

**SMITHS GROUP SERVICES CORPORATION
FLEXIBLE BENEFITS PLAN**

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TABLE OF CONTENTS**

**ARTICLE I
DEFINITIONS**

**ARTICLE II
PARTICIPATION**

2.1	ELIGIBILITY	7
2.2	EFFECTIVE DATE OF PARTICIPATION	7
2.3	APPLICATION TO PARTICIPATE.....	7
2.4	TERMINATION OF PARTICIPATION.....	7
2.5	TERMINATION OF EMPLOYMENT	7
2.6	DEATH.....	8

**ARTICLE III
CONTRIBUTIONS TO THE PLAN**

3.1	SALARY REDIRECTION	8
3.2	APPLICATION OF CONTRIBUTIONS	8
3.3	PERIODIC CONTRIBUTIONS	8

**ARTICLE IV
BENEFITS**

4.1	BENEFIT OPTIONS	8
4.2	HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT	9
4.3	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT	9
4.4	HEALTH INSURANCE BENEFIT	9
4.5	HEALTH SAVINGS ACCOUNT BENEFIT.....	9
4.6	NONDISCRIMINATION REQUIREMENTS	9

**ARTICLE V
PARTICIPANT ELECTIONS**

5.1	INITIAL ELECTIONS	10
5.2	SUBSEQUENT ANNUAL ELECTIONS	10
5.3	FAILURE TO ELECT.....	10
5.4	CHANGE IN STATUS.....	10

**ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT**

6.1	ESTABLISHMENT OF PLAN	13
6.2	DEFINITIONS	13
6.3	FORFEITURES	14
6.4	LIMITATION ON ALLOCATIONS	14
6.5	NONDISCRIMINATION REQUIREMENTS	15
6.6	COORDINATION WITH CAFETERIA PLAN.....	15
6.7	HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS	15
6.8	DEBIT AND CREDIT CARDS	16

6.9	QUALIFIED RESERVIST DISTRIBUTIONS	16
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**ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

7.1	ESTABLISHMENT OF ACCOUNT	17
7.2	DEFINITIONS	17
7.3	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS	18
7.4	INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS	18
7.5	DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS	18
7.6	ALLOWABLE DEPENDENT CARE REIMBURSEMENT	19
7.7	ANNUAL STATEMENT OF BENEFITS	19
7.8	FORFEITURES	19
7.9	LIMITATION ON PAYMENTS	19
7.10	NONDISCRIMINATION REQUIREMENTS	19
7.11	COORDINATION WITH CAFETERIA PLAN.....	19
7.12	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS	19

**ARTICLE VIII
BENEFITS AND RIGHTS**

8.1	CLAIM FOR BENEFITS	20
8.2	APPLICATION OF BENEFIT PLAN SURPLUS	22
8.3	NAMED FIDUCIARY	23
8.4	GENERAL FIDUCIARY RESPONSIBILITIES.....	23
8.5	NONASSIGNABILITY OF RIGHTS	23

**ARTICLE IX
ADMINISTRATION**

9.1	PLAN ADMINISTRATION.....	23
9.2	EXAMINATION OF RECORDS.....	24
9.3	PAYMENT OF EXPENSES	24
9.4	INSURANCE CONTROL CLAUSE	24
9.5	INDEMNIFICATION OF ADMINISTRATOR.....	24

**ARTICLE X
AMENDMENT OR TERMINATION OF PLAN**

10.1	AMENDMENT	25
10.2	TERMINATION.....	25

**ARTICLE XI
MISCELLANEOUS**

11.1	PLAN INTERPRETATION	25
11.2	GENDER, NUMBER AND TENSE	25
11.3	WRITTEN DOCUMENT	25
11.4	EXCLUSIVE BENEFIT	25
11.5	PARTICIPANT'S RIGHTS	25
11.6	ACTION BY THE EMPLOYER.....	26

11.7	NO GUARANTEE OF TAX CONSEQUENCES	26
11.8	INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS	26
11.9	FUNDING	26
11.10	GOVERNING LAW.....	26
11.11	SEVERABILITY.....	26
11.12	CAPTIONS.....	26
11.13	CONTINUATION OF COVERAGE (COBRA)	26
11.14	FAMILY AND MEDICAL LEAVE ACT (FMLA).....	26
11.15	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).....	27
11.16	UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)	27
11.17	COMPLIANCE WITH HIPAA PRIVACY STANDARDS	27
11.18	COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.....	28
11.19	MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT.....	28
11.20	GENETIC INFORMATION NONDISCRIMINATION ACT (GINA).....	28
11.21	WOMEN'S HEALTH AND CANCER RIGHTS ACT	29
11.22	NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT.....	29

