RIVIAN AUTOMOTIVE, LLC
FLEXIBLE BENEFITS PLAN

TABLE OF CONTENTS

RIVIAN AUTOMOTIVE, LLC
FLEXIBLE BENEFITS PLAN

INTRODUCTION

The Employer hereby restates the Rivian Automotive, LLC Flexible Benefits Plan (the "Plan"), effective January 1, 2020, to allow Employees to choose between cash compensation and certain different types of benefits based on their own particular goals, desires and needs.

The intention of the Employer is that the Plan qualify as a "cafeteria plan" within the meaning of Code Section 125 such that Employees' salary reduction elections under the Plan are excludable from the Employees' income under Code Section 125(a) and other applicable sections of the Code. The Plan provisions shall apply uniformly to all Eligible Employees. The Dependent Care Flexible Spending Account is intended to qualify as a dependent care assistance program within the meaning of Code Section 129, and the Health Flexible Spending Account and Limited Purpose Health Flexible Spending Account are intended to qualify as self-insured medical reimbursement plans under Code Section 105.

The Health Flexible Spending Account and Limited Purpose Health Flexible Spending Account portions of the Plan are "employee welfare benefit plans" within the meaning of ERISA Section 3(1). Certain requirements of ERISA, including the fiduciary responsibility provisions, apply to the Health Flexible Spending Account Plan and Limited Purpose Health Flexible Spending Account Plan. The Insurance Premium Payment Plan, the Dependent Care Flexible Spending Account Plan, and the Health Savings Account portions of the Plan are not subject to the requirements of ERISA, and the Plan shall not be interpreted as applying the requirements of ERISA to such portions of the Plan.

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the Employer unless the Employer has designated another person or entity pursuant to Section 9.1 to administer the Plan on behalf of the Employer.

1.2 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

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

1.4 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.5 **"Dependent"** means any individual who qualifies as a dependent under Code Section 105(b). Any child of a Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Section 609 shall be considered a Dependent under this Plan.

1.6 **"Dependent Care Flexible Spending Account"** means the notional account established for a Participant pursuant to this Article to which part of his Salary Redirections may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Individuals.

1.7 **"Domestic Partner"** means an individual who qualifies as a domestic partner for a Benefit.

1.8 **"Effective Date"** means January 1, 2020.

1.9 **"Election Form"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation and to have such amounts be applied as Salary Redirections. The Election Form shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and does not become subsequently available to the Participant.

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

1.11 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.12 **"Employee"** means any person who is employed by the Employer and who is scheduled to work twenty (20) hours or more per week or is on short-term disability. The term Employee shall not include leased employees within the meaning of Code Section 414(n)(2).

1.13 **"Employer"** means Rivian Automotive, LLC.

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

1.15 **"Grace Period"** means, with respect to any Plan Year, the time period ending on the fifteenth day of the third calendar month after the end of such Plan Year.

1.16 **"Health Flexible Spending Account"** means the account established for Participants to which part of their Salary Redirections may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

1.17 **"Insurance Premium Payment Plan"** means the arrangement contained in Section 4.1(1) of this Plan, which provides for the payment of Premium Expenses.

1.18 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.19 **"Limited Purpose Health Flexible Spending Account"** means the account established for Participants to which part of their Salary Redirections may be allocated and from which all allowable Limited Purpose Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

1.20 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.32 and has not for any reason become ineligible to participate further in the Plan.

1.21 **"Plan"** means the Rivian Automotive, LLC Flexible Benefits Plan.

1.22 **"Plan Year"** means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on the date that such Participant begins participating in the Plan and ending on the last day of such Plan Year.

1.23 **"Salary Redirection"** means the elections for Benefits made by the Participant pursuant to Section 3.1.

1.24 **"Spouse"** means an individual who is lawfully married to an Eligible Employee and who is not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following is true: (1) the individual was married in a state, possession, or territory of the United States and the individual is recognized as lawfully married by that state, possession, or territory of the United States; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the United States would recognize the individual as lawfully married. Solely with respect to the Benefits described in Section 4.1(1), a Spouse also includes a Domestic Partner.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY2.1 P.32.1

With respect to any of the Benefits available under the Plan, an Employee shall be an Eligible Employee on the date that he or she is hired. Any Employee who was an Eligible Employee on the Effective Date shall continue to be eligible to participate in the Plan.

