

**NORTONLIFELOCK
FLEXIBLE BENEFITS PLAN**

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**NORTONLIFELOCK
FLEXIBLE BENEFITS PLAN**

INTRODUCTION

Symantec Corporation previously established and maintained the Symantec Corporation Flexible Benefits Plan. In 2019 Symantec Corporation sold a portion of its assets and changed its corporate name to NortonLifeLock Inc. (“NortonLifeLock”). Effective November 4, 2019, all references to Symantec Corporation were changed to NortonLifeLock and the name of the Symantec Corporation Flexible Benefits Plan changed to the NortonLifeLock Flexible Benefits Plan (the “Plan”) The Plan is hereby amended and restated effective January 1, 2021, except where an earlier effective date is specifically noted. The Plan is a component of the NortonLifeLock Group Welfare benefits Plan (the “Wrap Plan”).

The intention of the Employer is that the Plan qualify as a “Cafeteria Plan” within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee’s income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

**ARTICLE I
DEFINITIONS**

1.1 **“Administrator”** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 10.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **“Affiliated Employer”** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o). “Affiliated Employer” also means any affiliated or subsidiary corporation or business organization of the Employer.

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

1.4 **“Cafeteria Plan Benefit Dollars”** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **“Code”** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 **“Compensation”** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **“Coverage Period”** generally means the Plan Year. Notwithstanding the foregoing: (i) If an individual’s participation in a Benefit Option begins after the first day of the Plan Year, then the Coverage Period begins on the first day of such participation. (ii) If an individual’s participation in a Benefit Option ends before the last day of the Plan Year, then the Coverage Period ends on the last day of such participation. (iii) If an individual properly elects COBRA continuation coverage for a Health Flexible Spending Account, the Coverage Period ends when the COBRA continuation coverage ends.

1.8 **“Dependent”** means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

“Dependent” shall include any child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant’s “child” includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant’s child will be an eligible Dependent until reaching the limiting age of 27, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase “placed for adoption” refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term “placed” means, with respect to adoption, the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The term “foster child” means a child placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

1.9 **“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. However, an Employee’s initial Election Period shall be determined pursuant to Section 5.1.

1.10 **“Eligible Employee”** means any Employee who has satisfied the provisions of Section 2.1.

1.11 **“Employee”** means any person reported on the payroll records of the Employer as a common law employee of the Employer. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not “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. Notwithstanding the foregoing, Employee shall not include (A) any employee of the Employer who is a member of a collective bargaining unit covered under a collective bargaining agreement unless the collective bargaining agreement provides for the Employee’s participation in the Plan; (B) any leased employee as defined under Code Section 414(n); (C) any person who is not classified by the Employer as a common law employee, notwithstanding the later reclassification by a court or any administrative agency of the person as a common law employee of the Employer; (D) any person classified by the Employer as a temporary employee, seasonal employee, casual employee or intern; (E) any nonresident aliens with no U.S. source income; or (F) any U.S. expatriate who is working for an overseas affiliate of an Employer but who is treated as a “localized worker” on the books and records of such Employer.

1.12 **“Employer”** means Symantec Corporation and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

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

1.14 **“High Deductible Health Plan”** means an arrangement that qualifies as a high deductible health plan under Code Section 223.

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

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

1.17 **“Participant”** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.18 **“Plan”** means this instrument, including all amendments thereto.

1.19 **“Plan Year”** means the 12-month period beginning January 1 and ending December 31.

1.20 **“Salary Redirection”** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants’ elections made under Article V.

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

1.22 **“Spouse”** means the “spouse,” as defined under Federal law, of a Participant, unless legally separated by court decree.

1.23 **“Wrap Plan”** means the NortonLifeLock Group Welfare Benefits Plan

ARTICLE II PARTICIPATION

2.1 ELIGIBILITY

(a) **General Rule.** An Employee is eligible if he is a full-time or part-time regular employee scheduled to work at least twenty (20) hours per week for the Employer (as determined by the Employer). Any Eligible Employee shall be eligible to participate hereunder as of his date of employment. However, any Eligible Employee who was a Participant in the Plan on the effective date of this restatement shall continue to be eligible to participate in the Plan.

