, an individual must be considered an "Eligible Caregiver" as defined under the Welfare Benefit Plan.

Section 12.04 Election Procedure. An Eligible Caregiver's election to allocate salary reductions to his or her Dependent Care Spending Account shall become effective as of the date set forth in the Welfare Benefit Plan, provided that the Eligible Caregiver timely completes the enrollment process pursuant to Article VI. An election to participate in the Dependent Care Spending Account Plan shall be irrevocable during the Plan Year, except as otherwise permitted under this Plan.

Section 12.05 Amount. Each Participant shall be entitled to receive for each Plan Year, reimbursement of Dependent Care Expenses which are incurred during the Plan Year up to the lesser of the dollar amount of the Dependent Care Expenses or the dollar amount of the Participant's Dependent Care Spending Account balance. If the Participant's Dependent Care Expenses exceed the dollar amount in his or her Dependent Care Spending Account at the date of the request for reimbursement, the Claims Administrator will make a partial reimbursement of such request equal to the amount in such Participant's Account at that time, and then reimburse the remaining portion of such request at the time that the Account has sufficient funds credited to it.

Section 12.06 Benefit Limitations. Notwithstanding any provision to the contrary in this Plan, the maximum annual amounts paid from a Participant's Dependent Care Spending Account for any taxable year of the Participant may not exceed the lesser of (a) or (b) below.

(a) Such amounts may not exceed $5,000 ($2,500 if a separate income tax return is filed by a Participant who is married as determined under the rules of Code Section 21(e)).

(b) Such amounts may not exceed (i) the Participant's Earned Income for the Plan Year or (ii) the actual or deemed Earned Income of the Participant's Spouse, if less, for the Plan Year.

The Plan Administrator may set a minimum amount that a Participant may elect to defer to his or her Dependent Care Spending Account, which amount, if any, shall be set forth in the Welfare Benefit Plan. The Participant has sole responsibility to determine the maximum amount that may be contributed and reimbursed from his or her Dependent Care Spending Account for a Plan Year under these benefit limitations.

Section 12.07 Benefits Limited to Expenses Incurred During Plan Year. The coverage elected by a Participant for a Plan Year is only available to reimburse expenses which are incurred during the Plan Year and for periods during which the Participant made contributions to the Plan. An expense is considered incurred during the Plan Year if the services giving rise to the expense are performed during the Plan Year. An expense shall not be deemed to be incurred during the Plan Year merely because a Participant receives a bill for the expense or pays for the expense during the Plan Year.

Section 12.08 Restrictions on Payments.

(a) In no event shall a Participant be reimbursed for Dependent Care Expenses paid to a related individual:

(1) for whom the Participant or his or her Spouse is entitled to a deduction under Code Section 151(c), or

(2) who is a child of the Participant under the age of 19 years.

(b) Services performed outside the household of a Participant for the care of a Dependent shall be reimbursable only if such Dependent regularly spends at least 8 hours each day in the Participant's household or the Dependent is under age 13.

(c) Dependent Care Expenses that are incurred for services performed by a Dependent Care Center shall be reimbursable hereunder only if such center complies with all applicable laws and regulations of the state and political subdivision in which it is located.

Section 12.09 Forfeiture. If a Participant incurs aggregate Dependent Care Expenses in an amount that is less than the dollar amount of coverage he or she has elected for a Plan Year, any remaining amount in his or her Dependent Care Spending Account shall be forfeited as of the end of the Plan Year (except to the extent specifically permitted under the terms of the Welfare Benefit Plan with respect to the Plan Administrator's adoption of the grace period feature). Any unused amount of coverage elected by a Participant for a Plan Year resulting from the Participant's failure to timely submit proper claims for reimbursement (in accordance with Section 12.16) shall be forfeited in the same manner. Subject to applicable law and regulations, such forfeitures shall be retained by the Employer or applied toward the payment of reasonable Plan administrative expenses, provided, however that the Plan Administrator shall have discretion to allocate the forfeitures on a reasonable and uniform basis to Participants. In no event, however, shall any such forfeitures be allocated among Participants based on their

individual claims experience, be used for other benefits under the Plan, or be carried over and applied to qualifying Dependent Care Expenses incurred more than 12 months after the year in which such amount was forfeited. Upon Plan termination, forfeitures shall occur as provided in Section 10.01.