2.2 APPLICATION TO PARTICIPATE2.3 P.32.3

An Eligible Employee who wishes to participate in the Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof. Any such Election Form shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.3 EFFECTIVE DATE OF PARTICIPATION

Participation in this Plan shall be effective as of the date of hire for new Eligible Employees and the first day of the Plan Year for all other Eligible Employees.

2.4 TERMINATION OF PARTICIPATION

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

(a) **Termination of employment.** The Participant's termination of employment;

(b) **Change in employment status.** The date the Participant is no longer an Eligible Employee;

(c) **Death.** The Participant's death, subject to the provisions of Section 2.5; or

(d) **Termination of the plan.** The termination of this Plan, subject to the provisions of Article X.

2.5 DEATH2.7 P.42.7

If a Participant dies, his participation in the Plan shall cease. However, such Participant's Spouse or Dependents may submit claims for expenses or benefits incurred before the Participant's death for the remainder of the Plan Year. In no event may reimbursements be paid to someone who is not a Spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account and Limited Purpose Health Flexible Spending Account.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION3.1 P.43.1

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Election Form and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Election Form shall only be applicable from the first day of the pay period following the date the Employee begins participating in the Plan up to and including the last day of the Plan Year.

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

3.2 APPLICATION OF CONTRIBUTIONS

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

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account and the Limited Purpose Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS4.1 P.54.1

Each Eligible Employee may elect any one or more of the following optional Benefits:

(1) Insurance Premium Payment Plan

(i) Health Insurance Benefit
(ii) Dental Insurance Benefit
(iii) Vision Insurance Benefit

(2) Health Flexible Spending Account

(3) Dependent Care Flexible Spending Account

(4) Limited Purpose Health Flexible Spending Account

(5) Health Savings Account

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Eligible Employee may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Eligible Employee may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 LIMITED PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Limited Purpose Health Flexible Spending Account option, in which case Article XII shall apply.

4.5 HEALTH SAVINGS ACCOUNT

Each Participant may elect to make Salary Redirections to a health savings account ("HSA"), which is an individual trust or custodial account described in Article XIII.

4.6 NONDISCRIMINATION REQUIREMENTS4.5 P.64.5

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees that the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits that (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. Contributions that are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS5.1 P.65.1

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

5.2 SUBSEQUENT ANNUAL ELECTIONS5.2 P.65.2

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, through the Election Form, which Benefit Options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit Options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

Any Participant failing to complete an Election Form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

5.4 CHANGE IN STATUS5.4 P.65.4

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the change is necessitated by and is consistent with a change in status which is acceptable under rules and regulations adopted by the IRS and/or Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict with this Section 5.4, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, termination of a domestic partnership with a Domestic Partner, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel coverage under a Benefit Option for any individual other than the one involved in such event.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or the individual’s Dependent becomes eligible for continuation coverage under Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by the IRS and Treasury regulations or other guidance:

(1) Legal Marital Status: Events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment, and the termination of a domestic partnership with a Domestic Partner;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, legal guardianship, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Individual" as defined under Code Section 21(b) shall also qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participant may change an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); provided that such Participant meets the thirty (30) or sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change an election to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan.

(e) **Cost increase or decrease.** If the cost of a Benefit increases or decreases during the Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their elections or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Sections 152(a)(1) and (2).

(h) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election for the Health Flexible Spending Account or Limited Purpose Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

(i) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke his election for coverage under the group health plan (that is not a Health Flexible Spending Account or Limited Purpose Health Flexible Spending Account) which provides minimum essential coverage (as defined in Code Section 5000A(f)(1)) provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

(1) The Participant has been reasonably expected to average at least thirty (30) hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than thirty (30) hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than thirty (30) hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT PLAN

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account Plan is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly. An Eligible Employee may not elect to participate in the Health Flexible Spending Account Plan for a Plan Year if he elects to make contributions to a Health Savings Account for that Plan Year (but may participate in the Limited Purpose Health Flexible Spending Account Plan).

6.2 DEFINITIONS

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

(a) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the five highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(b) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse, and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage, such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account Plan.