(b) **Additional Rules for Health Flexible Spending Accounts.** An Employee who is enrolled in the Health Savings Account benefit shall not be eligible for the Health Care Flexible Spending Account benefit. A Participant cannot participate in both the Health Care Flexible Spending Account benefit and the Limited Purpose Flexible Spending Account benefit for the same period of time.

(c) **Additional Rule for Health Savings Account.** An Employee shall not be eligible for the Health Savings Account benefit unless the Employee is enrolled in a High Deductible Health Plan sponsored by the Employer.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the date on which he satisfies the requirements of Section 2.1, provided that the Eligible Employee timely complies with Section 2.3.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate 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 or Section 5.5, as applicable.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation.

Notwithstanding the foregoing, an Eligible Employee who has enrolled in a High Deductible Health Plan sponsored by the Employer shall automatically become a Participant in the Health Savings Account benefit. Such a Participant shall be eligible for Employer Contributions to the Health Savings Account as described in Article VIII, but shall not be permitted to make Salary Redirection contributions to the Health Savings Account unless the Participant completes an application and a Salary Redirection Agreement as described in this Section.

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, subject to the provisions of Section 2.6;
- (b) **Change in employment status.** The end of the Plan Year during which the Participant became a limited Participant because of a change in employment status pursuant to Section 2.5;
- (c) **Death.** The Participant's death, subject to the provisions of Section 2.7; or
- (d) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be eligible to participate because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made on behalf of the Participant, and, except as otherwise provided herein, all further Benefit elections shall cease. However, any balances in the limited Participant's Dependent Care Flexible Spending Account may be used during such Plan Year to reimburse the limited Participant for any allowable Employment-Related Dependent Care incurred during the Plan Year. Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he otherwise satisfies the participation requirements set forth in this Article II as if he were a new Employee and makes an election in accordance with Section 5.1.

2.6 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

- (a) **Dependent Care Flexible Spending Account.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred through the remainder of the Plan Year in which such termination occurs based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination. Claims for expenses that were incurred during a Plan Year must be submitted no later than 90 days following the end of the Plan Year.
- (b) **COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 12.13 of this Plan. Claims for expenses that were incurred during a Plan Year must be submitted no later than 90 days following the end of the Plan Year.

2.7 DEATH

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 for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. Claims for expenses that were incurred during a Plan Year must be submitted no later than 90 days following the end 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.

2.8 REHIRE

If a Participant who is terminated returns to the employ of an Employer during the same Plan Year and within 30 days of his termination date, the benefit election that was in place prior to his termination shall be reinstated and he shall not be eligible to execute a new benefit election for the remaining portion of the Plan Year, unless he has experienced an intervening event that would permit him to execute a new benefit election, as described in Article 4 of the Plan. Upon the reinstatement of the benefit election, the amount of the Participant’s Salary Redirection to be withheld from each payroll period shall be recalculated, as necessary, to reflect the originally elected amount, and expenses incurred during the Participant’s gap in employment shall not be eligible for reimbursement under any Health Flexible Spending Account.

If a Participant who is terminated returns to the employ of the Employer during the same Plan Year, but more than 30 days after his termination date, he shall be eligible to execute a new benefit election for the remaining portion of the Plan Year.

**ARTICLE III
CONTRIBUTIONS TO THE PLAN**

3.1 IN GENERAL

Flexible Spending Account benefits under the Plan shall be financed by Salary Redirections sufficient to support the Flexible Spending Account benefits that a Participant has elected hereunder. Health Savings Account benefits under the Plan shall be financed by Employer Contributions and, if elected hereunder by a Participant, by Salary Redirections. 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. Any contribution made or withheld for a specific Account shall be credited to such Account.

3.2 EMPLOYER CONTRIBUTIONS

With respect to Eligible Employees participating in the Health Savings Account benefit, the Employer shall make Employer Contributions as specified in Article VIII.

3.3 SALARY REDIRECTION

Except as set forth in Section 3.2, Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected pursuant to Article IV. 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 Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee’s entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants’ elections made under Article IV.

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

3.4 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, 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 OPTIONS

The following benefits are available under this Plan, subject to the eligibility, enrollment, and participation requirements described herein:

- (a) Health Flexible Spending Account, which includes two options:
 - (i) Health Care Flexible Spending Account;
 - (ii) Limited Purpose Flexible Spending Account;
- (b) Dependent Care Flexible Spending Account; and
- (c) Health Savings Account.

