MEMORANDUM

Date: March 23, 2012

To: Administration Committee
From: Pamela A. Captain, City Attorney PAC

RE: City of Menasha Flexible Spending Plan/Cafeteria Plan

Effective January 1, 1996, the City of Menasha adopted a Flexible Benefits Plan (Plan), commonly known as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended. Briefly, the Plan allows employees to contribute funds into an account that can be used to reimburse them certain out of pocket medical and/or child care expenses. The Plan has tax advantages for the employee.

The Plan has been amended over the years primarily due to changes in the law requiring plan amendments. The Plan administrator has been Marshall & Ilsley Trust Company N.A. (M & I).

Recently, I became aware that the Administrative Services Agreement with M & I, as well as various Plan amendments and Business Associate Agreement were outdated and in need of updating and execution.

In an effort to ensure that the Plan, its Amendments, Administrative Services and Business Associate agreements are duly authorized I am requesting consideration and approval and in some cases re-approval by the common council.

I am also requesting that the common council authorize the City Attorney/HR Director to act on behalf of the common council in signing the necessary documents for the City of Menasha Flexible Benefits Plan, including future Plan Amendments necessary for administration of the Plan.

A copy of the City of Menasha Cafeteria Plan (Amended and restated effective January 1, 2001), proposed Administrative Services Agreement, Plan Sponsor's Authorization, Amendment and Adoption for the City of Menasha Flexible Spending Plan, Business Associate Agreement and Addendum, Business Associates Authorized Access Information for Plan Administration Purposes are attached. The original Plan is on file in the personnel department and is not provided with this memo.

A recommended motion is: **MOTION** to recommend approval and adoption by the Common Council of the City of Menasha Cafeteria Plan (adopted on January 1, 1996, amended and restated effective January 1, 2001) and authorize the City Attorney/HR Director to act on behalf of the Common Council in signing the necessary documents for the Plan, including future Plan amendments necessary for administration of the Plan.

CITY OF MENASHA
CAFETERIA PLAN

Amended and restated effective January 1, 2001

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CITY OF MENASHA CAFETERIA PLAN

INTRODUCTION

Effective January 1, 2001, the Employer amends and restates the Plan known as The City of Menasha Cafeteria Plan to recognize contributions made to the Employer by its Employees. The purpose of this Plan is to reward Employees 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 the City of Menasha Cafeteria Plan (the "Plan").

This document is designed to qualify as a "Cafeteria Plan" within the meaning of Code Section 125, under which an Employee elects to receive benefits under the Plan as included or excludable from the Employee's income under Section 125(a) and other applicable Code Sections. Portions of this document also reflect individual component plans designed to separately qualify as: (1) a Medical Reimbursement Plan under Code Section 105; (2) a Premium Conversion Plan under Code Section 106; and (3) a Dependent Care Assistance Plan under Code Section 129.

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the City of Menasha or the individual(s) or corporation appointed by the Employer to carry out the administration of the Plan. In the event an Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the 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"** 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, pursuant to Article III, to purchase Benefits. Each dollar contributed to this Plan shall be converted to 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 total cash remuneration received by the Participant from the Employer during a Plan Year prior to any Salary Redirection Agreement reductions authorized here under. Compensation shall include overtime, commissions, and bonuses.

1.7 **"Dependent"** means any individual who is a tax dependent of the Participant as defined in Code 152 except that: (a) for purposes of accident or health coverage, any child to whom Code 152(e) applies (regarding a child of divorced parents, etc, where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the year) is treated as a dependent of both parents; and (b) for purposes of the Dependent Care Assistance Program, a dependent means a qualifying individual as defined in Code 21(b)(1) with respect to the Participant and in the case of divorced parents, the child shall, as provided in Code 21(e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code 152(e)(1)), and shall not be treated as a qualifying individual with respect to the non-custodial parent. Notwithstanding the foregoing, the Health Care Reimbursement Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order, as defined in ERISA 609(a), even if the child does not meet the definition of "dependent".

1.8 **"Effective Date"** means January 1, 1996. The plan was amended and restated on January 1, 2001.

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

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1, is compensated on an hourly basis, is a member of AFSCME, AFL-CIO Local 1035 B, and meets the eligibility requirements of the employer's group health plan.

Employees whose employment is governed by the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code Section 7701(a)(46)) and the Employer under which benefits were the subject of good faith bargaining between the parties, *unless such agreement expressly provides for such coverage in this Plan*, will not be eligible to participate in the Flexible Spending Account programs established by the Employer.

1.11 **"Employee"** means any person who is employed by the Employer, but excludes any person who performs services as an independent contractor and does not include leased employees within the meaning of Code Section 414(n)(2). Any classification, reclassification or other characterization of any such individual as an employee of the Employer, whether as a statutory or common law employee, by a court of law or by action of any federal, state or local governmental agency shall be of no affect on the exclusion of such individual from participation in the plan.