**SMITHS GROUP SERVICES CORPORATION
FLEXIBLE BENEFITS PLAN**

INTRODUCTION

The Employer adopted this Plan previously and amends and restates this Plan effective August 1, 2023, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. The Plan shall be known as Smiths Group Services Corporation Flexible Benefits Plan (the "Plan"). This Plan is a component plan of the Smiths Group Services Corporation Welfare Plan (the "Welfare 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 9.1 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. The Administrator is also referred to herein as the "Plan Administrator."

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).

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 **"Dependent"** means (a) an Eligible Employee's child (as defined in Code section 152(f)(1)) who, as of the end of the taxable year, has not attained age 27; and (b) a child who is a dependent of the Eligible Employee under Code section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof. Any child to whom Code section 152(e) applies shall be treated as a dependent of both parents for purposes of this subsection. A special definition of "Dependent" applies for purposes of the Dependent Care Flexible Spending Account, as set forth in herein. The SPD for a benefit option the cost of which may be paid on a pre-tax basis through this Plan may impose additional requirements for an individual to be considered a "Dependent" for purposes of coverage and this Plan.

1.8 **"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.

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

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law

employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.10 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.11 **"Employer"** means Smiths Group Services 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 who has adopted the Plan with the consent of Smiths Group Services Corporation.

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

1.13 **"Grace Period"** means, with respect to any Plan Year, the time period ending on the fifteenth day of the third calendar month after the end of such Plan Year, during which Medical Expenses and Employment-Related Dependent Care Expenses incurred by a Participant will be deemed to have been incurred during such Plan Year. Effective August 1, 2024, the Grace Period shall no longer be available.

1.14 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.15 **"Insurer"** means any insurance company that underwrites a Benefit that may be paid for on a pre-tax basis through this Plan or, with respect to any self-funded benefits, the Employer.

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 August 1 and ending July 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.20 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the Benefits described in Section 4.1.

1.21 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

1.22 **"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.

1.23 **"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.

1.24 **"Spouse"** means spouse as determined under Federal law.

ARTICLE II PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the effective date of any election made in accordance with Section 5.1.

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 hereof.

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 pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

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

- (a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.5 or the date the Participant otherwise ceases to be an Eligible Employee;
- (b) **Death.** The Participant's death, subject to the provisions of Section 2.6;
- (c) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2; or
- (d) The date on which the Participant elects to terminate participation in the Plan or fails to pay any required premiums or contributions after any applicable grace period that may be applied by the Administrator for this purpose.

If a Participant fails to meet the definition of Eligible Employee solely on account of an approved leave of absence, he or she may participate in this Plan to the extent provided in the Employer's leave of absence policies, which policies shall comply with all applicable laws.

2.5 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) **Insurance Benefit.** With regard to Benefits provided under Section 4.1 (other than the Dependent Care Flexible Spending Account, discussed below), the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract or self-funded benefit for which premiums have already been paid.
- (b) **Dependent Care FSA.** 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 up to the participant's date of termination through the remainder of the Plan Year in which such termination occurs and submitted within 75 days after the end of the Plan Year, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.
- (c) **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 11.13 of the Plan.

2.6 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. 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.

ARTICLE III CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. 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, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the 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

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

- (1) Health Flexible Spending Account

- (2) Dependent Care Flexible Spending Account
- (3) Insurance Premium Payment Plan
 - (i) Health Insurance Benefit
- (4) Health Savings Account Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

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

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

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

4.4 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to pay the cost of coverage under the Employer's medical, dental and/or vision benefit programs which are part of the Smiths Group Services Corp. Welfare Plan on a pre-tax basis through this Plan.

(b) **Employer selects contracts.** The Employer may select suitable health Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing to participate in such benefit plans. The rights and conditions with respect to the benefits payable from such health Contract shall be determined therefrom.