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account benefit, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

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

4.4 HEALTH SAVINGS ACCOUNT

A Participant who is enrolled in a High Deductible Health Plan sponsored by the Employer shall automatically participate in the Health Savings Account benefit, in which case Article VIII shall apply.

4.5 NONDISCRIMINATION REQUIREMENTS

- (a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which 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 which (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.

ARTICLE V PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

- (a) **Flexible Spending Accounts.** An Employee who first meets the applicable eligibility requirements of Section 2.1 on or after the effective date of this restatement may elect to participate in the Health Flexible Spending Account or Dependent Care Flexible Spending Account for all or the remainder of the Plan Year, provided he elects to do so within 31 days. Notwithstanding the foregoing, because of the administrative processes involved with enrollment and elections, an Employee who is newly eligible on or after December 1 of a Plan Year will not be able to enroll in a Health Flexible Spending Account or Dependent Care Flexible Spending Account for that Plan Year, but will only be able to enroll in a Health Flexible Spending Account or Dependent Care Flexible Spending Account for the immediately following Plan Year. An Employee who is eligible for both the Health Care Flexible Spending Account and the Limited Purpose Flexible Spending Account may elect to enroll in one or the other, but not both.
- (b) **Health Savings Accounts.** An Employee who first meets the eligibility requirements of Sections 2.1(a) and 2.1(c) on or after the effective date of this restatement shall automatically be enrolled in the Health Savings Account benefit and may elect to make Salary Redirection contributions to the Health Savings Account for all or the remainder of the Plan Year, provided he elects to do so within

31 days. Notwithstanding the foregoing, because of the administrative processes involved with enrollment and elections, an Employee who is newly eligible on or after December 1 of a Plan Year will not be eligible for or enrolled in the Health Savings Account benefit for the Plan Year in which the Employee was hired, but if the Employee meets the eligibility requirements of Section 2.1 for the immediately following Plan Year, the Employee shall be enrolled in the Health Savings Account benefit for the immediately following Plan Year.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, 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 and not enrolling in a High Deductible Health Plan sponsored by the Employer;
- (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 and Section 5.5.

5.3 FAILURE TO ELECT

- (a) **Flexible Spending Accounts.** Any Participant failing to complete an election of benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Health Flexible Spending Account or Dependent Care Flexible Spending Account for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year, except as described in Section 5.4.
- (b) **Health Savings Account.** A Participant who is enrolled in a High Deductible Health Plan sponsored by the Employer shall be automatically enrolled in the Health Savings Account benefit for purposes of Employer Contributions. Any Participant failing to complete an election of benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to make Salary Redirection Contributions to the Health Savings Account for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year, except as described in Section 5.5.

5.4 CHANGE IN STATUS

- (a) **Applicability.** This Section applies to the Health Flexible Spending Account and Dependent Care Flexible Spending Account benefits only.
- (b) **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 changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

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

- (1) **Legal Marital Status:** events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;
- (2) **Number of Dependents:** Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, placement of a foster child, 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 Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

(c) **Special enrollment rights.** Notwithstanding subsection (b), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the 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.

(d) **Qualified Medical Support Order.** Notwithstanding subsection (b), 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.

(e) **Medicare or Medicaid.** Notwithstanding subsection (b), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). 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 if a benefit package option under the Plan provides similar coverage.

(f) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(g) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(h) **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 Section 152(a)(1) through (8).

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

Election changes must be submitted within 31 days after the date of the event, except as specified in 5.4(c). Notwithstanding the foregoing, in the case of a birth, adoption, placement for adoption, or divorce, the Participant shall have up to 60 days after the birth, adoption, placement for adoption, or divorce to notify the Administrator of the change in status and make a new benefit election.

5.5 PERIODIC CHANGES

A Participant in the Health Savings Account benefit may make a new election with respect to Salary Redirection contributions each pay period, using such change of election procedures as may be established by the Administrator from time to time.

ARTICLE VI HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This 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 Health Flexible Spending Account may submit claims for the reimbursement of applicable 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.

This Health Flexible Spending Account is a group health plan that is subject to ERISA. This Article VI, together with all relevant provisions of this Plan and of the Wrap Plan, constitutes the written plan document required by ERISA Section 402 and the summary plan description required by ERISA Section 102.

