ST. FRANCIS HEALTH SERVICES OF MORRIS, INC.
SELECTACCOUNT
FLEXIBLE BENEFIT PLAN

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ARTICLE I
DESCRIPTION AND PURPOSE

1.1. Plan Name and Purpose.

1. The Plan name is the "St. Francis Health Services of Morris, Inc. SelectAccount Flexible Benefit Plan."

2. This instrument, together with the applicable Benefit Option Summaries and the Plan Specifics, constitute the Plan Document.

3. This Plan is intended to qualify as a "cafeteria plan" under Code Section 125.

4. The purpose of this Plan is to permit Eligible Employees to choose to make Payroll Contributions on a pre-tax basis to pay for Qualified Benefits.

1.2. Plan Benefits.

The Qualified Benefits available under this Plan are (only the boxes that are checked apply):

☒ Pre-Tax Premium Benefit. The Pre-Tax Premium component is intended to permit Eligible Employees to pay the Premiums for Company-Sponsored Health Insurance elected by the Eligible Employee on a pre-tax basis. The terms and conditions of the Company-Sponsored Health Insurance Coverage, including eligibility for coverage, the benefits provided, and eligibility for benefits, are as provided in the plans or policies for the Company-Sponsored Health Insurance Coverage and are not governed by this Plan.

☒ Premium Reimbursement Account. The Premium Reimbursement Account component is intended to qualify as "employer-provided coverage under an accident or health plan" under Code section 106. The terms and conditions of the Other Health Insurance Coverage, including eligibility for coverage, the benefits provided, and eligibility for benefits, are as provided in the plans or policies for the Other Health Insurance Coverage and are not governed by this Plan. The Company does not sponsor, administer have any connection to or responsibility for the Other Health Insurance Coverage.

☒ Medical Flexible Spending Account. The Medical FSA component is intended to qualify as a "self-insured medical reimbursement plan" under Code section 105 and the Medical Expenses reimbursed from such Accounts are intended to be excludable from Participants' incomes under Code section 105(b).

☒ Dependent Care Flexible Spending Account. The Dependent Care FSA component is intended to qualify as a "dependent care assistance plan" under Code section 129 and the Dependent Care Expenses reimbursed from such Accounts are intended to be excludable from Participants' incomes under Code section 129.

☒ Health Savings Account. The Health Savings Account ("HSA") component is intended to qualify as a Health Savings Account under Code section 223.

Only the sections of this Plan Document that relate to the Qualified Benefits selected will be given effect.

ARTICLE II
DEFINITIONS AND INTERPRETATIONS

As used in this instrument, unless the context otherwise indicates, the terms defined in this Plan will have the meaning given them in the Plan Specifics or the applicable Option Summary, provided that each of the following terms shall have the meaning given below.

2.1. Affiliate or Affiliated Organization.

The Employer and any other corporation, trade or business which is under common control with the Employer under the provisions of section 414 of the Code. Unless specifically provided otherwise, such corporation, trade or business shall be deemed an Affiliate for all purposes, only from the date it came under the common control with the Employer. The term Affiliate shall include for all purposes of this Plan an affiliated service group as defined in section 414(m) of the Code and any other entity required to be aggregated with the Employer pursuant to regulations under section 414(o) of the Code.

2.2. Account.

A bookkeeping account to which Payroll Contributions are credited. A separate bookkeeping account is established for each Option elected by the Participant. A Participant's Account is charged as benefits are used.

2.3. Administrator or Plan Administrator.

The person or entity performing the administrative activities of the Plan. To the extent the Plan Administrator has delegated administrative activities to the Claims Administrator, the term "Administrator" may mean Claims Administrator.

2.4. Annual Contribution Election.

The amount elected by a Participant to be allocated to an Account for an entire Plan Year (or the Participant's Period of Coverage, if less than the Plan Year).

2.5. Choice Medical FSA.

A Medical FSA that includes a general-purpose FSA that reimburses all Eligible Medical Expenses and an HSA-Compatible Medical FSA.

2.6. Claims Administrator.

The person or entity performing claims administration and other administrative activities on behalf of the Plan. The Claims Administrator is named in the Plan Specifics.

2.7. Claims Submission Period.

The period stated in the Plan Specifics within which a claim must be submitted to the Claims Administrator to be eligible for reimbursement.

2.8. COBRA.

ERISA sections 601 through 608 and section 4980B of the Code.

2.9. Code or Internal Revenue Code.

The Internal Revenue Code of 1986, as amended. Any reference to a section of the Code refers to that section of the Internal Revenue Code of 1986, or the corresponding section of the Code as amended from time to time.

2.10. Company.

The company identified in the Plan Specifics and its successors and assigns.

2.11. Company-Sponsored Health Insurance or Company-Sponsored Health Insurance Coverage.

Coverage an employee has elected under a Company-sponsored health plan, whether insured through an insurance company or self-insured by the Company (benefits paid from general corporate assets), excluding the Medical FSA. The Company-sponsored health plans are listed in the Plan Specifics.

2.12. Compensation.

The amount that, if the Participant did not participate in the Plan, would be reportable by the Employer as the Participant's "wages" for such period for federal income tax purposes, excluding non-cash benefits and any items not payable on a regular payroll date basis.

2.13. Debit Card.

A card issued by the Administrator which permits conditional reimbursements for medical expenses to occur at the time the expense is incurred. A Participant is obligated to comply with all terms and conditions imposed on the use of a debit card and the expense must qualify as a Medical Expense under the terms of the Plan.