Section 12.10 Involuntary Election Modifications. In no event shall more than 25% of the amounts paid or incurred by the Employer for dependent care assistance and all other qualified benefits (within the meaning of Code Section 125(b)(2)) under the Plan during the Plan Year be provided to key employees (within the meaning of Code Section 416(i)(1)).

The average benefits provided to Caregivers who are not highly compensated employees (within the meaning of Code Section 414(q)) shall at all times equal at least 55% of the average benefits provided to highly compensated employees under the Dependent Care Spending Account Plan. For purposes of this paragraph, in the case of any benefits provided through a salary reduction agreement, there may be disregarded any employees whose compensation (within the meaning of Code Section 414(q)(7)) is less than $25,000.

If any of the limitations on benefits to key employees or highly compensated employees under the preceding paragraphs would be exceeded but for this paragraph, the Plan Administrator may reduce or cancel the compensation reduction of one or more key or highly compensated employees to satisfy these limitations.

Section 12.11 Reimbursements. All amounts reimbursed under the Plan for Dependent Care Expenses represent amounts elected by Participants to be reduced from their salary. When a Participant makes a request for reimbursement, such amounts will be payable directly to the Participant and solely from the general assets of the Employer. No separate Trust Fund will be maintained to hold Participants' salary reductions (unless subsequently required by law).

Section 12.12 Establishment of Accounts. The Plan Administrator shall establish and maintain on its books a Dependent Care Spending Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Dependent Care Expenses incurred during the Plan Year.

Section 12.13 Crediting of Accounts. There shall be credited to each Participant's Dependent Care Spending Account, as of each pay date, the amount designated on the Participant's election and salary reduction agreement under the Plan. All amounts credited to each such Dependent Care Spending Account shall be the property of the Employer until paid out pursuant to Section 12.16.

Section 12.14 Debiting of Accounts. A Participant's Dependent Care Spending Account for each Plan Year shall be debited in the amount of any payment made under Section 12.16 to or for the benefit of the Participant.

Section 12.15 Statement of Account. On or before January 31 of each year, the Claims Administrator shall make available (electronically or otherwise) to each Participant a statement showing the amounts paid or expenses incurred under such Participant's dependent care account during the previous calendar year.

Section 12.16 Reimbursement Procedure. Except as otherwise provided in the Welfare Benefit Plan (including with respect to any grace period adopted under the Welfare Benefit Plan):

(a) Each Participant who applies for reimbursement for Dependent Care Expenses under the Plan shall submit to the Claims Administrator a properly and timely completed claim process (which may be electronic) as established by the Claims Administrator. The Participant will be required to provide the following information:

(1) The Dependent or Dependents for whom the services were performed;

(2) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(3) The relationship, if any, of the person performing the services to the Participant;

(4) If the services are being performed by a child of the Participant, the age of the child;

(5) A statement as to where the services were performed;

(6) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(7) If the services were being performed in a day care center, a statement:

(i) that the day care center complies with all applicable laws and regulations of the state of residence,

(ii) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(iii) of the amount of fee paid to the provider.

(8) If the Participant is married, a statement containing the following:

(i) the Spouse's salary or wages if he or she is employed, or

(ii) if the Participant's Spouse is not employed, that he or she is incapacitated, or he or she is a full time student attending an educational institution and the months during the year which he or she attended such institution.

Additional information may be requested if deemed necessary by the Claims Administrator. Each such claim shall be submitted by the Participant in the manner required by the Claims Administrator and accompanied by relevant bills, statements, or receipts relating to

the claim. All properly submitted claims shall be reimbursed monthly, on such date as shall be designated by the Claims Administrator.

(b) A Participant may submit claims to the Claims Administrator for reimbursement of Dependent Care Expenses that are incurred during the Plan Year pursuant to this Section.

(c) Participants may submit a claim for reimbursement of an incurred Dependent Care Expense up to the deadline established under the Welfare Benefit Plan.

Section 12.17 Claims Procedure. Subject to the rules for a claim of reimbursement under Section 12.16 above, a claimant shall follow the rules set forth in Article VIII for the submission and appeal of a claim.