1.12 **"Employer"** means City of Menasha and any Affiliated Employer that shall adopt this Plan; any successor who shall maintain this Plan; and any predecessor which has maintained this Plan.

1.13 **"Employer Contribution"** means the contributions made by the Employer pursuant to Section 3.1 to enable a Participant to purchase Benefits. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the insured or self-funded Benefits established under the Plan pursuant to the Participants' elections made under Article V.

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

1.15 **"Highly Compensated Employee"** means, for the purposes of determining discrimination, an Employee described in Code Section 414(q) and the Treasury regulations thereunder.

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

1.17 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits, the Employer.

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

1.19 **"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.

1.20 **"Plan"** means this instrument, including all amendments thereto.

1.21 **"Plan Year"** means the 12-month period beginning January 1st and ending December 31st. The Plan Year shall be the coverage period for the Benefits provided 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.

1.22 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the self-funded or insured benefits described in Section 4.1.

1.23 **"Premium Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of the 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, a sub-account shall be established for each type of insured Benefit.

1.24 **"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 accounts established under the Plan pursuant to the Participants' elections made under this Plan.

1.25 **"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.

1.26 **"Spouse"** means the legally married husband or wife of a Participant, unless legally separated by court decree.

ARTICLE II

PARTICIPATION

2.1 ELIGIBILITY DATE

Any Eligible Employee, as defined in Section 1.10, shall be entitled to participate hereunder upon satisfying the eligibility requirements of the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. Any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

If a former Participant is rehired during the same Plan Year in which termination of employment occurs and the former Participant qualifies as an Eligible Employee, such former Participant shall be eligible for Salary Redirection pursuant to Section 2.6.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee who makes an initial election to participate under Section 5.1 shall become a Participant in the Plan effective as of the first day of the next pay period coinciding with or next following the date on which such Employee met the requirements of Section 2.1 and returned a properly completed election form.

An Eligible Employee who makes an election to participate under Section 5.2 shall become a Participant in the Plan effective as of the first day of the Plan Year following such election, provided the requirements for participation under Section 5.2 are satisfied during the applicable Election Period.

Notwithstanding the foregoing, an Eligible Employee shall become a Participant with respect to the insured Benefits effective as of the entry date under the Employer's group medical plan.

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 and make an election of benefits, which the

Administrator shall furnish to the Employee. The election made on such form 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 execute 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 beginning on the Employee's effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-funded Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

2.4 TERMINATION OF PARTICIPATION

A Participant shall cease to be a Participant in this Plan upon the earlier of:

(a) The expiration of the plan Year for which the Employee elected to Participate, unless the Participant makes a timely election to continue participation subject to Section 2.3.

(b) The date on which the Employee ceases to be an employee eligible to participate under Section 2.1 because of retirement, termination of employment subject to provisions of Section 2.6, layoff, reduction in hours subject to Section 2.5, death subject to Section 2.7 or any other reason.

(c) The date the Participant revokes an election to participate under a circumstance when such change is permitted under the terms of this plan, or

(d) The termination of this Plan, subject to the provisions of Section 10.2.

Participation under insured Benefits will cease as of the date specified by the specific health insurance plan.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be an Eligible Employee because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made on behalf of the Participant, and except as otherwise provided herein, all further Benefit elections shall cease, subject to the limited Participant's right to continue coverage under the individual health benefits. Without continuation coverage, any balance in the limited Participant's Medical Reimbursement Account may be used to reimburse the limited Participant for any allowable Medical Expenses incurred during the portion of the Plan Year during which he was an Eligible Employee (except as otherwise provided in Section 2.6(c)(1)). The limited Participant's Dependent Care Assistance Program balance may be used during such Plan Year to reimburse the limited Participant for any allowable Employment-Related Dependent Care Expenses incurred during the Plan Year. Subject to the provisions of Section 2.6, if the limited

Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he otherwise satisfies the participation requirements set forth in this Article II as if he were a new Employee and made an election in accordance with Section 5.1.

2.6 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Plan shall be governed in accordance with the following:

(a) With regard to Insurance Benefits provided under Section 4.1, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) With regard to the Dependent Care Assistance Program, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may request reimbursement for any qualified Employment-Related Dependent Care Expenses per Section 7.2(d), incurred during the Participant's coverage period and continuing through the end of the Plan Year in which the termination occurs, based on the level of the Dependent Care Assistance Account as of the date of termination.

(c) With regard to the Health Care Reimbursement Plan, the Participant may elect to continue the participation in the Plan to the extent required under Code Section 4980B and Section 11.13 of the Plan as set forth herein.

(1) If the Participant elects to continue participation in the Health Care Reimbursement Plan to the extent required under Code Section 4980B and Section 11.13 of the Plan as set forth herein, the Participant may continue to seek reimbursement from the Health Care Reimbursement Fund based on the elections made prior to the beginning of the Plan Year. However, such contributions after termination of employment shall be with after-tax dollars instead of Salary Redirections.