2.14. Dependent.

1. Generally, a person who qualifies as a "dependent' of the Participant under the relevant provision of the Code. The requirements that must be met for a person to qualify as the Participant's dependent differ depending on the type of benefit.

2. For a Pre-Tax Premium, Premium Reimbursement Account, Medical FSA or HSA, the term means a "dependent' within the meaning of Code sections 105 and 106.

3. For a Dependent Care FSA, the term means a Qualifying Individual. The term "Qualifying Individual" will be defined and construed in accordance with Code sections 129 and 21.

2.15. Dependent Care Expense.

An expense a Participant incurs for dependent care provided to a Qualified Individual that meets all of the requirements necessary to be eligible for reimbursement under this Plan and the Dependent Care Plan.

2.16. Dependent Care FSA.

The Account from which a Participant's Dependent Care Expenses is reimbursed.

2.17. Dependent Care Plan.

The Company's Dependent Care Plan, as set forth in the Dependent Care FSA Summary and this Plan Document.

2.18. Election Change Event.

An event permitting an election change as outlined in the Plan.

2.19. Eligible Employee.

1. An Employee who meets the eligibility requirements stated in the Plan Specifics and the applicable Option Summary.

2. No judicial or administrative reclassification or reclassification by the Employer, of a person as a common-law employee or otherwise Eligible Employee will be applied to grant retroactive eligibility to any person under this Plan.

2.20. Eligible Expense.

An expense that meets all of the requirements to be eligible for reimbursement under the Plan and the applicable Option.

2.21. Employee.

An individual, who is employed by a Participating Employer, classified by the Employer as a common-law employee under the Employer's employment and payroll practices and employed within the United States or is a United States expatriate.

2.22. Employer or Participating Employer.

The Company or any Affiliated Organizations and their successors and assigns, if any, that have adopted the Plan with the Company's consent. Any of those entities may be considered the "Employer" when that term is used in the Plan. The plural use of the term will include the Company and all those participating employers.

2.23. ERISA.

The Employee Retirement Income Security Act of 1974, as amended from time to time.

2.24. Excluded Individual.

An individual excluded from participation in the Plan as stated in the Plan Specifics. An Excluded Individual cannot be an Eligible Employee.

2.25. FMLA Leave.

A leave of absence taken by a Participant pursuant to the Family and Medical Leave Act of 1993, as amended from time to time.

2.26. High Deductible Health Plan or HDHP.

A health plan described in Code section 223(c)(2).

2.27. HIPAA.

The Health Insurance Portability and Accountability Act of 1996, as amended.

2.28. HSA-Compatible Medical FSA.

A Medical FSA that only permits reimbursement of (A) vision and dental Eligible Medical Expenses; and/or (B) Eligible Medical Expenses once the deductible for the High Deductible Health Plan HSA been satisfied, as indicated in the Medical FSA Summary of Benefits.

2.29. HSA or Health Savings Account.

A tax-favored individual account to be used in conjunction with a High Deductible Health Plan to pay Medical Expenses not covered by the High Deductible Health Plan.

2.30. Medical Expense.

An expense incurred by the Participant for medical care within the meaning of Code section

213(d) for the Participant or his or her spouse or Dependent that is eligible for reimbursement from a Medical FSA or HSA pursuant to the applicable Code section and regulations, Option Summary and Plan Rules.

2.31. Medical FSA.

The flexible spending Account from which a Participant's Medical Expenses is reimbursed.

2.32. Open Enrollment or Open Enrollment Period.

The period preceding each Plan Year, as designated by the Plan Administrator, during which Eligible Employees may make elections for Plan benefits to be effective for such Plan Year.

2.33. Option or Benefit Option.

A Qualified Benefit under this Plan.

2.34. Other Health Insurance or Other Health Insurance Coverage.

Individual or group health plan coverage (whether insured through an insurance company or self-insured) for the employee, his or her spouse, and his or Dependents obtained by the employee or his or her spouse.

2.35. Participant.

An Eligible Employee who has satisfied any Service Requirement and enrolled in the Plan in the manner required by the Plan Administrator.

2.36. Payroll Contributions.

Participant contributions for benefits elected under the Plan taken from the Participant's Compensation.

2.37. Payroll Period.

A payroll period of the Employer in which, under the Employer's standard payroll practices, charges for Plan benefits payable by an Eligible Employee are normally deducted from his or her pay.

2.38. Period of Coverage.

The period during a Plan Year in which a Participant is covered under the Plan. When participation ends, the Participant's Period of Coverage will also end unless the Participant continues coverage as provided under the Plan.

2.39. Plan.

The Company's SelectAccount Flexible Benefit Plan, as amended from time to time.

2.40. Plan Rules.

Rules established by the Plan Administrator or Claims Administrator with respect to administration of the Plan. The Plan Administrator or Claims Administrator may implement or change a Plan Rule by a written instrument or by practice without prior notice to any person**.**

2.41. Plan Specifics.

The document that states the Plan-identifying information and Company-specific Plan terms.

2.42. Plan Year.

The annual period indicated in the Plan Specifics.

2.43. Premium.

The amount that, without regard to this Plan, would be required to be paid by a Participant for Company-Sponsored Health Insurance Coverage elected by the Participant or Other Health Insurance Coverage obtained by the Participant. To be covered, Premiums must eligible for payment through the Pre-Tax Premium Benefit or Premium Reimbursement Account pursuant to the applicable Code section and regulations, Option Summary and Plan Rules.

2.44. Premium Reimbursement Account.

The Account from which a Participant's Premiums for Other Health Insurance Coverage is reimbursed.