6.2 DEFINITIONS

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

(a) **“Health Flexible Spending Account”** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars 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. Subject to the provisions of this Plan, there are two types of Health Flexible Spending Accounts under this Plan:

(1) A **“Health Care Flexible Spending Account”** may reimburse all “Medical Expenses” as defined below.

(2) A **“Limited Purpose Flexible Spending Account”** may reimburse a “Medical Expense” incurred for vision care or dental care and may reimburse “Post-Deductible Medical Expenses.”

(b) **“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 5 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).

Effective January 1, 2020, subsection 6.2(c) is deleted in its entirety and replaced with the following:

(c) **“Medical Expense”** 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. A Medical Expense must be incurred during the applicable Coverage Period; with respect to amounts carried over from one Plan Year to the following Plan Year pursuant to Section 6.5(e), the applicable Coverage Period begins on the first day of the latter Plan Year. “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.

Notwithstanding the foregoing, “Medical Expense” does not include:

(1) 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; or

(2) “qualified long-term care services” as defined in Code Section 7702B(c).

(d) “**Post Deductible Medical Expense**” means a Medical Expense (as defined above) that is incurred by a Participant who is enrolled in a High Deductible Health Plan sponsored by the Employer and is incurred after the Participant:

(1) if enrolled in employee-only coverage, has met the individual deductible in such High Deductible Health Plan during the Coverage Period; or

(2) if enrolled in other than employee-only coverage, has met the family deductible in such High Deductible Health Plan during the Coverage Period.

(e) 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.

6.3 ELIGIBILITY, PARTICIPATION, AND ENROLLMENT

(a) Each Eligible Employee may elect to participate in the Limited Purpose Flexible Spending Account benefit, subject to subsection (b).

(b) An Eligible Employee shall not be permitted to participate in both the Limited Purpose Flexible Spending Account and the Health Care Flexible Spending Account at the same time.

(c) A Participant enrolled in a High Deductible Health Plan sponsored by the Employer shall not be eligible for the Health Care Flexible Spending Account benefit.

6.4 FORFEITURES

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 6.8 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.5 LIMITATION ON ALLOCATIONS

(a) **Maximum.** The maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is \$2,750 as of January 1, 2021. For subsequent Plan Years, the maximum amount shall be the adjusted amount described in Section 6.5(c) below or, if lower, the maximum amount communicated to Participants at the time of enrollment.

(b) **Minimum.** The minimum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is \$120.

(c) **Cost of Living Adjustment.** In no event shall the amount of salary redirections on the Health Flexible Spending Account exceed the amount permitted by Code Section 125(i)(2), including any adjustments for increases in the cost-of-living in accordance with Code Section 125(i)(2). The cost-of-living adjustment in effect for a calendar year applies to any Plan Year beginning with or within such calendar year. The dollar increase in effect on January 1 of any calendar year shall be effective for the Plan Year beginning with or within such calendar year. 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).

(d) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the maximum set forth in Section 6.5(a). 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 \$2,750 (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to \$2,750 (as adjusted) under each Employer’s Health Flexible Spending Account.

Effective January 1, 2020, subsection 6.5(e) is deleted in its entirety and replaced with the following:

(e) **Carryover.** A Participant in the Health Flexible Spending Account may carry over unused amounts in the Health Flexible Spending Account remaining at the end of one Plan Year to the immediately following Plan Year if the Participant enrolls in the Health Flexible Spending Account in the immediately following Plan Year. Unused amounts are those remaining after all timely filed claims have been adjudicated and reimbursed. The amount of the carryover shall not be less than \$50 nor more than 20% of the adjusted amount described in Section 6.5(c) above. Amounts in excess of \$500 will be forfeited. The carryover amounts can be used during the following Plan Year for expenses incurred in that Plan Year; if the carryover amount are not exhausted by the end of the Plan Year, they may continue to be carried over, subject to the other terms of this subsection (e). The carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit. The

carryover amounts do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts. The Participant's election to enroll in a Health Care Flexible Spending Account or Limited Purpose Flexible Spending Account in a given Plan Year will apply equally to carryover amounts and salary redirection contributions.

6.6 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this 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 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.

6.7 COORDINATION WITH PLAN

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

6.8 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(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 subject to Section 2.6, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. 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) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund 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 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.

(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 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

6.9 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 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. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.5.

(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, 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

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account 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) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"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.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents 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 incurred for a Qualifying Dependent 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 for a Qualifying Dependent 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 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 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.