(2) If the Participant does not elect to continue participation in the Health Care Reimbursement Plan for the remainder of the Plan Year in which such termination occurs, participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses incurred during the portion of the Plan Year preceding the date of termination.

(3) Effective January 1, 2001, no Participant will be allowed to continue coverage under Code Section 4980B in accordance to Section 11.13 unless the Participant's maximum unpaid contributions are less than or equal to the Participant's maximum Health Care Reimbursement Plan benefits for the remainder of the Plan Year. Even if a Participant may continue coverage under Code Section 4980B (as stated in Section 11.13 of the Plan) through the

application of the preceding sentence, the Participant may not continue such coverage during any subsequent Plan Year.

(d) In the event a Participant terminates his participation in the Health Care Reimbursement Plan during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

(e) This Section shall be applied and administered consistent with such further rights a Participant and his Dependents may acquire pursuant to Code Section 4980B and Section 11.13 of the Plan.

2.7 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his estate, may submit claims for any allowable medical expenses incurred during the portion of the Plan Year preceding the Participant's death (except as otherwise provided in Section 2.6(c)(1)), or Employment-Related Dependent Care Expenses incurred during the Plan Year. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Administrator may designate the Participant's Spouse, one of his Dependents or a representative of his estate.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 EMPLOYER CONTRIBUTION

Effective January 1, 1998, Employees will receive from the Employer the following sums to be contributed to the Health Care Reimbursement Plan: $30 per month for employees who have elected family insurance coverage; $15 per month for employees who have elected single health insurance coverage. The amount will be prorated for part-time employees who have elected health insurance coverage. If no Benefits are selected, there shall be no Employer Contribution.

3.2 SALARY REDIRECTION

If a Participant's Employer Contribution is not sufficient to cover the cost of Benefits or Premium Expenses he elects pursuant to Article IV, his Compensation will be reduced in an amount equal to the difference between the cost of benefits he elected and the amount of Employer Contribution available to him. Such reduction shall be his Salary Redirection, which the Employer will use on his behalf, together with his Employer Contribution, to pay for the Benefits he elected. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreements 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 V.

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 work or family status or 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.

3.3 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection and Employer Contribution to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Care Reimbursement Fund or Dependent Care Assistance 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.

3.4 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Care Reimbursement Plan, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections are not made on a pro-rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 2.6(d).

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect to have the amount of his Cafeteria Plan Benefit Dollars applied to any one or more of the following optional Benefits:

(1) Health Care Reimbursement Plan
(2) Dependent Care Assistance Program
(3) Cash Benefit (i.e., Any portion of a Participant's Compensation that could have been contributed to the Plan, but which the Participant elected, or was deemed to have elected, not to contribute to the Plan.)

In addition, each Participant shall have a sufficient portion of his Cafeteria Plan Benefit Dollars applied to the following insured benefits unless the Participant elects not to receive such benefits:

(4) Health Insurance Benefit
(5) Dental Insurance Benefit

4.2 HEALTH CARE REIMBURSEMENT PLAN BENEFIT

Each Participant may elect coverage under the Health Care Reimbursement Plan Option, in which case Article VI shall apply.

4.3 DEPENDENT CARE ASSISTANCE PROGRAM BENEFIT

Each Participant may elect coverage under the Dependent Care Assistance Program option, in which case Article VII shall apply.

4.4 CASH BENEFIT

If a Participant does not elect any Salary Redirections, such Participant shall be deemed to have chosen the Cash Benefit (or was not deemed to have elected) as his sole Benefit option.

4.5 HEALTH INSURANCE BENEFIT

(a) Each Participant may elect to be covered under a Health and Hospitalization Insurance Contract for the Participant, his or her spouse, and his or her Dependents. The Employer may select suitable Health and Hospitalization Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(b) The rights and conditions with respect to the benefits payable from such Health and Hospitalization Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.6 DENTAL INSURANCE BENEFIT

(a) Each Participant may elect to be covered by the Employer's Dental Insurance Contract. The Employer may select suitable Dental Insurance Contracts for use in providing this Dental insurance benefit, for which the policies will provide uniform benefits for all Participants electing this Benefit.

(b) The rights and conditions with respect to the benefits payable from such Dental Insurance Contract shall be determined therefrom, and such Dental Insurance Contract shall be incorporated herein by reference.

4.7 NONDISCRIMINATION REQUIREMENTS

(a) 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 Section 125.