2.45. Pre-Tax Premium Benefit or Pre-Tax Premium.

The ability for a Participant to pay Premiums for Company-Sponsored Health Insurance on a pre-tax basis through this Plan.

2.46. Qualified Benefits.

The benefits provided under this Plan that are listed in section 1.2.

2.47. Qualifying Election Change.

An election change made due to an Election Change Event that is consistent with the election change as required by the Plan and IRS regulations.

2.48. Qualifying Individual.

In general, a Dependent of a Participant who is under the age of thirteen or a Participant's spouse or Dependent of any age who is physically or mentally incapable of self care. A detailed

definition of this term is provided in the Summary for the Dependent Care FSA. Only expenses incurred for the care of a Qualifying Individual are eligible for reimbursement from the Dependent Care FSA.

2.49. Service Requirement.

The period an Eligible Employee must be employed before he or she is permitted to enroll in and participate in the Plan as stated in the Plan Specifics.

2.50. Similar Coverage Option.

Coverage for the same category of benefits for the same individuals. The coverage can be provided under the plan of the Employer or the plan of a Participant's spouse's or Dependent's employer. This term is relevant with respect to change in cost or coverage Election Change Events.

2.51. Summary.

The Summary document for a Benefit Option. The Summary and Plan Specifics serve as the Summary Plan Description for an ERISA-governed Option.

ARTICLE III
PARTICIPATION

3.1. Eligibility to Participate.

All Eligible Employees who have satisfied the Service Requirements are eligible to participate in the Plan.

3.2. Terms and Conditions of Participation.

The terms and conditions of participation, including commencement, termination, and continuation of participation, for an Option are as provided in the Summary for that Option.

ARTICLE IV
PLAN BENEFITS AND FUNDING

4.1. Plan Benefits.

The Plan provides the Qualified Benefits selected in section 1.2. Additional terms and conditions applicable to each Option are as described in the Summary for the Option.

4.2. Funding of Plan Benefits.

Election amounts will be funded through Participant Payroll Contributions made on a Payroll Period basis on behalf of Eligible Employees. Any remaining Compensation will be paid to the Participant in cash, subject to such other charges as may be imposed on such Compensation. No separate fund or trust is maintained to pay Plan benefits, all of which are paid from the general assets of the Company.

4.3. Employer Contribution.

If an Employer contribution is made, the Employer will contribute an equal amount to each Participant in the same Eligible Employee category who participates the entire Plan Year, provided that contributions made for highly compensated employees, as defined by Code section 414(q), can be lower than non-highly compensated employees in the same Eligible Employee category. If a Participant's Period of Coverage is less than a Plan Year, the amount will be adjusted accordingly. The Employer contribution, if any, is stated in the *Plan Specifics*.

4.4. Participant's Account.

1. An "Account," with respect to a Participant, is the bookkeeping reserve account or subaccount, as the context may require, used to track allocation and payment of Plan benefits.

2. The Administrator will establish and maintain an Account in the name of each Participant.

3. The Administrator will establish and maintain under each Participant's Account a subaccount for each Option elected by the Participant.

4. Each Participant's Account will be credited and debited in accordance with the remaining provisions of this Article.

4.5. Allocation to Accounts.

Allocations to the Participant's Account will be made proportionately on a Payroll Period basis throughout the Plan Year (or the Participant's Period of Coverage, if less than the Plan Year) except as otherwise deemed appropriate by the Administrator.

4.6. Payments from Accounts.

1. A Participant's Account will be debited with the amount of each payment of Plan benefits. Payments will be debited as of the date they are made.

2. Amounts allocated to a Participant's Pre-Tax Premium Benefit Account will be paid to the insurer, on a monthly basis or as otherwise required by the terms of the Company-Sponsored Health Insurance, provided that the Premium payment will not exceed the credit balance of the Participant's Pre-Tax Premium Benefit Account as of the date the Premiums payable from such Account are paid.

3. Reimbursements to Participants for the cost of Premiums from a Premium Reimbursement Account will be made upon submission of a proper claim for reimbursement pursuant to the procedure described in the Summary. The Administrator may prescribe the minimum reimbursement amount that will be paid and the frequency and timing of reimbursement payments. The amount contributed to a Participant's Premium Reimbursement Account at the time a claim is paid will be available to the Participant for reimbursement.

4. Reimbursements to Participants for the cost of Eligible Expenses from a Medical FSA or Dependent Care FSA will be made upon submission of a proper claim for reimbursement pursuant to the procedure described in the Summary. The Administrator may prescribe the minimum reimbursement amount that will be paid and the frequency and timing of reimbursement payments.

5. The full Annual Contribution Election to the Participant's Medical FSA for the Plan Year will be available to the Participant from the first day in the Plan Year on which he or she is a Participant.

6. The amount contributed to a Participant's Dependent Care FSA at the time a claim is paid, reduced by amounts previously paid from such FSA for the Plan Year, will be available to the Participant for reimbursement.

7. The amount contributed to a Participant's HSA at the time a claim is paid, reduced by amounts previously paid from such HSA for the Plan Year, will be available to the Participant for reimbursement.

8. If the Participant's benefit election or the Premium payable for the Participant's Company-Sponsored Health Insurance changes during the Plan Year, subsequent allocations to the Participant's Pre-Tax Premium Benefit Account will be changed accordingly.

9. Amounts allocated to one Account cannot be used to provide benefits through another Account.

4.7. Cash.

1. The excess, if any, of (1) the amount of Payroll Contributions allocated to the Participant's Account on any payroll date over (2) the total allocation to the benefit sub-accounts on such date will be paid to the Participant in cash.