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the 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; or

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

This paragraph is effective as of January 1, 2020. Notwithstanding the foregoing, if a Participant has unused amounts that are carried over from the 2020 Plan Year into the 2021 Plan Year as described in Section 7.4, then for the 2021 Plan Year, a "Qualifying Dependent" shall include the Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 14;

(e) 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.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars 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 Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

This paragraph is effective as of January 1, 2020. Any unused amounts remaining in a Participant's Dependent Care Flexible Spending Account at the end of the 2020 Plan Year shall be carried over into the 2021 Plan Year. Unused amounts are those remaining after all timely filed claims have been adjudicated and reimbursed. The carryover amounts can be used during the 2021 Plan Year for expenses incurred in that Plan Year. The carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit. The carryover amounts do not affect the Participant's maximum amount of salary redirection contributions for the 2021 Plan Year to which they are carried over. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts.

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 REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care 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 or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT 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 FORFEITURES

Effective January 1, 2020, the text of Section 7.8 is deleted in its entirety and replaced with the following:

Subject to the carryover described in Section 7.4, the amount in a Participant's Dependent Care 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 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 PAYMENTS

(a) **Plan limits.** Notwithstanding any provision contained in this Dependent Care Flexible Spending Account to the contrary, the following limits apply in addition to the Code limits. The minimum amount that may be allocated to the Dependent Care Flexible Spending Account by a Participant in or on account of any Plan Year is \$120.

(b) **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)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account 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 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.

7.11 COORDINATION WITH PLAN

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

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care 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 and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- (a) The Dependent or Dependents for whom the services were performed;
- (b) The nature of the services performed for the Participant, the cost of 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 Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
- (g) If the services were being performed in a 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 6 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 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

**ARTICLE VIII
HEALTH SAVINGS ACCOUNT**

8.1 ESTABLISHMENT OF ACCOUNT

Subject to Section 5.1(b), when an Eligible Employee enrolls in a High Deductible Health Plan sponsored by the Employer, the Employer shall establish a Health Savings Account, in the name of the Eligible Employee, with a qualified trustee/custodian of the Employer's choice. The Eligible Employee shall be automatically become a Participant enrolled in the Health Savings Account benefit. This Benefit allows the Employer and the Participant to make pretax contributions to the Participant's Health Savings Account.

The Health Savings Account is established and maintained outside of this Plan. The Employer Contributions and Salary Redirection contributions (described below) shall be forwarded to the trustee/custodian. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the Health Savings Account and not in this Plan. The Employer has no authority or control over the funds deposited in a Health Savings Account. Even though this Plan may allow contributions to a Health Savings Account, the Health Savings Account is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

8.2 EMPLOYER CONTRIBUTIONS

Employer contributions will be made as soon as feasible after a Participant is enrolled in the Health Savings Account benefit. The Employer Contribution will be made in full, and will not be prorated, for Eligible Enrollees who begin participating after the first day of the Plan Year. The amount of the Employer Contribution will depend on the Participant's coverage level in the High Deductible Health Plan sponsored by the Employer:

If the Participant is enrolled in the High Deductible Health Plan at this coverage level:	Then the Employer Contribution will be this amount:
Employee Only	\$500
Employee Plus Spouse	\$1,000
Employee Plus Children	\$1,000
Family	\$1,500

If the Participant changes to a higher coverage level in the High Deductible Health Plan during the Plan Year, the Employer will make an additional Employer Contribution, equal to the difference between the Employer Contribution for the lower coverage level and the higher coverage level, as soon as administratively feasible thereafter. (For example, if a Participant initially enrolls in Employee Only coverage, the Employer Contribution will be \$500. If, during the same Plan Year, the Participant changes to Family coverage, the Employer will make an additional Employer Contribution of \$1,000.)

8.3 SALARY REDIRECTION

A Participant may elect to make Salary Redirection contributions to the Health Savings Account established by the Employer pursuant to this Plan. The maximum annual amount that may be elected for Salary Redirection is the statutory amount for Health Savings Account contributions as set forth in Code Section 223, less the amount of the Employer Contribution. Participants who are age 55 or older may contribute an additional catch up contribution as permitted by Code Section 223.

8.4 CLAIMS

The procedure for filing Health Savings Account claims is determined by the Health Savings Account custodian/trustee, not by this Plan.