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

(c) 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, 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. If the Administrator decides to reduce contributions or non-taxable benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has elected the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has elected the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Care Reimbursement Plan Benefits and Dependent Care Assistance Program benefits, and once all these Benefits are expended, proportionately among insured Benefits. 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, will have an additional 30 days from the date he or she becomes an Eligible Employee to elect participation in this Plan for all or the remainder of such Plan Year in accordance to Section 2.3. Participation in the Plan shall not be effective until after receipt of the Participant's election pursuant to Section 2.2 and shall be limited to Benefit expenses incurred for the balance of the Plan Year for which the election is made.

If such Eligible Employee fails to make such election or satisfy such requirements within this 30 day initial Election Period, such Eligible Employee will be deemed to have elected not to participate in the Plan for all or the remainder of the Plan Year. Section 5.2 will be applicable with regard to subsequent annual elections to participate in the Plan.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-funded benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

If a former Participant is rehired to an Eligible Employee position during the same Plan Year in which termination of employment occurred and that Participant's prior coverage was terminated, the following shall apply:

(a) If the Employee meets an Eligible Employee status within 30 days or less of the termination of employment the Participant shall be reinstated with the same Benefit election such Participant had prior to termination without loss of coverage. Salary Redirection for the Health Care Reimbursement Plan and Dependent Care Assistance Program for the remainder of the Plan Year will be in an amount equal to the prior Benefit Election for the Plan Year less prior Plan Year Benefit contributions subject to the Participant's right to change his Benefit Elections pursuant to Section 5.4.

(b) If the Employee meets the Eligible Employee status 30 days or more after termination of employment the Participant shall be entitled to make a new Benefit Election in accordance to Section 2.2 and Section 2.3. The new Benefit Election and Salary Redirection for non-insured Benefits for the remainder of the Plan Year may not exceed the difference of the maximum account allowance less the prior Benefit elections for the that Plan Year.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant (and each Eligible Employee who elected not to participate in the Plan in the prior Plan Year) shall be given the opportunity to make a Benefit election regarding Plan Benefits for the next Plan Year. The Participant or Eligible Employee must make such an election and satisfy the requirements of Section 2.3 during the Election Period. 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 Eligible 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;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, with respect to spending account Benefits.

(d) Participants with insured benefit coverage shall be automatically enrolled with the same coverage for the subsequent Plan Year unless the Participant elects, during the Election

Period, not to participate in the Plan or to change the benefit election for the new Plan Year.

5.3 FAILURE TO ELECT

Any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be treated in the following manner:

(a) With regard to Benefits available under the Plan for which no Premium Expenses apply, such Participant shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for subsequent Plan Year for such Benefits.

(b) With regard to Benefits available under the Plan that are insured and for which Premium Expenses apply, such Participant shall be deemed to have made the same Benefit elections as then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such insured Benefit options.

5.4 CHANGE OF ELECTION

A Participant may change a Benefit election up to five (5) times after the Plan Year to which such election relates, has commenced and make new Benefit election changes with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and consistent with change of election events acceptable under the rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. However, no Participant shall be allowed to reduce an election for Health Care Reimbursement or Dependent Care Assistance Benefits to a point where the annualized contribution for such benefit is less than the amount already reimbursed. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

An election change is considered consistent if the qualifying event affects eligibility under an Employer's Plan, and that the same event results in an increase or decrease in the number of family members who may benefit from coverage under the Plan. The qualifying event must directly affect coverage for the individual the change in election is made for. In addition, if the Participant, Spouse or Dependent gains eligibility for coverage under a family member's plan as a result of a change in marital status or a change in employment status, then a Participant's election change to cease or decrease coverage for that individual 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 Participant, the Participant's spouse, or dependent becomes eligible for continuation coverage under the Employer's group health plans as provided in Code Section 4980B or any similar state law and the Participant retains eligibility under the Cafeteria Plan hereunder, the Participant may use Salary Redirection under this Plan to pay for the continuation coverage.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first day of the next pay period coinciding with or next following the day a new election form is received by the Administrator, not withstanding special enrollment rights provided for in Code Section 9801(f). For the purposes of this subsection, a change in election shall include the following events or other events permitted by Treasury regulations:

(a) *Change in Status.* A Participant may change or terminate an actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of and corresponds with a Change in Status that affects coverage eligibility of a Participant, Participant's Spouse, or Dependent. The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming the general consistency requirement is satisfied, a requested change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter an election based on that change.

(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, incurring a reduction or increase in hours of employment, or a change in work site. 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. For the Dependent Care Assistance Program, a dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) qualified as a change in status; and

(5) Residency: A change in the place of residence of the Participant, the Participant's Spouse or Dependent allows the Participant to change or drop insured Benefits.