2. To the extent that an amount paid from the Participant's Dependent Care FSA is includable in the Participant's gross income for federal income tax purposes, because it exceeds the earned income limitation of Code section 129(b), the Participant fails to comply with the reporting requirements of Code section 129(e)(9) or otherwise, such amount will be treated as a cash distribution to the Participant.

3. To the extent that the Premium for Company-Sponsored Health Insurance Coverage for a non-tax dependent is paid through the Pre-Tax Premium Benefit, the Employer will impute income to the Participant for the fair market value of the coverage.

4.8. Forfeiture of Balance in Accounts (not applicable to HSA).

1. As of the end of the last day of each Plan Year or, if earlier, on termination of participation, the balance of each Participant's Account and subaccounts to which such period applies will be reduced to zero. This reduction will be made retroactively upon the expiration of the Claims Submission Period.

2. Forfeited amounts will be used by the Plan Administrator, in its discretion, to pay the cost of benefits under the Plan, for administrative costs of the Plan, or to provide additional benefits to Participants.

4.9. Status of Accounts.

1. Accruing benefits under this Plan will not vest in a Participant any right, title or interest in or to any assets of the Company.

2. To the extent that benefits accrued to a Participant's Account are not paid when due, the Participant will become a general unsecured creditor of the Company.

3. None of the amounts credited to a Participant's Account will be considered to be held in trust or escrow or as any other form of asset segregation for any Participant.

4. Except for the unsecured contractual right to receive benefits payable under the Plan, no person shall have any right, title or interest in or to the assets of the Employer.

4.10. Distribution of Benefits Upon Termination of Plan or Employer Participation.

If the Company terminates the Plan, or an Employer terminates its participation in the Plan, each affected Participant's Account balance, as of the date of such termination, will continue to be applied in the manner provided in the preceding provisions of this article, but no allocations will be made to the Participant's Accounts following the date of such termination.

ARTICLE V
ELECTIONS

5.1. Benefit Elections.

1. Each Eligible Employee desiring to participate in the Plan and each Participant will make Plan benefit elections in the manner prescribed by the Administrator.

2. The Administrator may impose conditions and limitations on the benefit elections, including the minimum and maximum election amounts, subject to any limitations imposed by law.

3. All Premiums for Company-Sponsored Health Insurance Coverage will be paid pre-tax, except to the extent required to be paid after-tax by the Code or provision of this Plan, unless the Plan Administrator permits Eligible Employees to opt out of participation and the Eligible Employee does so.

4. No Participant will be eligible to participate in the Pre-Tax Premium Benefit Account or Premium Reimbursement Account prior to the date on which the Participant first becomes covered under the Company-Sponsored Health Insurance or Other Health Insurance, as applicable.

5. Benefit elections will be made prospectively.

6. A Participant in the Medical FSA or in the HSA who has Company-Sponsored Health Insurance through Blue Cross Blue Shield of Minnesota may elect to have the Company-Sponsored Health Insurance automatically submit requests for reimbursement of non-covered medical expenses, such as deductible amounts. This "crossover" election will remain in effect until the Participant notifies the Plan Administrator of the revocation of the election.

(G) The Medical FSA for a Plan that offers both Medical FSA and HSA Benefit Options is a Choice Medical FSA. Eligible Employees who elect to participate in both the Plan's Medical FSA Benefit Option and the HSA Benefit Option for the same Plan Year will be limited to an HSA-Compatible Medical FSA. Eligible Employees who do not elect to participate in an HSA through this Plan may still choose to participate in the HSA-Compatible Medical FSA to maintain their eligibility and/or the eligibility of their spouses to participate in HSAs outside of this Plan.

5.2. Limitations on Maximum Annual Contributions Imposed by Law.

1. Dependent Care FSA. The Maximum Contribution Election for the Dependent Care FSA cannot be greater than:

a. $5,000 per household ($2,500 if the Participant is married but filing a separate federal tax return) or, if less,

b. the lesser of the Earned Income of the Participant and, if the Participant is married, the Earned Income of the Participant's spouse.

2. HSA. The maximum contribution election for the Health Savings Account is the product of $1/12^{th}$ of the annual maximum multiplied by the number of months during the Plan Year on the first day of each of which the Participant is covered under a High Deductible Health Plan and is otherwise eligible to contribute to an HSA. A Participant who is eligible to contribute to an HSA as of December 1 will be allowed to make the entire annual maximum contribution election for that year as long as the High Deductible Health Plan is maintained through December of the following year.

a. The annual maximum is the amount prescribed in Code section 223(b)(2)(A)(ii) if the Participant has self-only coverage under the High Deductible Health Plan and the amount prescribed in Code section 223(b)(2)(B)(ii) if the Participant has family coverage under the High Deductible Health Plan.

b. The maximum contribution for a Participant who has attained age 55 before the end of a taxable year is increased by the amount specified in Code section 223(b)(3)(B).

3. The Plan Administrator can reduce an election that exceeds the Maximum Contribution Election to the Maximum Contribution Election.

5.3. Time of Election.

A Participant's election with respect to a Plan Year will be made during the Open Enrollment Period for such Plan Year and will remain in effect for the entire Plan Year unless a Qualifying Election Change is made.

5.4. Deemed Election.

1. An Eligible Employee who fails to make an election for the Premium Reimbursement Account, Medical FSA, Dependent Care FSA, or HSA during Open Enrollment or, with respect to a new Employee, during the time period provided in the Summary, will be deemed to have elected no allocation for the Plan Year to such Accounts.

2. A Participant who experiences an Election Change Event but does not make a new election within the period provided in the Summary will continue the elections he or she had in effect prior to the Election Change Event.