4.5 HEALTH SAVINGS ACCOUNT BENEFIT

Each Participant may elect to have a portion of his Salary Redirections contributed to a Health Savings Account, as defined in Code Section 223. The amounts contributed shall be subject to the terms of the Health Savings Account Program as established and described in Appendix A hereto.

4.6 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. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

**ARTICLE V
PARTICIPANT ELECTIONS**

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2. If a Participant is enrolled in a default medical benefit option, he or she will be deemed to have made an election to pay the premiums for such coverage on a pre-tax basis through this Plan.

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 timely electing any Benefit options unless the Administrator notifies Participants that a failure to make an election for the Plan Year means the Participant is deemed to have made the same election as was in effect on the last day of the preceding Plan Year in which case such election shall continue for the next Plan Year;
- (c) An Employee who elects not to participate for the Plan Year following the Election Period (or fails to timely make an election) will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

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

5.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the 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.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

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, 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 guidance thereunder, shall qualify as a change in status.

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

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

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

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change 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.

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

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

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

(g) **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.

(h) **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.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **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).

(k) **Health FSA 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.

(l) **Health Savings Account changes.** With regard to the Health Savings Account Benefit specified in Section 4.5, a Participant who has elected to make elective contributions under such arrangement may modify or revoke the election prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder.

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

Conditions for revocation due to reduction in hours of service:

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

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

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

Conditions for revocation due to enrollment in a Qualified Health Plan:

- (1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and
- (2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

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 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.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria 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.
- (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).

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

Over-the-counter medications and menstrual care products as allowed under IRS regulations are reimbursable under this Plan.

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

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

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

6.3 FORFEITURES

(a) For Plan Years that begin prior to August 1, 2024, the amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) 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.

(b) For Plan Years that begin on or after August 1, 2024, if, following the end of the Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof), the Plan determines that a Participant has an unused balance in his or her Health Flexible Spending Account, such unused amount, up to the maximum permitted under the Code, shall be carried over to the Participant's Health Flexible Spending Account for the following Plan Year (a "Health FSA Carryover"). An Eligible Employee must elect (or be deemed to have elected) to participate in the Health Flexible Spending Account for the next Plan Year to be eligible for the Health FSA Carryover. The Health FSA Carryover shall be available for the reimbursement of Medical Expenses incurred in such next Plan Year while the individual remains a Health Flexible Spending Account Participant. Any unused amount in excess of the Health FSA Carryover shall be forfeited and credited to the benefit plan surplus, subject to the Plan's claims and appeals procedures. In addition, any unused amount at the time participation in the Plan ceases (such as upon termination of employment) shall be forfeited and credited to the benefit plan surplus, unless the individual elects COBRA continuation coverage. The Health FSA Carryover amount shall be interpreted and administered in a manner consistent with applicable guidance that has been or may be issued by the IRS.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary reductions that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is the statutory amount under Code Section 125(i)(2), as adjusted for increases in the cost of living. 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).

(b) **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 statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Flexible Spending Account.

(c) **Grace Period.** Payment of expenses from a previous year in the first months of the next Plan Year, the limit above applies to the Plan Year including the Grace Period (if available). Amounts carried into the next Plan Year as part of the Grace Period (if available) shall not affect the limit for that next Plan Year.

6.5 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. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria 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 Cafeteria Plan.

6.7 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 including the Grace Period (if available) shall be reimbursed during the Plan Year subject to Section 2.5, 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) **Grace Period.** Notwithstanding anything in this Section to the contrary, Medical Expenses incurred during the Grace Period (if available), up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Grace Period relates. Effective August 1, 2024, the Grace Period shall no longer be available, and Medical Expenses must be incurred during the Plan Year in order to be reimbursed from the remaining account balance for that Plan Year.

(e) **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 75 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

6.8 DEBIT AND CREDIT CARDS

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

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that 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 6.4.

(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, menstrual care products and 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.

6.9 QUALIFIED RESERVIST DISTRIBUTIONS

(a) **Qualified Reservist Distribution.** A Participant may request a Qualified Reservist Distribution, provided the following provisions are satisfied. "Qualified Reservist Distribution" means any distribution to a Participant of all or a portion of the balance in the Participant's Health Flexible Spending Account if:

- (1) Such Participant was an individual who was (by reason of being a member of a reserve component (as defined in Section 101 of Title 37, United States Code)) ordered or called to active duty for a period of 180 days or more or for an indefinite period.