(b) *HIPAA Special Enrollment Rights.* If a Participant, Spouse, or Dependent is entitled to a special enrollment right under a group health plan, as required by Code Section 9801(f), then the Participant may revoke a prior election for health or accident coverage and make a new election (including salary reduction), provided the election corresponds with such

special enrollment rights. A special enrollment right might arise if medical coverage was declined for the Employee, Spouse or Dependent under the group health plan because of outside medical coverage and eligibility for such coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or if a new Dependent is acquired. For purposes of this provision, (1) an election to prospectively add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right; and (2) a HIPAA special enrollment election attributable to the birth or adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

(c) *Certain Judgments, Decrees and Orders.* Notwithstanding subsection (a), if a judgment, decree, or order ("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) requires accident or health coverage for a Participant's Dependent child (including a foster child who is a dependent), a Participant may:

(1) The Participant may elect to add or increase coverage if an order requires the Participant to cover a Dependent; or

(2) The Participant may decrease or cancel coverage for the child if the order requires the Participant's spouse, former spouse or another individual to cover the Dependent, and the Dependent actually becomes covered under the Plan of the spouse, former spouse or other individual.

(d) *Medicare and Medicaid.* Notwithstanding subsection (a), if a Participant, Spouse or Dependent who is enrolled in an accident or health benefit under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act program for distribution of pediatric vaccines, the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to coverage. Furthermore, if the Participant, Spouse, or Dependent entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the health or accident coverage.

(e) *Change in Cost.* A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a change under this subsection.

(1) *Automatic Decrease or Increase.* If the Participant's share of the premium decreases during a Plan Year or insignificantly increases, then the Salary Redirections under each affected Participant's election shall be retrospectively adjusted to reflect such change. The Plan Administrator will decide, in accordance with prevailing IRS guidance, whether increases in costs are "insignificant" based upon all surrounding facts and circumstance (including, but not limited to, the dollar amount or percentage of the cost change).

(2) *Significant Cost Increase.* If the Participant's cost of a benefit package option increases significantly, attributable to action by the Employee or the Employer, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their election and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage. If the increase is deemed to be significant and no other similar coverage is available, the Participant may drop coverage. The Plan Administrator will decide, in accordance with prevailing IRS guidance, which defines similar coverage to be coverage for the same category of benefits for the same individual, whether a substitute Benefit package constitutes "similar coverage" based upon all surrounding facts and circumstances.

(3) *Significant Cost Decrease.* If the Participant's cost of a benefit package option decreases significantly during a Plan Year, Employees who had not previously enrolled may enroll and Participants who elected another option providing similar coverage may revoke their current coverage election and elect the option that has decreased in cost since the coverage period commenced if permitted under each respective insured Benefit.

(4) *Dependent Care Plan Change in Cost Limitation.* A "change in cost" provision applies to the Dependent Care Assistance Program only if the cost change is imposed by a service provider who is <u>not</u> a "relative" of the Participant by blood or marriage, as defined in Proposed Treas. Reg. Section 1.125-4(f)(2)(iii).

(f) *Change in Coverage.* A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a change under this subsection.

(1) *Significant Curtailment or Cessation of Coverage.* If the coverage under a Benefit is deemed by the Administrator to be 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. Accident and health plan coverage is deemed "significantly curtailed" only if there is an overall reduction in coverage, which reduces coverage to all Participants in general. If a significant curtailment does not result in a loss of coverage, alternate coverage can be elected, but coverage cannot be dropped. If the curtailment results in a loss of coverage, the election can be dropped, but only if no other benefit option for similar coverage is available.

The Plan Administrator will decide, in accordance with prevailing IRS guidance which states that a significant curtailment of coverage includes a significant increase in deductible; significant increase in co-payments; and a significant increase in the out-of-pocket cost sharing amounts under the Plan, whether curtailment is "significant" and whether a substitute benefit option constitutes "similar coverage" based upon all surrounding facts and circumstances. The Plan Administrator will also decide, in accordance with prevailing IRS guidance, what constitutes a "loss of coverage" based on final regulations stating plan sponsors may consider the following events: a substantial decrease in the medical providers

available under the option; a reduction in benefits for a specific type of medical condition for which treatment is being received; and any similar fundamental loss of coverage.

(2) *Addition or Elimination of Benefit Package Option Providing Similar Coverage.* If, during the Plan Year the Plan adds or eliminates a benefit package option or other coverage option, then 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. If the Plan significantly improves a Benefit, Participants who elected other Benefit Options and Employee who are not enrolled, may elect the Benefit if allowed on each respective insured plan. The Plan Administrator will decide, in accordance with prevailing IRS guidance, whether other benefit options constitute "similar coverage" based upon all surrounding facts and circumstances.

(3) *Change in Coverage of Spouse or Dependent Under Another Employer's Plan.* A Participant may make a prospective election change that corresponds with changes made under any Employer's cafeteria or qualified benefits plan, so long as (a) the Spouse's or Dependent's plan permits the change and the change is permitted under Code Section 125 or (b) the Spouse or Dependent makes the change during an annual enrollment period that occurs in the middle of the Participant's Plan Year. The Plan Administrator will decide, in accordance with prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the plan of the Spouse's or Dependent's employer.