5.5. Restrictions on Election Changes.

1. HSA elections may be changed at anytime. This section does not apply to HSAs.

2. An Annual Contribution Election is irrevocable during the Plan Year, except for certain Qualified Election Changes.

3. A Participant may make a Qualifying Election Change to a Pre-Tax Premium Benefit, Premium Reimbursement Account, Medical FSA or Dependent Care FSA in the manner prescribed by the Plan Administrator and Claims Administrator and in accordance with the following rules.

a. An election will not be a Qualifying Election Change if the amount elected is less than the amount of reimbursements claimed from such Account for the Plan Year prior to the election.

b. The adjustment to the Participant's pre-tax contributions will not occur until the first payroll period after the Administrator receives, approves, and processes the Qualifying Election Change.

c. An election must be for prospective coverage only, except that in the case of an election change made to Company-Sponsored Health Insurance Coverage or Other Health Insurance Coverage as a result of a HIPAA special enrollment as a result of the birth, adoption, or placement for adoption of a child, the period of retroactive Company-Sponsored Health Insurance Coverage or Other Health Insurance Coverage required by HIPAA can be paid on a pre-tax basis.

4. Qualifying Election Change Events include change in status events, changes in cost or coverage events, and additional election change events.

a. A "change in status" event is:

(1) a change in the Eligible Employee's marital status, including

marriage, divorce, or death of a spouse,

(2) a change in the number of the Eligible Employee's Dependents, including birth, adoption, placement for adoption or death of a Dependent;

(3) an Eligible Employee's Dependent satisfies or fails to satisfy the Dependent eligibility requirements under a component plan;

(4) a change in the employment status of the Eligible Employee or his or her spouse or Dependent, including termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, reduction or increase in hours, change in job location, or any other change in employment status that affects eligibility under an employer plan; or

(5) a change in residence for the Eligible Employee or his or her spouse or Dependents.

b. The change in status event must affect eligibility for coverage under an employer plan and the election change under the employer plan must be on account of, and correspond with, the change in status event. A change in status event "affects eligibility for coverage" if it results in a gain or loss of eligibility for coverage, a change in the number of an Employee's family members who may benefit from the coverage, or for the Dependent Care FSA, a gain or loss of eligibility for reimbursement of Dependent Care Expenses.

c. Changes in cost or coverage events do not apply to the Medical FSA and a Dependent Care FSA election cannot be changed due to a change in cost imposed by a provider who is related to the Participant. The changes in cost and coverage events and the election changes that are permitted as a result of such events are as follows:

(1) An insignificant cost change will result in an automatic adjustment to the Participant's Pre-Tax Premium.

(2) A significant increase in the cost of a coverage option will permit a Participant to change to a Similar Coverage Option, and if one is not available, to cancel coverage.

(3) A significant decrease in the cost of a coverage option will permit a Participant or an Eligible Employee to elect that coverage option.

(4) The loss of a coverage option will permit a Participant to change to a Similar Coverage Option or, if one is not available, to cancel coverage;

(5) The reduction of coverage within a coverage option will permit a Participant who has that coverage option to change to a Similar Coverage Option;

(6) The addition or significant improvement of a coverage option will permit an Eligible Employee or a Participant to elect the new or improved coverage option.

(7) An election change made under a plan of another employer, such as the plan of the employer of the Participant's spouse or Dependent, if either such other plan permits its participants to make an election change in accordance with the regulations under Code Section 125 or the Plan Year under this Plan and the plan year under such other plan are different will permit a corresponding election change under this Plan.

d. The following are additional election change events and the election changes permitted as a result of such events.

(1) The Participant may change his or her election for the Pre-Tax Premium Benefit, the Premium Reimbursement Account and the Medical FSA in a manner that is consistent with a judgment, decree or order (including a qualified medical child support order) resulting from a divorce, legal separation, annulment or change in legal custody ("Order") that requires either that coverage be provided for the Participant's child under the Employer's health plan or that another individual provide health coverage for the child. The Participant can only elect to add coverage for the child under the Employer's health plan if the child is a Dependent. The Participant can only elect to cancel coverage for the child under the Employer's health plan if the Order requires another individual to provide health coverage for the child and that coverage is actually provided.

(2) The Participant may change his or her election for the Pre-Tax Premium Benefit, Premium Reimbursement Account and Medical FSA in a manner that is consistent with the Participant's, the Participant's spouse's, or the Participant's Dependent's gain or loss of entitlement to Medicare (Part A or Part B) or Medicaid, other than coverage under the program for distribution of pediatric vaccines.

(3) If a Participant exercises special enrollment rights under Code section 9801 for Company-Sponsored Health Insurance Coverage, the Participant's Pre-Tax Premium contributions under this Plan will be changed automatically.

(4) If group health plan coverage is lost under a state children's health insurance program under Title XXI of the Social Security Act ("SCHIPS"), a tribal plan, a state health benefits risk pool, or a foreign governmental plan, and the Participant or Eligible Employee enrolls individual(s) losing the coverage in Company-Sponsored Health Insurance Coverage or Other Health Insurance Coverage, the Pre-Tax Premium or Premium Reimbursement Account, as applicable, may be adjusted accordingly.

(5) A Participant may change his or her election for the Pre-Tax Premium Benefit, Premium Reimbursement Account, Medical FSA, or Dependent Care FSA election when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan Rules.