- (2) A Participant may have been called prior to June 18, 2008, provided the individual's active duty continues after June 18, 2008 and the period of duty complies with subsection (a).
- (3) The distribution is made during the period beginning on the date of the order or call that applies to the Participant and ending on the last day of the Plan Year (or Grace Period, if available) which includes the date of such order or call.
- (4) The Qualified Reservist Distribution option is offered to all Participants who qualify under this Article.
- (5) Qualified Reservist Distributions may only be made if the Participant is ordered or called to active duty, not the Participant's spouse or dependents.
- (6) Under Section 101 of the Title 37 of the United States Code, "reserve component" means: (1) the Army National Guard, (2) the Army Reserve, (3) the Navy Reserve, (4) the Marine Corps Reserve, (5) the Air National Guard, (6) the Air Force Reserve, (7) the Coast Guard Reserve, or (8) the Reserve Corps of the Public Health Service.
- (b) **Conditions:** The following conditions apply:
- (1) The Employer must receive a copy of the order or call to active duty and may rely on the order or call to determine the period that the Participant has been ordered or called to duty.
- (2) Eligibility for a Qualified Reservist Distribution is not affected if the order or call is for 180 days or more or is indefinite, but the actual period of active duty is less than 180 days or is changed otherwise from the order or call.
- (3) If the original order is less than 180 days, then no Qualified Reservist Distribution is allowed. However, if subsequent calls or orders increase the total days of active duty to 180 or more, then a Qualified Reservist Distribution will be allowed.
- (c) **Amount:** The amount a Participant may be reimbursed from the Health Flexible Spending Account is the amount contributed by the Participant to the Health Flexible Spending Account as of the date of the distribution request, less any reimbursements received as of the date of the distribution request.
- (d) **Procedure.** The Employer must specify a process for requesting the distribution. The Employer may limit the number of distributions processed for a Participant to 2 per Plan Year. The distribution request must be made on or after the call or order and before the last day of the Plan Year (or Grace Period if available). The QRD shall be paid within a reasonable time but in no event more than 60 days after the date of the request.
- (e) **Claims.** Claims incurred prior to the date of the request of the distribution shall be paid as any other claim. Claims incurred after the date of the distribution shall be paid on submission as any other claim.

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 Cafeteria 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).

(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.

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

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 subject to the Plan's claims and appeals procedures. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

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

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. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria 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 Cafeteria 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 including the Grace Period (if available) 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) **Grace Period.** Notwithstanding anything in this Section to the contrary, Employment-Related Dependent Care Expenses incurred during the Grace Period (if applicable), up to the remaining account balance, shall also be deemed to have been incurred during the Plan Year to which the Grace Period relates. Effective August 1, 2024, the Grace Period shall no longer be available, and Employment-Related Dependent Care Expenses must be incurred during the Plan Year in order to be reimbursed from the remaining account balance.
- (j) **Claims for reimbursement.** If a Participant fails to submit a claim within 75 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

ARTICLE VIII BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

- (a) **Cafeteria Plan claims.** Any claim relating to the pre-tax payment of premiums shall be made to the Employer. If the Employer denies any claim, the Participant or beneficiary shall follow the Employer's claims review procedure.
- (b) **Dependent Care Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account Benefits that is not timely submitted 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.

(c) **Appeal.** 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.

(d) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) **Health FSA claims.** Any claim under the Health Flexible Spending Account that is not timely submitted 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
Review of claim denial	60 days

The Plan 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 60 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

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

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

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

(f) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account, subject to the Health FSA Carryover described in Section 6.3, or the Participant's Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year and Grace Period (if available) shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because 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.

(g) **Discretionary Authority.** The Administrator (and its delegate) shall have the exclusive discretionary authority to make decisions or determinations that are contemplated by (or permissible under) the terms of this Plan. This discretionary authority includes the right to construe and to interpret the Plan, to determine entitlement to eligibility, coverage and benefits. All decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on judicial review, unless it is shown that the interpretation or determination was arbitrary and capricious (i.e., an abuse of discretion). Benefits under this Plan will be paid only if the Administrator (or its delegate) determines in its discretion that the Claimant is entitled to them.

(h) **Additional Requirements.** The provisions of the Smiths Group Services Corporation Welfare Plan, of which this Plan is a part, apply to this Plan, including but not limited to the provisions requiring the exhaustion of claims procedures prior to bringing legal action, the limitations on actions, and the restrictions on venue.