(4) *Loss of Coverage under a Plan Maintained by a Governmental or Educational Institution.* A Participant may add coverage for a Participant, Spouse or Dependent, if the same Participant, Spouse, or Dependent loses coverage under any group health coverage plan sponsored by a governmental or Educational Institution.

A Participant who terminates and is rehired within thirty (30) days shall be deemed to have continued coverage during such period of termination as if he or she was never terminated unless there is another qualifying event. Missing payments shall be made whole during the remainder of the Plan Year. There shall be no coverage loss to the Participant.

A Participant who terminates and is rehired after thirty (30) days shall be able to change elections. The Health Care Reimbursement Plan maximum election for the remainder of the Plan Year will be the difference between the annual maximum less any prior election. The Dependent Care Assistance Program maximum election for the remainder of the Plan Year will be the difference between the annual maximum less any prior contributions. There may be a coverage loss if the Participant did not or was not able to continue under COBRA.

ARTICLE VI
HEALTH CARE REIMBURSEMENT PLAN

6.1 ESTABLISHMENT OF PLAN

This Health Care Reimbursement Plan is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section 105 and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Reimbursement Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed under this Health Care Reimbursement Plan shall be periodically paid from amounts allocated to the Health Care Reimbursement Fund. Periodic payments reimbursing Participants from the Health Care Reimbursement Fund 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 Care Reimbursement Fund" means the fund established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses may be reimbursed.

(b) "Health Care Reimbursement Plan" means the plan of benefits contained in this Article, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant or his Dependents.

(c) "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).

(d) "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213 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. However, 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. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Plan.

6.3 FORFEITURES

The amount in the Health Care Reimbursement Fund 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.

6.4 LIMITATION ON ALLOCATIONS

The maximum annual Benefit amount that a Participant may elect to receive under the Health Care Reimbursement Plan in any Plan Year shall be **$4,000.00.**

6.5 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Health Care Reimbursement Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) If the Administrator deems it necessary to avoid discrimination under this Health Care Reimbursement Plan, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Care Reimbursement Fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Sections 105 who has elected the second highest contribution to the Health Care Reimbursement Fund for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. 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 Care Reimbursement Plan. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Care Reimbursement Plan. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH CARE REIMBURSEMENT PLAN CLAIMS

(a) All Medical Expenses incurred by a Participant, Spouse, or Dependent shall be reimbursed during the Plan Year subject to Section 2.6, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the

Medical Expenses were incurred during the applicable Plan Year, (but prior to the date coverage ceases, except as otherwise provided in Section 2.5, 2.6 and 2.7). 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) The Administrator shall direct reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Reimbursement Fund 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 sponsored by the Employer, a governmental agency or any other plan covering a Participant and/or his Spouse or Dependents.

(c) 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 the 90 day period immediately following the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

(d) 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 other health plan coverage and, if reimbursed from the Health Care Reimbursement Fund, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(e) If a Participant fails to accept or cash a claim reimbursement within 120 days after a reimbursement has been issued and the Administrator has made reasonable attempt to reimburse the Participant, the funds shall be considered unclaimed and will be treated as plan forfeitures under Section 6.3 provided that, if a Participant should later renew his or her written request for reimbursement of said amount, the Company shall reimburse such amount to Participant within 90 days of the renewed reimbursement request.

ARTICLE VII
DEPENDENT CARE ASSISTANCE PROGRAM

7.1 ESTABLISHMENT OF PROGRAM

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

(b) "Dependent Care Assistance Program" means the program of benefits contained in this Article, which provides for the reimbursement of eligible expenses for the care of the Qualifying Dependents of Participants.

(c) "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.

(d) "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 or 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 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(e)(1) (or deemed to be, as described in Section 7.2(e)(1) pursuant to Section 7.2(e)(3)), or for a Qualifying Dependent as defined in Section 7.2(e)(2) (or deemed to be, as described in Section 7.2(e)(2) pursuant to Section 7.2(e)(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.

(e) "Qualifying Dependent" means, for Dependent Care Assistance Program purposes,

(1) A Dependent of a Participant who is under the age of 13, with respect to whom the Participant is entitled to an exemption under Code Section 151(c);

(2) A Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself; 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).

(f) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Program.

7.3 DEPENDENT CARE ASSISTANCE ACCOUNTS

The Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Assistance Program benefits.

7.4 INCREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance 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 Assistance Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE ASSISTANCE ACCOUNTS

A Participant's Dependent Care Assistance 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 ASSISTANCE 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 Assistance 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.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Assistance 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 by the Participant and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary or negotiated union contracts to the contrary, the amounts paid from a Participant's Dependent Care Assistance 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) It is the intent of this Dependent Care Assistance Program that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Sections 129(d).