Section 12.18 Refund of Duplicate Reimbursement. If a Participant receives a reimbursement under this Plan and reimbursement for the same Dependent Care Expense is made from another source, or fails to properly substantiate the claim, he or she shall be required to refund the reimbursement to the Employer.

Section 12.19 Termination of Participation. A Participant will cease to be a Participant as of the earliest of the date on which:

(a) the Dependent Care Spending Account Plan terminates;

(b) The Participant's election to receive Dependent Care Expense Reimbursements expires or is terminated under the Plan;

(c) The Participant terminates employment with the Employer;

(d) The Participant fails to satisfy the Plan's eligibility requirements, including transferring to an ineligible group of employees; or

(e) any other event causing termination of participation as described in this Plan or in the Welfare Benefit Plan.

Section 12.20 Effect of Termination of Participation. In the event that a Participant ceases to be a Participant in the Plan for any reason during a Plan Year, the Participant's salary reduction agreement relating to the Plan shall terminate. The Participant shall be entitled to reimbursement only for Dependent Care Expenses incurred before the Participant ceased participation in the Plan. Such reimbursement shall be made in accordance with and subject to Section 12.16 (including the requirement that the Participant must timely submit his or her reimbursement request by the applicable deadline) as set forth in the Welfare Benefit Plan document and any unused amounts are forfeited as set forth in Section 12.09 above and the Welfare Benefit Plan.

Section 12.21 Leave of Absence. If a Participant is absent from work due to an unpaid leave of absence, the Participant will have the right to revoke his or her coverage under the Dependent Care Spending Account Plan for the remainder of the Plan Year. In any event, the Participant's coverage under such Plan will be suspended during an unpaid leave period. If the

Participant does not elect to revoke his or her coverage for the remainder of the Plan Year, coverage will be reinstated upon his or her return to work with the Employer and will resume without any change in the Participant's prior elections under such Plan for such Plan Year. The Participant's cash compensation will be reduced to the rate in effect on the day before the leave commenced.

In no event is a Participant entitled to (i) reimbursement for claims incurred during the period when coverage was suspended, nor (ii) greater benefits upon restoration for the remainder of the Plan Year relative to contributions paid by a Participant who is continuously employed during the Plan Year.

If the Participant returns from an unpaid leave in a Plan Year subsequent to the year the leave commenced, the Participant will be required to timely and properly complete the enrollment process under the Plan if he or she wants to resume participation in the Dependent Care Spending Account Plan. Participation in the Dependent Care Spending Account Plan will commence as of the first pay period immediately following the Claims Administrator's acceptance of the Participant's completed enrollment process (as such later date as specified in the Welfare Benefit Plan).

ARTICLE XIII

HEALTH CARE SPENDING ACCOUNT PLAN

Section 13.01 Health Care Spending Account Plan Authority. The Employer has established a Health Care Spending Account Plan as described in this Article XIII, which is intended to qualify as a separate, nontaxable employee benefit plan under Code Section 105, providing health care benefits to Participants and is to be interpreted in a manner consistent with the requirements of Code Section 105.

Section 13.02 Definitions. The following definitions shall apply for purposes of this Article XIII:

(a) **"Dependent"** means any individual who is:

(1) the legal Spouse of a Caregiver (as defined below);

(2) any individual who falls within the definition of dependent under Code Section (without regard to the earnings limit under Code Section 152(d)(1)(B); the special exclusions of Code Section 152(b)(1) and (2); or the age or student status requirements under §152(c)(3), provided that such qualifying child is age 26 or under during the entire Plan Year); and

(3) any individual to the extent required under any Qualified Medical Child Support Order.

(b) **"Health Care Spending Account"** means an account described in Plan Section 13.10 below.

(c) **"Medical Care"** shall have the meaning set forth in Code Section 213, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise (other than under this Plan) and subject to any changes made under the Welfare Benefits Plan. Medical Care also will include insulin, and effective January 1, 2020, over-the-counter (OTC) medicines and menstrual cycle productions. Under the Plan, however, Medical Care does not include Participants' premium payments for health coverage and will not include vitamins and other items designed to maintain general health (rather than treat an illness).