ARTICLE VI
ADMINISTRATION OF PLAN

6.1. Administrator, Named Fiduciary.

The general administration of the Plan and the duty to carry out its provisions will be vested in the Company, which will be the "named fiduciary" of the Plan for purposes of ERISA. The Company's Corporate Benefits Department will perform such administrative duties on behalf of the Company and may delegate all or any portion of such administrative duties to a named person and may from time to time revoke such authority and delegate it to another person. Each such delegation to a person who is not an employee of the Company will be in writing, and a copy will be furnished to the person to whom the duty is delegated. Such person will file a written acceptance with the Company's Corporate Benefits Department. Such person's duty will terminate upon withdrawal of such authority by the Company's Corporate Benefits Department or upon withdrawal of such acceptance by the person to whom the duty was delegated. Any such withdrawal will be in writing, and will be effective upon delivery of a copy to the person to whom the duty was delegated or to the Company's Corporate Benefits Department, as the case may be. Any delegation to an employee of the Company will terminate when such individual ceases to be an employee or upon its earlier revocation by the Company's Corporate Benefits Department.

6.2. Administrator's Compensation.

The Administrator, if an employee of the Company, will receive no compensation for services as Administrator but will be entitled to reimbursement by the Company for any amounts reasonably and necessarily expended in the performance of the Administrator's duties.

6.3. Administrator's Discretion.

1. The Administrator has the sole, exclusive, absolute and complete discretionary power and authority with respect to administration of the Plan including, but not limited to, the discretionary power and authority to:

a. make all determinations (except those determinations which the Plan requires others to make) and to take all actions that the Administrator deems advisable for administration of the Plan, including entering into any contracts and administrative agreements;

b. construe, interpret, apply and enforce all Plan documents and to take or direct any course of action that the Administrator deems advisable to carry out the Plan's intent and purpose as determined by the Administrator;

c. decide all questions that arise that relate to the Plan and to make all factual determinations;

d. determine eligibility and coverage for participation and benefits;

e. establish and change the contributions required to be made for coverage under the Plan;

f. determine whether an individual is entitled to benefits and to decide the type, amount, manner of allocation and distribution of all benefits determined by the Administrator to be due and payable under the Plan;

g. remedy all defects, ambiguities, inconsistencies, omissions, and mathematical or arithmetical errors, including erroneous account balances; and

h. make or require rules, regulations, policies, and procedures that the Administrator deems advisable for the administration of the Plan and to change or modify any such rules, regulations, policies or procedures at any time.

2. Benefits under the Plan will only be paid if the Administrator decides in its discretion that an applicant is entitled to them.

6.4. Professional Assistance.

The Administrator may retain such accounting, legal, clerical and other services as may reasonably be required in the administration of the Plan, and may pay reasonable compensation for such services.

6.5. Reliance on Others.

1. To the extent permitted by applicable law, the Administrator, the Company, the Employers, the board of directors and the officers of the Company or any other Employer may rely upon all certificates and reports made by an officer of the Company, and upon all reports and opinions within the area of expertise of, and given by, accountants, legal counsel and other professionals retained by them; and, to such extent, such persons will be fully protected with respect to any action taken or suffered by them in good faith in reliance upon any such certificates, reports and opinions and all actions so taken or suffered will be conclusive upon each of them and upon all Participants.

2. The Administrator will be entitled to rely upon any data or information furnished by the Company, any other Employer, or by a Participant as to age, service and compensation of any person, and as to any other information pertinent to any calculation or determination to be made under the provisions of the Plan and, as a condition to payment of any benefit under the Plan, may request any Participant to furnish such information as the Administrator deems necessary or desirable in administering the Plan.

6.6. Indemnification.

The Participating Employers jointly and severally agree to indemnify and hold harmless, to the extent permitted by law, each director, officer, and employee of the Company and any Affiliated Organization against any and all liabilities, losses, costs and expenses (including legal fees) of every kind and nature that may be imposed on, incurred by, or asserted against such person at any time by reason of such person's services in connection with the Plan, but only if such person did not act with gross negligence, intentional misconduct, in bad faith or in willful violation of the law or regulations under which such liability, loss, cost or expense arises. The Participating Employers will have the right, but not the obligation, to select counsel and control the defense and settlement of any action for which a person may be entitled to indemnification under this provision.

6.7. Reports to Participants.

Within a reasonable time after the end of each Plan Year and at such other times as the Administrator deems necessary or desirable, the Administrator will provide a report to each Participant of the status of his or her Account.

6.8. Claim Procedure.

The Claims and Appeal procedure is described in the Summary for each Option.

6.9. Fiscal Records.

The fiscal records of the Plan are maintained on a Plan Year basis.

ARTICLE VII
MISCELLANEOUS

7.1. HIPAA Privacy and Security.

The HIPAA privacy and security rules are stated in Exhibit A and only apply to the Premium Reimbursement Account and Medical FSA Benefit Options.

7.2. Governing Law.

Except to the extent that state law has been preempted by provisions of ERISA, the Code or any other laws of the United States, as amended from time to time, this Plan will be administered, construed and enforced according to the laws of the State of Minnesota.

7.3. Limitations on Actions.

Notwithstanding any statutory limitations period or conflict of law provision, no action with respect to any Benefit under this Plan may be brought more than six months following the final decision in any appeal brought pursuant to the claim and appeal procedures set forth in this Plan.

7.4. Number and Gender.

Wherever appropriate, the singular number may be read as the plural and the plural may be read as the singular and the feminine gender may be read as the masculine gender and the masculine gender may be read as the feminine gender.

7.5. Reference to an Officer of the Company.

Any reference to a specific officer of the Company means the person who, from time to time, holds such office or, in the event that the name or function of such office is changed, such officer of the Company who succeeds to the functions of such office.