ARTICLE IX ERISA PROVISIONS

9.1 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 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. 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 references to the pertinent Plan provisions on which the denial is based;
- (2) 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
- (3) 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 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 Flexible Spending Account claims.** If a Participant fails to submit a claim under the Health Flexible Spending Account within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. 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

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 Section 502 of ERISA 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.
- (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 request a review of 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. 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.

A decision on review will be made not later than 60 days after the request for review is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

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.** Subject to the carryover provisions in Section 6.5(e), any balance remaining in the Participant's Health Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and credited to the benefit plan surplus pursuant to Section 6.4 or Section 7.8, whichever is applicable. The previous sentence shall not apply if the Participant made a claim for such Plan Year, in writing, which was 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.

9.2 APPLICATION OF BENEFIT PLAN SURPLUS

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; 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. Amounts credited to the benefit plan surplus may be retained by the Employer, used to defray any administrative costs and experience losses of the Plan, or used to provide additional benefits under the Plan.

9.3 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.

9.4 GENERAL FIDUCIARY RESPONSIBILITIES

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

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

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent 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.

9.5 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 X ADMINISTRATION

10.1 PLAN ADMINISTRATION

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. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer or be removed by the Employer by delivery of written notice of removal, 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 the Act, 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 Employees entitled to participate in the Plan. 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.

10.2 EXAMINATION OF RECORDS

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

10.3 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.

10.4 INDEMNIFICATION OF ADMINISTRATOR

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

ARTICLE XI AMENDMENT OR TERMINATION OF PLAN

11.1 AMENDMENT

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

11.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, 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 XII
MISCELLANEOUS**

12.1 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.

12.2 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.

12.3 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.

12.4 EXCLUSIVE BENEFIT

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

12.5 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.

12.6 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.

12.7 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. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

12.8 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.

12.9 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit. 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.

12.10 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 California.

12.11 SEVERABILITY

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

12.12 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.

12.13 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

12.14 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 Regulation 1.125-3.

12.15 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 Uniform Services Employment and Reemployment Rights Act (USERRA) and the regulations thereunder.

12.16 HIPAA

Notwithstanding anything in the Plan to the contrary, the Health Flexible Spending Account shall be operated in accordance with HIPAA. The Wrap Plan (of which this Plan is a component) has been amended in compliance with 42 USC § 164.504(f).

IN WITNESS WHEREOF, this Plan document is hereby executed this 12 day of April, 2021.

NortonLifeLock Inc.



By:
Andrea Oswald
Head of Total Rewards

APPENDIX A CONTINUATION COVERAGE NOTICE

Introduction

This notice applies only to the Health Flexible Spending Account (“Health FSA”) portion of this Plan. If you have a Health FSA under this Plan, then read this entire notice carefully.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of Health FSA coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Health FSA coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice.

After a qualifying event, and after any required notice of that event has been properly provided, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Health FSA is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA coverage for the Health FSA will be offered only to qualified beneficiaries who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the COBRA premiums that will be charged for the remainder of the plan year for the Health FSA.

What are the Qualifying Events and Who are the Qualified Beneficiaries?

If you are an employee, you will become a qualified beneficiary if you lose your Health FSA coverage because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your Health FSA coverage because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than his or her gross misconduct; or
4. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose Health FSA coverage because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee’s hours of employment are reduced;
3. The parent-employee’s employment ends for any reason other than his or her gross misconduct;
4. The parents become divorced or legally separated; or
5. The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify Administrator. **The Plan requires you to notify the Administrator within 60 days after the qualifying event occurs.** You must provide this notice **in writing** to: HealthEquity/WageWorks, Inc., P.O. Box 226101, Dallas, TX 75222-6101.

How is COBRA Coverage Provided?

Once the Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Each qualified beneficiary will receive an Election Notice, which must be completed and returned within 60 days. COBRA continuation coverage is a temporary continuation of coverage. COBRA coverage under this Plan will end on December 31 of the year in which the qualifying event occurs. If you have unused funds remaining in your Health FSA after reimbursement for expenses incurred during the Plan Year of the qualifying event, the unused funds will be forfeited.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

If you have COBRA questions, please contact HealthEquity/WageWorks, Inc. by phone at 1-877-630-7215 or by mail at HealthEquity/WageWorks, Inc., P.O. Box 226101, Dallas, TX 75222-6101.