(d) **"Medical Care Expenses"** means amounts which are expended for the Medical Care of a Participant or his or her Dependents during the Plan Year.

Section 13.03 Eligibility. To be eligible to participate in the Health Care Spending Account Plan, the Caregiver must be considered an Eligible Caregiver as defined under and must satisfy all other conditions set forth in the Welfare Benefit Plan.

Section 13.04 Election Procedure. An eligible Caregiver's election to allocate salary reductions to his or her Health Care Spending Account shall become effective as of the as of the date set forth in the Welfare Benefit Plan, provided such Caregiver timely elects Benefits for such Plan Year pursuant to Article VI. An election to participate in the Health Care Spending Account Plan shall be irrevocable during the Plan Year, except as otherwise permitted under this Plan.

Section 13.05 Amount. Each Participant shall be entitled to receive for each Plan Year, reimbursement of Medical Care Expenses which are incurred during the Plan Year, but only if such expenses are not reimbursed by any other source as provided in Section 13.15. The maximum reimbursement to a Participant shall be the annual dollar amount of coverage elected under the Plan by the Participant to be contributed to his or her Health Care Spending Account for that Plan Year.

The Plan Administrator, at its discretion, may set minimum and maximum amounts for a Plan Year that a Participant may elect to credit to his or her Health Care Spending Account, which amounts shall be set forth in the Welfare Benefit Plan; provided, however, that the maximum amount per Plan Year shall not exceed the IRS limits.

At all times during the Plan Year, the maximum dollar amount of coverage the Participant has elected for the Plan Year, less any Medical Care Expenses previously reimbursed during such Plan Year, shall be available for reimbursement for qualifying Medical Care Expenses, regardless of whether a Participant's Medical Care Expenses exceed the total dollar amount in his or her Health Care Spending Account at any time a particular request for reimbursement is made.

Section 13.06 Benefits Limited to Expenses Incurred During Plan Year. The coverage elected by a Participant for a Plan Year is only available to reimburse expenses that are incurred during the Plan Year and for periods during which the Participant made contributions to the Plan. An expense is considered incurred during the Plan Year if the services giving rise to the expense are performed during the Plan Year. An expense shall not be deemed to be incurred

during the Plan Year merely because a Participant receives a bill for the expense or pays for the expense during the Plan Year.

Section 13.07 Forfeiture. If, during a Plan Year, a Participant incurs aggregate Medical Care Expenses in an amount which is less than the dollar amount of coverage he or she has elected for a Plan Year, any remaining amount in his or her Health Care Spending Account shall be forfeited as of the end of the Plan Year (or as of the termination date of the Participant's participation in the Plan), except as otherwise provided in the Welfare Benefit Plan document (for example, with respect to a carryover feature or a grace period feature that has been adopted under the Welfare Benefit Plan provisions; provided, however, that a Participant shall not be entitled to both the carryover and grace period features during the same Plan Year). Unused dollars existing in the Participant's account for a Plan Year resulting from the Participant's failure to timely submit proper claims for reimbursement (pursuant to Section 13.14) shall be forfeited in the same manner. Subject to applicable law and regulations, such forfeitures shall be retained by the Employer or applied toward the payment of reasonable Plan administrative expenses, provided, however that the Plan Administrator shall have discretion to allocate the forfeitures on a reasonable and uniform basis to Participants. In no event, however, shall any such forfeiture be allocated among Participants based on their individual claims experience, be used for other Benefits under the Plan, or be carried over and applied to Medical Care Expenses incurred more than 12 months after the end of the Plan Year in which the forfeiture occurred. Upon termination of the Plan, forfeitures shall occur as provided in Section 10.01.

Section 13.08 Involuntary Election Modifications. At any time prior to or during the Plan Year, the Plan Administrator may require some or all Participants to modify their elections under the Plan if the Plan Administrator determines to its satisfaction that such modifications are necessary in order to preserve the tax-preferred status of this Plan under Code Sections 125 or 105(h) or under any other applicable provision of the Code and the regulations promulgated thereunder, or are otherwise required under the eligibility terms set forth in the Welfare Benefit Plan document. For example, such modifications may be required to enable the Plan to satisfy the nondiscrimination requirements of applicable provisions of the Code, or to enable an Eligible Caregiver to be considered an Eligible Individual. The Plan Administrator shall adopt and follow uniform and nondiscriminatory rules for purposes of this section and its decisions regarding involuntary election modifications shall be final and binding.