7.6. No Employment Rights.

Nothing contained in this Plan shall be construed as a contract of initial or continued employment between any Employee and the Employer, as a limitation of the right of the Employer to discharge any Employee with or without cause, or as an assurance of any benefit not expressly set forth in this Plan.

7.7. Severability.

If any provision of this Plan is held to be illegal or invalid for any reason, that illegality or invalidity will not affect the remaining parts of this Plan. In such case, this Plan will be construed and enforced as if the illegal or invalid provision were not included in the Plan.

7.8. Withholding.

Notwithstanding any contrary provision of this Plan, the Company or any other Employer may withhold from any payment charged against a Participant's Account such amounts as may be required under sections 3102 and 3402 of the Code or under a similar law of any state, but will not be liable for any loss or damage incurred by a Participant on account of the Company's or other Employer's failure to do so.

7.9. Non-Assignability of Benefits.

No benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber or charge the same will be void, and no such benefit will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of the person entitled to such benefit.

7.10. Disabled Participants.

If the Administrator determines that any person entitled to receive any payment under this Plan is physically, mentally or legally incapable of receiving or acknowledging receipt of such payment, and no legal representative has been appointed for such person, the Administrator, in its discretion, may (but will not be required to) cause any sum otherwise payable to such person to be paid to such one or more as may be chosen by the Administrator from the following: the institution maintaining the person or the person's spouse, children, parents or other relatives by blood or marriage. Any payment so made will be a complete discharge of all liability under the Plan with respect to such payment.

7.11. Death of Participant.

After the death of a Participant, benefits that would have been payable from the Participant's Account had the Participant survived will be paid to the Participant's spouse or dependents. If the Participant's spouse or dependents are eligible for and elect continuing coverage for Company-Sponsored Health Insurance, any amounts credited to the Pre-Tax Premium Account will be applied to reduce the cost of such continuing coverage. If no spouse or dependent is eligible to receive such payment, such payment will be made to the personal representative of the Participant's estate or to such other person whom the Administrator, in its sole discretion, determines to be legally entitled to such payment. Any payment so made will be a complete discharge of all liability under the Plan with respect to any such payment.

7.12. Satisfaction of Claims.

Any payment to or for the benefit of any Participant, legal representative or person chosen by the Administrator in accordance with the provisions of the Plan will, to the extent of such payment, be in full satisfaction of all claims against the Administrator and the Company, either of which may require the payee to execute a receipted release as a condition precedent to such payment.

7.13. Participant Tax Consequences.

1. None of the Company, Plan Administrator, Claims Administrator and Employer make any commitment, guarantee, warranty or other representation regarding a Participant's ability to exclude the benefits paid under this Plan from his or her gross income for federal, state or local income tax purposes.

2. If any benefits paid under this Plan are determined to be includable in income, the Participant has no recourse against the Company or Administrator and the Company and the Administrator accept no liability for any damages or losses, including penalties, suffered by the Participant.

3. It shall be the obligation of each Participant to determine whether each payment or other benefit under the Plan is excludable from the Participant's gross income for federal, state and local income tax purposes. Any Participant, by accepting the benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus interest and penalties.

7.14. Non-Discrimination

Federal tax laws impose a variety of "nondiscrimination requirements" that must be satisfied before benefits provided under the Plan can be provided to employees on a tax-free basis. The non-discrimination requirements are generally intended to restrict the amount of nontaxable benefits available to certain employees of the Company who are officers, directors, "key employees" or "highly compensated." If the Company believes that the Plan may violate Code requirements prohibiting discrimination in favor of such employees with respect to eligibility, availability of benefits or utilization of benefits, it may limit the amount of pre-tax contributions that certain Participants can make, reduce benefits payable to certain Participants or take such other action as it deems advisable to avoid or eliminate such violation.

ARTICLE VIII
ADOPTION, AMENDMENT AND TERMINATION

8.1. Adoption and Termination by Affiliated Organization.

1. An Affiliated Organization may adopt this Plan and become an Employer in the manner prescribed by the Administrator.

2. An Affiliated Organization may terminate its participation in the Plan by providing written notice to the Administrator.

8.2. Amendment Procedure.

The Company reserves the right to amend the Plan at any time, to any extent that it may deem advisable, and without prior notice. Each amendment will be stated in a written instrument. The Plan will be deemed to have been amended as set forth in the instrument and all Participants and Employers will be bound by the amendment; provided, however, that no amendment will have any retroactive effect so as to deprive any Participant of any benefit already accrued by means of the occurrence of an event entitling the Participant to a payment under the Plan.

8.3. Termination Procedure.

The Company reserves the right to terminate the Plan at any time and without prior notice. Termination will occur by written instrument.

Appendix A:
HIPAA Privacy and Security

(1) HIPAA Privacy.

(A) Purpose.

This section is intended to comply with the Standards for Privacy of Individually Identifiable Health Information, Title 45, Parts 160 and 164, Subparts A and E, of the Code of Federal Regulations, promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91 ("Privacy Rule").

(B) Definitions.

The following definitions will apply to the provisions in this Article:

1. "Health Information" is any information that:

   a. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

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

2. "Health Care Operations" means the administration and operation of the Plan, including:

   a. conducting quality assessment and improvement;

   b. accreditation, certification, licensing, or credentialing;

   c. underwriting, premium rating, and the placement of stop loss coverage;

   d. conducting or arranging for medical review, legal services, and auditing;

   e. cost-management and planning related to operation and management of the Plan;

   f. management activities related to Privacy Rule compliance;

   g. resolution of grievances; and

h. Plan activities resulting from sale, transfer, merger, or consolidation.

3. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91.

4. "Individually Identifiable Health Information" is Health Information created or received by the Plan or the Employer that:

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

   b. identifies the individual directly or reasonably could be used to identify the individual.

5. "Payment" includes activities undertaken to obtain contributions, determine or fulfill responsibility for coverage and benefits, or obtain or provide reimbursement for health care expenses; including, but not limited to:

   a. determinations of eligibility for coverage;

   b. coordination of benefits;

   c. claims adjudication;

   d. subrogation;

   e. claims management;

   f. collection activities;

   g. obtaining payment under a stop loss contract;

   h. medical necessity reviews;

   i. utilization review activities, including pre-authorization, pre-certification, concurrent and retrospective reviews;

   j. disclosure of certain information to consumer reporting agencies to collect premiums or reimbursement.

6. "Plan Administration Functions" are administration functions performed by the Administrator on behalf of the Plan, including Payment and Health Care Operations activities.

7. "Plan Sponsor" refers to the Company acting as Plan Sponsor as defined in at section 3(16)(B) of ERISA, codified as 29 U.S.C. 1002(16)(B).

8. "Privacy Rule" refers to the privacy regulations promulgated by the Department of Health and Human Services pursuant to HIPAA. The regulations are codified at 45 C.F.R. Part 164.

9. "Protected Health Information" or "PHI" is Individually Identifiable Health Information that is transmitted or maintained in any form or medium by the Plan.

(C) Uses and Disclosures of Protected Health Information. Unless the subject individual authorizes a use or disclosure of PHI, the following restrictions will apply.

1. The Company may use PHI for Plan Administration Functions. The Company is currently involved with the following Plan administration activities: eligibility/enrollment, premium payment, Plan interpretation, receipt of Plan service provider reports, responding to Employee complaints and handling COBRA and Health Care Reimbursement Account administration in house. The Company may disclose PHI as permitted or required by the Privacy Rule or the privacy policies and procedures of the Plan.

2. The Company will not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law.

3. The Company will ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

4. The Company will not use or disclose PHI for employment-related actions and decisions or in connection with any other Company benefit or employee benefit plan.

5. The Company will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(D) Certification Required to Disclose Protected Health Information to Company. The Plan will disclose PHI to the Company only upon receipt of a certification by the Plan Sponsor that the Plan Documents have been amended as required by the Privacy Rule.

(E) Subject Individual Rights With Respect to PHI.

1. The Company will make PHI available for access in accordance with the Privacy Rule section 164.524;

2. The Company will make PHI available for amendment and incorporate any amendments to PHI in accordance with Privacy Rule section 164.526; and

3. The Company will make PHI available required to make an accounting of disclosures required by Privacy Rule section 164.528.

(F) Provide Information to the Department of Health and Human Services. The Company will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule.

(G) No Longer Needed PHI. When any PHI received from the Plan ceases to be needed for the purpose for which it was disclosed, the Company will return or destroy such information maintained in any form and retain no copies of such information, except that, if return or destruction is not feasible, the Company will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(H) Adequate Separation Between Plan and Company.

1. The Company will provide adequate separation between the Plan and the Company in its capacity as other than the Administrator.

2. The Company designates the following employees, classes of employees, or persons to use and disclose PHI on behalf of the Plan for purposes of Plan Administration Functions: Human Resources.

3. Access to and use of PHI by the employees and other persons described in subsection (2) will be limited to the Plan Administration Functions that the Company performs for the Plan.

4. Those persons described in subsection (2) who fail to comply with the Privacy Rule or the Privacy Policies and Procedures of the Plan may be subject to disciplinary action up to and including termination.

(2) HIPAA Security.

(A) Purpose. This article is intended to comply with the Standards for Security Standards for the Protection of Electronic Protected Health Information, Title 45, Parts 160 and 164, Subpart C, of the Code of Federal Regulations, promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91.

(B) Definitions. The following definitions will apply to the provisions in this Article:

1. "Availability" means the property that data or information is accessible and useable upon demand by an authorized person.

2. "Confidentiality" means the property that data or information is not made available or disclosed to unauthorized persons or processes.

3. "Electronic Media" means (1) storage in memory devices in computers or any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk or digital memory card; and (2) transmission media used to exchange information already in electronic storage media, including, for example, the internet, extranet, leased lines, dial-up lines, private networks and physical movement of removable/transportable electronic storage media.

4. "Electronic Protected Health Information" or "e-PHI" means Protected Health Information that is transmitted by, or maintained in, Electronic Media.

5. "Integrity" means the property that data or information have not been altered or destroyed in an unauthorized manner.

6. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification or destruction of e-PHI or interference with system operations in an information system containing e-PHI.

(C) Administrative, Physical and Technical Safeguards. The Company will implement adequate administrative, physical and technical safeguards that will reasonably and appropriately protect the Confidentiality, Integrity and Availability of e-PHI that it creates, receives, maintains or transmits on behalf of the Plan.

(D) Separation Between Plan and Company. The Company will ensure that the adequate separation between the Plan and the Company in its capacity as other than the Administrator, as required by the "Adequate Separation of the Plan and Company" provision in the HIPAA Privacy Rule amendment to the Plan, is supported by reasonable and appropriate security measures.

(E) Agents and Subcontractors. The Company will ensure that any agent, including a subcontractor, to whom it provides e-PHI received from the Plan agrees to implement reasonable and appropriate security measures to protect the e-PHI.

(F) Security Incident Reports. The Company will report to the Plan any Security Incident of which it becomes aware that are not already known by the Plan.