8.2 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. Except as provided in Section 6.3, 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 in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan. No amounts attributable to the Health Savings Account shall be subject to the benefit plan surplus.

8.3 NAMED FIDUCIARY

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

8.4 GENERAL FIDUCIARY RESPONSIBILITIES

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

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

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

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

8.5 NONASSIGNABILITY OF RIGHTS

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

ARTICLE IX ADMINISTRATION

9.1 PLAN ADMINISTRATION

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

9.2 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.

9.3 PAYMENT OF EXPENSES

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

9.4 INSURANCE CONTROL CLAUSE

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

9.5 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 X AMENDMENT OR TERMINATION OF PLAN

10.1 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.

10.2 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. Benefits under any Contract shall be paid in accordance with the terms of the Contract.

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 XI MISCELLANEOUS

11.1 PLAN INTERPRETATION

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

11.2 GENDER, NUMBER AND TENSE

Wherever any words are used herein in one gender, they shall be construed as though they were also used in all genders in all cases where they would so apply; 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; and whenever any words are used herein in the past or present tense, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

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

11.4 EXCLUSIVE BENEFIT

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

11.5 PARTICIPANT'S RIGHTS

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

11.6 ACTION BY THE EMPLOYER

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

11.7 NO GUARANTEE OF TAX CONSEQUENCES

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

11.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

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

11.9 FUNDING

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

11.10 GOVERNING LAW

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

11.11 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.

11.12 CAPTIONS

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

11.13 CONTINUATION OF COVERAGE (COBRA)

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.

11.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

11.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

11.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

11.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

- (2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
- (5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.18 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

- (a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.17.

11.19 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

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

11.20 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

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

11.21 WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

11.22 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

11.23 Written Notice

Any written notice provided under this Plan shall be deemed received by a Participant or Eligible Employee if sent by regular mail, postage prepaid, to the last address of the Participant or Eligible Employee on the records of the Plan Administrator.

11.24 Information to be Furnished

Participants shall provide the Employer and Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

11.25 Clerical Error/Delay

Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan and the applicable benefit plan regardless of whether any contributions with respect to a Participant have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

11.26 Waiver

No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppels against enforcing any provision of the Plan, except in writing by Plan Administrator. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Participant other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

IN WITNESS WHEREOF, this Plan document is hereby executed this _____ day of _____.

Smiths Group Services Corporation

By _____
EMPLOYER

APPENDIX A

HEALTH SAVINGS ACCOUNT PROGRAM

ARTICLE I

INTRODUCTION

1.1 Purpose and Effect

The provisions of this section, in conjunction with the preceding provisions of the Smiths Group Services Corporation Flexible Benefits Plan, constitute the Smiths Group Services Corporation Health Savings Account Program (“HSA Program”), which is intended to comply with Code Section 223. The purpose of this document is to set forth the provisions governing the operation and administration of the HSA Program, to specify the amount an Eligible Employee may allocate each Plan Year to the HSA, and to describe the HSA Program in further detail.

1.2 Effective Date of Program

The HSA Program is effective as of September 1, 2009.

1.3 Interpretation and Law

The HSA Program is intended to qualify as a health saving account plan under Code Section 223, to comply with the Code and the regulations and rules promulgated thereunder and shall be construed and interpreted in a manner consistent with all relevant provisions of the Code. The HSA Program is not intended to be a welfare benefit plan under ERISA and therefore shall be construed and administered within such intent. Accordingly, administration of the HSA Program is subject to the provisions of the Smiths Group Services Corporation Flexible Benefits Plan.