Section 13.09 Reimbursements. All amounts reimbursed under the Plan for Medical Care Expenses represent amounts elected by Participants to be reduced from their salary. When a Participant makes a request for reimbursement, such amounts will be payable directly to the Participant and solely from the general assets of the Employer. No separate Trust Fund will be maintained to hold Participants' salary reductions (unless subsequently required by law).

Section 13.10 Establishment of Accounts. The Plan Administrator shall establish and maintain on its books a Health Care Spending Account for each Plan Year with respect to each Participant who has elected under the Plan to receive reimbursement of Medical Care Expenses incurred during the Plan Year.

Section 13.11 Crediting of Accounts. There shall be credited to each Participant's Health Care Spending Account as of each pay date the amount designated on the Participant's

election and salary reduction agreement under the Plan. All amounts credited to each such Health Care Spending Account shall be the property of the Employer until paid out pursuant to Section 13.14.

Section 13.12 Debiting of Accounts. A Participant's Health Care Spending Account for each Plan Year shall be debited in the amount of any payment made under Section 13.14 to or for the benefit of the Participant for Medical Care Expenses incurred during such Plan Year.

Section 13.13 Statement of Account. Throughout the Plan Year, the Claims Administrator may make available (electronically or otherwise) to each Participant a statement showing the amounts paid or expenses incurred under such Participant's Health Care Spending Account during the previous calendar year.

Section 13.14 Reimbursement Procedure. Except as otherwise provided in the Welfare Benefit Plan (including with respect to a grace period or a carryover feature adopted under the Welfare Benefit Plan):

(a) Each Participant who applies for reimbursement for Medical Care Expenses under the Plan shall submit to the Claim Administrator a properly and timely completed claim process (which may be electronic) as established by the Claims Administrator. The Participant will be required to submit the following information to the Claims Administrator:

(1) the amount and purpose of each expense and the date incurred;

(2) the name of the individual for whom the expense was incurred and, if applicable, the relationship to the Participant; and

(3) the name of the individual or entity to whom the expense was, or is to be, paid.

(b) By completing the claims process, the Participant is certifying that the expense has not been paid by, and that the Participant is not entitled to reimbursement or payment from, another source pursuant to this Article, and shall be accompanied by relevant bills, statements, or receipts from an independent third party that relate to the claim. The Claims Administrator, upon the Claims Administrator's request in its sole discretion, may provide Participants with a Flex Debit Card to be used for reimbursement of Medical Care Expenses (in lieu of a Participant completing the claims process established by the Claims Administrator). The terms of any such Flex Debit Card program will be established by the Claims Administrator in accordance with Code Section 125 and communicated to Participants. The Claims Administrator, if it deems necessary, may require that a Participant submit additional information for the Claims Administrator's consideration of a Participant's request for reimbursement or for the Claims Administrator to substantiate charges on a Flex Debit Card. Properly submitted claims will be reimbursed, on such date as designated by the Claims Administrator and may take other action to recover reimbursed amounts if the Participant fails to substantiate the expenses consistent with IRS guidance.

(c) A Participant may submit a claim for reimbursement to the Claims Administrator for only those Medical Care Expenses that are incurred during the Plan Year.

(d) Participants may submit claims for incurred Medical Care Expenses no later than the deadline established under the Welfare Benefit Plan for the Health Care Spending Account Plan.

Section 13.15 Payment Limitations. Reimbursement or payment under the Plan shall be made by the Plan Administrator only to the extent that the claim for reimbursement has not been paid by and is not payable from another source, including but not limited to (a) any insurance policy, whether owned by the Employer, by the Participant, by an employer of the Participant's Spouse or Dependents, or by any other person or entity, (b) any other health or accident plan, whether insured or self-insured, or (c) any government program or plan.

Section 13.16 Refund of Duplicate Reimbursement. If a Participant receives a reimbursement under this Plan and reimbursement for the same Medical Care Expense is made from another source, or he or she fails to properly substantiate a claim, the Participant shall be required to refund the reimbursement to the Employer.