6.3 FORFEITURES6.3 P.106.3

Up to $500 of the amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) can be carried over to the Health Flexible Spending Account for the next Plan Year. If the Participant elects to participate in a high deductible health plan for that next Plan Year, the amounts shall be carried over to a Limited

Purpose Health Flexible Spending Account. Any amounts over $500 shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS6.4 P.106.4

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the minimum amount of salary reductions that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $100, and the maximum amount is $2,750, as adjusted for increases in the cost of living in accordance with Code Section 125(i)(2). For any short Plan Year, the limit shall be an amount equal to the limit for the calendar year in which the Plan Year begins multiplied by the ratio obtained by dividing the number of full months in the short Plan Year by twelve (12).

(b) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), (m), or (o) relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each employer's health flexible spending account.

6.5 NONDISCRIMINATION REQUIREMENTS6.5 P.106.5

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account Plan, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

Matters concerning contributions, elections, and the like shall be governed by the general provisions of the Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS6.7 P.116.7

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse, and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year, through the time period specified in subsection (d). Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for, the medical care.

(b) **Reimbursements.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount of Salary Redirections designated by the Participant for the Health Flexible Spending Account Plan for the Plan Year plus any carryover from a prior Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Salary Redirections which have been allocated to the Participant’s account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under the Health Flexible Spending Account Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications, as required by applicable law.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 60 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 60 days after termination of employment.

6.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that the Health Flexible Spending Account portion of such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's effective date of participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year as set forth in Section 6.4 plus any amounts carried over from a prior Plan Year.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense or the Participant does not submit any required substantiation, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account Plan is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

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

(a) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(b) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services that if paid by the Participant would be considered employment-related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Individual, to the extent that such expenses are incurred to enable the Participant and his/her Spouse to be gainfully employed or his/her Spouse to be a full-time student for any period for which there are one or more Qualifying Individuals with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Individuals are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for, the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if (a) incurred for a Qualifying Individual as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or (b) incurred for a Qualifying Individual as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least eight hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(c) **"Qualifying Individual"** means, for Dependent Care Flexible Spending Account Plan purposes,

(1) a Participant's dependent child (as defined in Code Section 152(a)(1)) who has not attained age 13; 7.2(d)(1) p.137.2(d)(1)

(2) a dependent (as defined in Code Section 152, without regard to subsections (b)(1), (b)(2), and (d)(1)(B)) or Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or7.2(d)(2) p.137.2(d)(2)

(3) a child that is deemed to be a Qualifying Individual described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5). 7.2(d)(3) p.137.2(d)(3)

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account Plan.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Salary Redirections to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Salary Redirections that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT7.6 P.147.6

Subject to limitations contained in Section 7.9, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year and Grace Period or portion thereof during which he is a Participant.

7.7 W-2 REPORTING OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES7.8 P.147.8

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

7.9 LIMITATION ON PAYMENTS7.9 P.147.9

(a) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)). The minimum Salary Redirection that a Participant can elect for the Dependent Care Flexible Spending Account for a Plan Year is $100.

7.10 NONDISCRIMINATION REQUIREMENTS7.10 P.147.10

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account Plan that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account Plan that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

Matters concerning contributions, elections, and the like shall be governed by the general provisions of the Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS7.12 P.147.12

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

(a) The Qualifying Individual(s) for whom the services were performed;

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

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

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

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

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

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

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

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

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

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

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

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) 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.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 60 days after the end of the Grace Period, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 60 days after termination of employment.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) **Dependent Care Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account Benefits shall be made to the Administrator. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 60 days after the end of the Grace Period, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 60 days after termination of employment. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific reason or reason(s) 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 the claimant to perfect the claim and an explanation as to why such information is necessary; and

(4) an explanation of the Plan's claim procedure.

Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

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 which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(b) **Health FSA claims.** If a Participant fails to submit a claim under the Health Flexible Spending Account or the Limited Purpose Health Flexible Spending Account within 60 days after the end of the Plan Year, those claims shall not be

considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 60 days after termination of employment. Once a claim is submitted, the following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Administrator will provide written or electronic notification of any claim denial. The notice will state:

(1) the specific reason or reasons for the denial;

(2) reference to the specific Plan provisions on which the denial was based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under ERISA Section 502 following a denial on review;

(5) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(6) if the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

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

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

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

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

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

(c) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account, Limited Purpose Health Flexible Spending Account, or Dependent Care Flexible Spending Account as of the end of the time for claims

reimbursement for each Plan Year and Grace Period (if applicable), except for any amount carried over pursuant to Section 6.3 or Section 12.3 shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3, Section 7.8, or Section 12.3, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, that has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited and returned to the Employer following a reasonable time after the date any such payment first became due.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS8.2 P.178.2

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan (except carryovers permitted under Section 6.3 and Section 12.3); nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations or other IRS guidance. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

8.3 NAMED FIDUCIARY

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

8.4 GENERAL FIDUCIARY RESPONSIBILITIES

To the extent ERISA applies, the Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

8.5 NONASSIGNABILITY OF RIGHTS

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

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION 9.1 P.189.1

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator.

An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal (in writing or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of ERISA, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Eligible Employees. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the

purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and

(i) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

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

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant and Employee such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any trust fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INDEMNIFICATION OF ADMINISTRATOR

(1) To the fullest extent authorized by law, and to the extent not otherwise covered by insurance, the officers and employees of the Employer who provide services to the Plan shall be indemnified by the Employer against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, unless (1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted gross negligence or willful misconduct, or (2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted gross negligence or willful misconduct.

(2) To the fullest extent authorized by law, and to the extent not first covered by insurance or the Employer’s indemnity set forth above in (1), the officers and employees of the Employer who provide services to the Plan shall be fully indemnified by the Plan against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, unless (1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted a breach of fiduciary duty, gross negligence or willful

misconduct, or (2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted a breach of fiduciary duty, gross negligence or willful misconduct.

ARTICLE X
AMENDMENT AND TERMINATION OF PLAN

10.1 AMENDMENT AND TERMINATION

The Employer has the right to amend or terminate the Plan at any time. This reservation of the right to amend or terminate benefits applies to benefits for current employees and their dependents and also to retired or terminated employees and their survivors or dependents. Nothing in this document or other communication from the Employer or its delegee with respect to the Plan shall be deemed to create or imply a continuing obligation by the Employer to provide or fund benefits to current employees or their dependents, or retired or terminated employees or their dependents or survivors.

All amendments to the Plan shall be in writing, and any oral statements or representations made by any individual or entity that purport to alter, modify, amend, or are inconsistent with the written terms of the Plan shall be invalid and unenforceable and may not be relied upon by any individual or entity.

No further additions shall be made to the Health Flexible Spending Account, Limited Purpose Health Flexible Spending Account, or Dependent Care Flexible Spending Account upon termination of the Plan, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.11.

11.2 GENDER AND NUMBER

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

11.3 WRITTEN DOCUMENT

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

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Participants.

11.5 PARTICIPANT'S RIGHTS

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

11.6 ACTION BY THE EMPLOYER

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

11.7 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

11.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

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

11.9 FUNDING

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

11.10 GOVERNING LAW

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

11.11 SEVERABILITY11.12 P.2111.12

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

11.12 CAPTIONS

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

11.13 CONTINUATION OF COVERAGE (COBRA) 11.14 P.2111.14

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

In general, the continuation coverage rules for the Health Flexible Spending Account and the Limited Purpose Health Flexible Spending Account are as follows:

(a) **Account Balance**. A Participant, Spouse, or Dependent shall only be entitled to elect continuation coverage if the maximum benefit available under the Health Flexible Spending Account or the Limited Purpose Health Flexible Spending Account, whichever is applicable, for the year as of the date of the Qualifying Event equals or exceeds the continuation coverage premium that applies for coverage for the remainder of the Plan Year.

(b) **"Qualifying Event"** means any of the following events that would otherwise result in a Participant's or his/her Spouse or Dependent's loss of coverage under the Health Flexible Spending Account or the Limited Purpose Health Flexible Spending Account in the absence of continuation coverage:

(1) A Participant's termination of employment, for any reason other than gross misconduct;

(2) A Participant's reduction in work hours resulting in a change of status such that the Participant is no longer eligible to be a Participant;

(3) A Participant's divorce or legal separation (Spouse only);

(4) A Dependent ceasing to qualify as a Dependent under the provisions of the Health Flexible Spending Account and the Limited Purpose Health Flexible Spending Account (Dependent only); or

(5) The death of a Participant (Spouse or Dependent only).