ARTICLE II

DEFINITIONS

The Smiths Group Services Corporation Flexible Benefits Plan (“the Flexible Benefits Plan”) sets forth definitions for this section. Such definitions are incorporated by reference into this section, Health Savings Account Program. In addition, the following words and phrases supplement the definitions set forth in the Flexible Benefits Plan, and as used herein shall have the following meanings unless a different meaning is plainly required by the context:

- 2.1 **Coverage Option** means the amount to be credited to a Participant’s HSA defined in Section 5.2, and elected by a Participant in accordance with the election procedures defined in the Smiths Group Services Corporation Flexible Benefits Plan.
- 2.2 **Family Unit** means a Participant’s “Family Unit” including the Participant’s Spouse and such other Dependents within the meaning of Code Section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof).
- 2.3 **Health Savings Account or HSA** means the account described in Article V of the HSA Program.
- 2.4 **HSA Program** means the Smiths Group Services Corporation Health Savings Account Program as described in this document, together with any and all amendments, supplements and appendices hereto.
- 2.5 **Participant** means each Eligible Employee who participates in the HSA Program in accordance with Article III, who has commenced participation in the HSA Program accordingly and whose participation has not terminated under any other applicable provisions of the HSA Program.
- 2.6 **Plan or Smiths Group Services Corporation Flexible Benefits Plan** means the Smiths Group Services Corporation Flexible Benefits Plan, together with any and all amendments, supplements and appendices attached thereto, providing Employees the opportunity to choose among cash and certain benefits as therein described.
- 2.7 **Qualified Medical Expenses as used in this HSA Program**, means, with respect to a Participant, amounts paid by such Participant for medical care, within the meaning of Code Section 213(d), for the Participant or any other member of the Participant’s Family Unit, for which the Participant is not reimbursed pursuant to any group medical insurance policy or program. Qualified Medical Expenses include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. Qualified Medical Expenses do not include premiums paid for insurance except for premiums for:
- a. Long-term care insurance (subject to Internal Revenue Service mandated limits based on age and adjusted annually);
 - b. Health care continuation coverage (such as coverage under COBRA); and
 - c. Health care coverage while receiving unemployment compensation under federal or state law; Medicare and other health care coverage if you were 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap).

Whenever used in this HSA Program, a masculine pronoun or adjective shall be deemed to include the masculine and feminine gender, and a singular word shall be deemed to include the singular and the plural, unless the context clearly indicates otherwise.

ARTICLE III
PARTICIPATION

3.1 Eligibility

Employees shall be eligible to participate in the HSA Program in accordance with the provisions of the Smiths Group Services Corporation Flexible Benefits Plan. Smiths Group Services Corporation Flexible Benefits Plan shall govern the terms of eligibility and participation generally, supplemented by the provisions of this HSA Program Article III. Only those Eligible Employees who are enrolled in a medical plan Coverage Option that meets the requirements of a "high deductible health plan," as described in Code Section 223(c)(2), and who are not covered by any other health insurance plan that is not a high deductible health plan, (including a plan sponsored by a Spouse's employer that also covers the Eligible Employee), who are not enrolled in Medicare and do not have any other disqualifying coverage and are eligible to contribute to an HSA under Code Section 223, may elect to contribute to a HSA.

3.2 Determination of Eligibility by Plan Administrator

For purposes of making contributions to a HSA on a pre-tax basis, the determination of an Employee's eligibility to contribute shall be made by the Plan Administrator, and the Plan Administrator's good faith determination shall be binding and conclusive upon all persons, taking into account an Employee's participation in a high deductible health plan (as defined by the Code) and in any health care reimbursement account.

3.3 Commencement of Participation

An Eligible Employee shall become a Participant under the HSA Program provided that the Eligible Employee elected to participate by making an election to have a portion of his or her compensation for any Plan Year contributed on a pre-tax basis to his or her HSA. In addition, the Eligible Employee must begin participation in a high deductible health plan (as defined by the Code) and provide proof that he established an HSA with a provider that is maintained outside of the Smiths Group Services Corporation Flexible Benefits Plan.

3.4 Reinstatement of Former Participant

A former Participant shall become a Participant again in accordance with the provisions of Section 3.3 above, if and when he meets the eligibility requirements of Section 3.1 above, and commences participation in accordance with Section 3.3.

3.5 Participation During Leaves of Absence

- a. Any Participant, who is not at work because of a paid or unpaid Leave of Absence may continue his HSA Program election in accordance with the written Leave of Absence policies of the Employer and applicable law. The Participant must continue his high deductible health plan participation in order to continue his HSA contributions under this HSA Program.
- b. Any Participant returning from an unpaid Leave of Absence may resume his HSA contributions.

ARTICLE IV

ELECTION TO CONTRIBUTE TO A HEALTH SAVINGS ACCOUNT

4.1 Election Procedure

An Eligible Employee may elect to make pre-tax contributions to an HSA under the HSA Program. The amount of the pre-tax contributions to an HSA may be increased, decreased or revoked at any time and for any reason, but only on a prospective basis, effective as soon as administratively feasible.