Section 13.17 Termination of Participation. Subject to Section 13.19, a Participant will cease to be a Participant as of the earliest of the date on which:

(a) the Health Care Spending Account Plan terminates;

(b) his or her election to receive reimbursement of Medical Care Expense expires or is terminated under the Plan;

(c) he or she terminates employment with the Employer;

(d) the date on which he or she fails to satisfy the Plan's eligibility requirements, including transferring to an ineligible group of employees; or

(e) any other event causing termination of participation as described in this Plan or the Welfare Benefit Plan.

Section 13.18 Effect of Termination of Participation. In the event that a Participant ceases to be a Participant in the Health Care Spending Account Plan for any reason during a Plan Year, the Participant's salary reduction agreement relating to the Plan shall terminate.

The Participant shall be entitled to reimbursement only for Medical Care Expenses incurred before the effective date of the Participant's termination of participation in the Plan, except as otherwise provided under Section 13.19 (COBRA Continuation Coverage), and shall have no right to carryover or receive any unused balances.

Except as otherwise provided in this Article XIII, reimbursement shall be made in accordance with Section 13.14 upon termination of participation.

Section 13.19 COBRA Continuation Coverage. If a Participant of the Health Care Spending Account Plan terminates employment with the Employer, or he or she (or his or her Spouse or dependent child) experiences another qualifying event under COBRA (e.g. reduced hours in employment, divorce, death, loss of dependent status, entitlement to Medicare, etc.), the Participant (or his or her Spouse or dependent-child) may be offered a limited opportunity to continue coverage under the Health Care Spending Account Plan as follows:

(a) COBRA continuation coverage under the Health Care Spending Account Plan will be offered to such a Participant (or his or her Spouse or Dependent child) only if the maximum amount available to the Participant under the Health Care Spending Account Plan for the remainder of the Plan Year is more than the maximum amount that the Employer may charge such individual to maintain COBRA continuation coverage under the Health Care Spending Account Plan.

(b) Any available COBRA continuation coverage will be offered to such a Participant (or his or her Spouse or Dependent child) only for the remainder of the Plan Year in which the qualifying event occurred.

(c) In most cases, this means that the Participant would continue to contribute to his or her Health Care Spending Account not by salary reductions, but by after-tax payments. The after-tax cost for COBRA continuation of coverage would be 102% of the level of coverage in effect prior to COBRA.

(d) If the Participant elects COBRA coverage, he or she could continue to be reimbursed for medical expenses from his or her Health Care Spending Account for the remainder of that Plan Year. The advantage of electing COBRA coverage under the Health Care Spending Account Plan is the Participant's ability to be reimbursed out of his or her account for medical expenses incurred after the date of termination or other qualifying event.

(e) When a qualifying event occurs, the Claims Administrator will provide the Participant with more information regarding COBRA rights, if any, including election requirements, procedures and duration of COBRA coverage. **Note:** in the event of a divorce, legal separation or a child's losing dependent status, the Participant or his or her family member must notify the Claims Administrator within 60 days of such event. Failure to do so will forfeit the Participant and his or her Spouse's or dependent-child's COBRA rights, if any.

Section 13.20 Claims Procedure. Subject to the rules for a claim of reimbursement under Section 13.14 above, a claimant shall follow the rules set forth in Article VIII for the submission and appeal of a claim.

Section 13.21 Qualified Medical Child Support Orders. The Plan Administrator has established procedures to be followed if the Health Care Spending Account Plan receives a medical child support order that requires a Participant to provide health care coverage for his or her child under such Plan, which are set forth in the Welfare Benefit Plan.

Section 13.22 HIPAA Privacy and Security Laws. The Health Care Spending Account Plan is subject to the privacy and security laws of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as described in the Welfare Benefit Plan.

IN WITNESS WHEREOF, Sparrow Health System has caused this Plan to be amended and restated effective January 1, 2021.

SPARROW HEALTH SYSTEM

By: Teresa Znidarsic
Teresa Znidarsic (Jul 9, 2021 16:32 EDT)

Date: July 9, 2021

Its: SVP-CHRO