(b) It is the intent of this Dependent Care Assistance Program 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) 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. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Assistance Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Assistance Account for the Plan Year. This process

shall continue until the nondiscrimination tests set forth in this Section are satisfied. 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 Assistance Program. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Assistance Program. 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 ASSISTANCE PROGRAM CLAIMS

The Administrator shall direct the payment of all such Dependent Care Assistance 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 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 to the Administrator 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) the amount of fee paid to the center.

(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, a statement 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) If a Participant fails to submit a claim within the 90-day period immediately following the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

(j) If a Participant fails to accept or cash a claim reimbursement within 120 days after a reimbursement has been issued and the Administrator has made reasonable attempt to reimburse the Participant, the funds shall be considered unclaimed and will be treated as plan forfeitures under Section 7.8 provided that, if a Participant should later renew his or her written request for reimbursement of said amount, the Company shall reimburse such amount to Participant within 90 days of the renewed reimbursement request.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS (this section is effective January 1, 2002)

(a) Any claim for Benefits underwritten by insured Contracts shall be made in accordance that specific Benefit plan. If the Benefit is denied, the Participant or beneficiary shall allow the claims review procedures for that insured Benefit. A 'Claim for Benefits' under the Health Care Reimbursement Plan or the Dependent Care Assistance Plan for purposes of triggering ERISA is deemed to have been made when a signed claim request is received by the Plan Administrator or authorized representative from the Participant, beneficiary or authorized representative using a pre-approved form and attaching third-party documentation substantiating health care expenses per Section 6.7 or dependent care expenses per Section 7.12, and such other information as is reasonably necessary to determine the validity of the claim.

(b) The Administrator shall make a benefit determination within a reasonable time period not longer than 30 days after receipt, unless for matters beyond the control of the Plan Administrator a 15-day extension is required, in which case, the claimant will be notified. A claim for benefits will be deemed incomplete if information necessary to render a full and fair claim determination under the Plan is missing, a notice detailing information necessary to perfect the claim or make it whole shall be issued to the claimant. The Participant has 45 days after receipt of the incomplete notice to provide

such information to the Administrator. The Administrator's time period for making a benefit determination is tolled from the date an incomplete notice is issued to the date the claimant responds.

(c) If an adverse determination is made regarding a claim for benefits, the claimant shall, in a manner calculated to be understood by the claimant, be notified of:

(1) the specific reason(s) for the adverse determination;

(2) specific plan provisions on which the determination is based;

(3) description of addition materials or information necessary from the claimant to complete the claim;

(4) the plan's review or appeal procedures, including time limits and a statement of the claimant's rights to bring civil action under 502(a) of the Act following the appeal.

A Participant shall have 180 days from receipt of an adverse determination to submit written comments, documents or information to support the claim for benefits under Code provisions and Cafeteria Plan and request a review of the determination. If no action is taken, the Participant's ERISA rights of appeal for the claim expire.

(d) If a Participant makes a written request for an adverse decision appeal in a timely manner, an authorized representative of the Administrator other than the representative or subordinate of the representative making the initial adverse determination shall independently review the claim for benefits and as well as all subsequently submitted materials. The Participant shall be notified of a decision within 60 days. The written decision shall be made in accordance with governing plan documents and where appropriate, Plan provisions that have been applied consistently with respect to similarly situated claimants. If an adverse determination is made, the Administrator shall set forth:

(1) the specific reasons for the adverse decision;

(2) reference to Plan provision(s) on which the decision is based;

(3) a description of claimant's review or appeal procedures, including time limits, and if applicable, any internal rules, protocol or similar criterion used in make the decision; and

(4) a statement of the claimant's right to bring suit under ERISA after the appeal.

(e) Any balance remaining in a Participant's Health Care Reimbursement Plan or Dependent Care Assistance Program at the end of each Plan Year 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, unless the Participant had made a written claim for such Plan Year, which has been denied and is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount

held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

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. 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 applied in any manner determined by the Employer that shall not violate the Code, ERISA, or any regulations thereunder, including defraying of administrative costs and experience losses.

8.3 NAMED FIDUCIARY

Amounts in the benefit plan surplus shall first be used to defray any administrative costs and experience losses and thereafter be retained by the Employer.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

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 to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

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

(b) To interpret 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;

(f) To approve reimbursement requests and to authorize the payment of benefits; and

(g) To appoint such agents, counsel, accountants, consultants, and actuaries 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. Benefits under this Plan will be paid only if the Administrator decides in its discretion that the Participant is entitled to them.

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 is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the 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 Insurance Contract shall be paid in accordance with the terms of the Contract.

No further additions shall be made to the Health Care Reimbursement Fund or Dependent Care Assistance Account, but all payments from such Fund shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims). Any amounts remaining in any such account as of the end of the Plan Year in which Plan termination occurs shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

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

11.2 GENDER AND NUMBER

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

11.3 WRITTEN DOCUMENT

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

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the 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 shall instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.10 GOVERNING LAW

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

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

Notwithstanding anything in the Plan to the contrary, in the event any welfare benefit under this Plan, subject to the continuation coverage requirements of Code Section 4980B becomes unavailable, the Participant may be entitled to continuation coverage as prescribed in Code Section 4980B.