(c) **Period of Continuation Coverage for Qualified Beneficiaries**. A qualified beneficiary who qualifies for continuation coverage may remain covered until the end of the Plan Year in which the Qualifying Event occurs plus any carryover period. Continuation coverage may not continue beyond: (1) the date on which the Employer ceases to maintain any Health Flexible Spending Account or Limited Purpose Health Flexible Spending Account; or (2) the last day of the month for which

premium payments have been made, if the individual fails to make premium payments on time (except that no premiums are required for the carryover periods).

(d) **Contribution Requirements for Continuation Coverage**. Qualified beneficiaries who elect continuation coverage will be required to pay "Continuation Coverage Contributions." Qualified beneficiaries must make the Continuation Coverage Contributions monthly prior to the first day of the month in which the coverage will take effect. However, a qualified beneficiary has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage Contributions for the first month's payment and the cost for the period between the date medical coverage would otherwise have terminated due to the Qualifying Event and the date the qualified beneficiary actually elects continuation coverage. The qualified beneficiary shall have a thirty (30) day grace period to make the Continuation Coverage Contributions due thereafter. Continuation Coverage Contributions must be postmarked on or before the completion of the thirty (30) day grace period. If Continuation Coverage Contributions are not made on a timely basis, continuation coverage will terminate as of the last day of the month for which such premiums were made. The thirty (30) day grace period shall not apply to the forty-five (45) day period for payment of Continuation Coverage Contributions as set out in this Section 11.13(d).

(e) **Limitation on Qualified Beneficiary's Rights to Continuation Coverage**. If a Spouse or Dependent loses, or will lose, coverage under the Health Flexible Spending Account or the Limited Purpose Health Flexible Spending Account as a result of divorce, legal separation, annulment, or ceasing to be a covered Dependent, such Spouse or Dependent must notify the Administrator within sixty (60) days of the divorce, legal separation, or loss of Dependent status in order to elect continuation coverage. Failure to make timely notification will terminate the Spouse or Dependent's rights to continuation coverage. For all other Qualifying Events, no notification by the Participant, Spouse, or Dependent is required.

A qualified beneficiary (or a third party on behalf of the qualified beneficiary) must complete and return the required enrollment materials within sixty (60) days from the later of (i) loss of coverage, or (ii) the date the Administrator sends notice of eligibility for continuation coverage. Failure to enroll for continuation coverage during this sixty (60) day period will terminate all rights to continuation coverage. Elections for continuation coverage may be made by the qualified beneficiary or on his/her behalf by a third party (including a third party that is not a qualified beneficiary).

(f) **Deficient Continuation Coverage Contribution Amount**. If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not less than $50 or 10% of the amount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made.

11.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Treasury regulation 1.125-3.

11.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA) and the regulations thereunder.

11.17 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

11.18 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

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

11.19 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

11.20 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

ARTICLE XII
LIMITED PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT

12.1 ESTABLISHMENT OF PLAN

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

12.2 DEFINITIONS

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

(a) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the five highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(b) **"Limited Purpose Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder that is for dental or vision care, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Limited Purpose Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Limited Purpose Medical Expenses, when the Participant is provided with the medical care that gives rise to the Limited Purpose Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(c) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Limited Purpose Health Flexible Spending Account.

12.3 FORFEITURES6.3 P.106.3

Up to $500 of the amount in the Limited Purpose Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 12.7 hereof) can be carried over to the Limited Purpose Health Flexible Spending Account for the next Plan Year. If the Participant does not elect to participate in a high deductible health plan for that next Plan Year, the amounts shall be carried over to a Health Flexible Spending Account. Any amounts over $500 shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

12.4 LIMITATION ON ALLOCATIONS6.4 P.106.4

(a) Notwithstanding any provision contained in this Limited Purpose Health Flexible Spending Account to the contrary, the minimum amount of salary reductions that may be allocated to the Limited Purpose Health Flexible Spending Account by a Participant in or on account of any Plan Year is $100, and the maximum amount is $2,750, as adjusted for increases in the cost of living in accordance with Code Section 125(i)(2). For any short Plan Year, the limit shall be an amount equal to the limit for the calendar year in which the Plan Year begins multiplied by the ratio obtained by dividing the number of full months in the short Plan Year by twelve (12).