4.2 Contribution Limits

- a. The maximum amount which the Eligible Employee may elect to contribute pre-tax to an HSA in any Plan Year under the HSA Program shall be limited according to federal law and communicated annually by the Plan Administrator.
- b. An Eligible Employee who will attain age 55 before the end of a calendar year may elect to allocate an additional amount per year to his HSA in accordance with Code Section 223(b)(3), in addition to the amounts set out in Code Section 223(b)(2).
- c. In accordance with such election, each payroll period of the Participant, a pro rata portion of such annual elected amount shall be withheld from the Participant's Compensation on a pre-tax basis and as soon as practicable thereafter an identical amount shall be forwarded to the HSA provider for deposit into the Participant's HSA.
- d. Any HSA deposit elections made under this section shall be effective no earlier than the later of the first day of the Plan Year to which the election relates and the first day of the next calendar month following the date the election change was filed by the Plan Administrator (or as soon as administratively practicable thereafter) and shall be subject to modification or revocation by the Participant at any time during the Plan Year.

ARTICLE V

HEALTH SAVINGS ACCOUNTS

5.1 Establishment of Account

The Participant who has elected to contribute to an HSA on a pre-tax basis shall establish and maintain an HSA for each Plan Year. This is an individual account separately established and maintained by a provider outside of the Smiths Group Services Corporation Flexible Benefit Plan. The Employer will not establish or maintain such HSAs but may limit the number of HSA providers to whom it will forward contributions that the Participant makes on a pre-tax basis under the HSA Program. Such HSA providers are not endorsed by the Employer in any manner. The Employer will pay over to the provider of such accounts the contribution amounts elected and reduced from Compensation on behalf of the Participants. The annual contribution for a Participant's HSA benefits shall be equal to the annual benefit amount elected by the Participant, not to exceed any limits required by applicable law, including any applicable catch-up contributions.

The maximum annual contribution allowable by applicable law shall be:

- a. Reduced by any matching (or other) Employer contribution made on the Participant's behalf, if any, made under the Smiths Group Services Corporation Flexible Benefit Plan;
- b. Prorated for the number of months in which the Participant is an HSA-eligible individual (as defined by applicable law);
- c. Any other amount as provided by applicable law.

The Plan Administrator will maintain records to track HSA contributions made by Participants on a pre-tax basis, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

5.2 Provider Agreement; HSA Program Not Intended To Be an ERISA Plan

HSA Program benefits consist solely of the ability to make contributions to an HSA on a pre-tax basis. Terms and conditions of coverage and benefits (e.g., eligible medical expense, claims procedures, etc.) will be provided by and are set forth in the HSA Program, not the Smiths Group Services Corporation Flexible Benefits Plan. The terms and conditions of each Participant's HSA are supplied by the applicable HSA provider.

The HSA Program is not an Employer-sponsored welfare benefits plan under ERISA or any other applicable law. It is a savings account that is established and maintained by an HSA provider outside of the Smiths Group Services Corporation Flexible Benefits Plan to be used primarily for reimbursement of "Qualified Medical Expenses" as set forth in Code Section 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA.

5.3 Employer Contributions

For each Participant who elects coverage under the HSA Program for a Plan Year and establishes an HSA, the Employer shall contribute to the Participant's HSA an amount set forth in the enrollment material applicable for such Plan Year or such other method determined by the Plan Administrator which amount may be based on the number of individuals the Participant enrolls in the high deductible health plan offered by the Employer, the level of coverage elected at annual or initial enrollment or as otherwise set forth in the enrollment material or communicated to the Participant. If the HSA Participant is not eligible for an HSA under the Code or fails to complete any forms or provide any information requested by the qualified trustee/custodian within the required period but not later than December 31 of the Plan Year in which the HSA Participant elects coverage, the HSA Participant shall not be entitled to receive the employer contribution.

ARTICLE VI

TERMINATION OF PARTICIPATION

6.1 Effect of Termination

In the event that a Participant ceases to be a Participant in the HSA Program any election to make contributions pre-tax to an HSA under the Smiths Group Services Corporation Flexible Benefits Plan shall terminate. However, the Participant will maintain ownership of his HSA.