(b) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), (m), or (o) relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Limited Purpose Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each employer's health flexible spending account.

12.5 NONDISCRIMINATION REQUIREMENTS6.5 P.106.5

(a) **Intent to be nondiscriminatory.** It is the intent of this Limited Purpose Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Limited Purpose Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

12.6 COORDINATION WITH CAFETERIA PLAN

Matters concerning contributions, elections and the like shall be governed by the general provisions of the Plan.

12.7 LIMITED PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS6.7 P.116.7

(a) **Expenses must be incurred during Plan Year.** All Limited Purpose Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year, through the time period specified in subsection (d). Limited Purpose Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for, the medical care.

(b) **Reimbursements.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Limited Purpose Medical Expenses, up to a maximum of the amount of Salary Redirections designated by the Participant for the Limited Purpose Health Flexible Spending Account for the Plan Year plus any carryover from a prior Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Salary Redirections which have been allocated to the Participant’s account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Limited Purpose Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Limited Purpose Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Limited Purpose Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications, as required by applicable law.

(d) **Claims for reimbursement.** Claims for the reimbursement of Limited Purpose Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 60 days after the end of the Plan Year, those Limited Purpose Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Limited Purpose Medical Expenses must be submitted within 60 days after termination of employment.

12.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Limited Purpose Medical Expenses, subject to the following terms:

(a) **Card only for limited purpose medical expenses.** Each Participant issued a card shall certify that the Limited Purpose Health Flexible Spending Account portion of such card shall only be used for Limited Purpose Medical Expenses. The Participant shall also certify that any Limited Purpose Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's effective date of participation and reissued for each Plan Year the Participant remains a Participant in the Limited Purpose Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Limited Purpose Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year as set forth in Section 12.4 plus any amounts carried over from a prior Plan Year.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Limited Purpose Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other dental or vision care;

(2) Purchase of dental or vision drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of dental or vision medical items such as eyeglasses.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Limited Purpose Medical Expense or the Participant does not submit any required substantiation, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE XIII
HEALTH SAVINGS ACCOUNT

13.1 HSA BENEFITS

An Eligible Employee can elect to participate in the HSA by electing to salary reduce on a pre-tax basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian with which the Employer has entered into an agreement to forward contributions to be deposited (this funding feature constitutes the HSA benefits offered under this Plan). Such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

For each Plan Year that a Participant elects to contribute to a Health Savings Account as described in this Article XIII, he shall be permitted to participate in a Limited Purpose Health Care Flexible Spending Account as described in Article XII but shall not be permitted to participate in a Health Care Flexible Spending Account described in Article VI.

13.2 CONTRIBUTIONS FOR COST OF COVERAGE FOR HSA; MAXIMUM LIMITS

HSAs are governed by the IRS rules and are subject to annual maximums that include both employee and employer contributions. The annual contribution for a Participant's HSA benefits is equal to the annual benefit amount elected by the Participant, but in no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's high-deductible health plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. An additional catch-up contribution may be made by Participants who are age 55 or older per the statutory guidelines.

In addition, the maximum annual contribution shall be:

(a) reduced by any matching (or other) Employer contribution made on the Participant's behalf; and

(b) prorated for the number of months in which the Participant is an HSA-eligible individual.

13.3 RECORDING CONTRIBUTIONS FOR HSA

The HSA is not an employer-sponsored employee benefit plan subject to ERISA—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The Employer will identify an HSA provider or providers to whom it will forward contributions that the Participant makes via Salary Redirection, but such choice is not an endorsement of any particular HSA provider. The Administrator will maintain records to track HSA contributions by a Participant, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

13.4 TAX TREATMENT OF HSA CONTRIBUTIONS AND DISTRIBUTIONS

The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

13.5 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. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan or subject to ERISA.

IN WITNESS WHEREOF, this Plan document is hereby restated, effective January 1, 2020.

Rivian Automotive, LLC

By:_____