11.14 FAMILY AND MEDICAL LEAVE ACT

Notwithstanding any provision in the Plan to the contrary, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) and elects to continue coverage(s) while on leave, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's insured and uninsured group health benefits on the same terms and conditions as if the Participant were still active.

If the Participant elects to continue coverage while on leave, he shall enter into a payment agreement with the Employer prior to leave based on the Participant's share of the premium due for the current Plan Year. One or more of the following payment methods may be used:

(a) Payment with after-tax dollars, by sending monthly payment to the Employer;

(b) Payment with pre-tax salary reduction by pre-paying all or a portion of the coverage contributions during the leave for that Plan Year; or

(c) Payment with pre-tax salary reduction by catching-up on all or a portion of the coverage contributions during the leave for that Plan Year. Salary redirection must be from the same Plan Year as the leave.

If a Participant's coverage ceases while on FMLA leave, the Participant, will be permitted to re-enter the Plan upon return from such leave on the same basis he participated in the Plan prior to the leave, or as otherwise required by the FMLA.

11.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

11.16 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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 USERRA and the regulations thereunder.

CITY OF MENASHA
CAFETERIA PLAN
DECLARATION OF AMENDMENT

2001 RESTATEMENT

The City of Menasha amends and restates the City of Menasha Cafeteria Plan in its entirety to read as set forth in the attached document, entitled the City of Menasha Cafeteria Plan.

This restatement is being adopted to incorporate into the plan changes needed to conform to Internal Revenue Service and Department of Labor regulations. This amendment will be effective as of January 1, 2001. (except as otherwise noted in the document)

IN WITNESS WHEREOF, the City has caused this instrument to be executed by its authorized officials(s) on:

Signed by:_____

Witnesses as to Employer

_____

_____

INSTITUTIONAL TRUST SERVICES

Administrative Services Agreement

Recitals

A. CITY OF MENASHA (Employer) has established certain employee benefit plans, including the following: A health flexible spending arrangement (Health Care FSA) under Code § 105, and a dependent care assistance plan (Dependent Care FSA) under Code § 129, are each offered under a Code § 125 cafeteria plan.

B. Employer has requested Marshall & Ilsley Trust Company N.A (Administrative Agent) to act on its behalf in making payment of certain benefits and furnishing certain service for the Health Care FSA and Dependent Care FSA, as described in this Agreement (collectively, the Plan).

Article I. Introduction

In consideration of the mutual promises contained in this Agreement, Employer and Administrative Agent agrees as follows.

1.1 Effective Date and Term

The effective date of this Agreement is January 1, 2012 ("Effective Date"). The initial term shall be the initial twelve (12) months unless this Agreement is terminated in accordance with the provisions of Section 7.6.

1.2 Scope of Undertaking

Employer has sole and final authority to control and manage the operation of the Plan. Administrative Agent is and shall remain an independent contractor with respect to the services being performed hereunder and shall not for any purpose be deemed an employee of Employer. Nor shall Administrative Agent and Employer be deemed partners, engaged in a joint venture or governed by any legal relationship other than that of independent contractor. Administrative Agent does not assume any responsibility for the general policy design of the Plan, the adequacy of its funding, or any act or omission or breach of duty by Employer. Nor is Administrative Agent in any way to be deemed an insurer, underwriter, or guarantor with respect to any benefits payable under the Plan. Administrative Agent generally provides reimbursement service only and does not assume any financial risk or obligation with respect to claims for benefits payable by Employer under the Plan. Nothing herein shall be deemed to constitute Administrative Agent as a party to the Plan or to confer upon Administrative Agent any discretionary authority or control respecting management of the Plan, discretionary authority or responsibility in connection with administration of the Plan, or responsibility for the terms or validity of the Plan. Nothing in this Agreement shall be deemed to impose upon Administrative Agent any obligation to any employee of Employer or any person who is participating in the plan ("Participant").

1.3 Definitions

"Administrative Agent" has the meaning given under the Recitals.

"Agreement" means this Administrative Services Agreement, including all Appendices hereto.

"Bank" means Bancorp.
"Card" means the BMO Qualified Expense Card.
"Cardholder Agreement" means the agreement entered into between Bank and each Participant who is issued a Card.
"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
"Code" means the Internal Revenue Code of 1986, as amended.
"Dependent Care FSA" has the meaning given in the Recitals.
"Eligible Expenses" means expenses that are eligible for payment or reimbursement to the Participant under the applicable Plan.
"Eligibility Changes" means any change in employee eligibility, new enrollments, terminations, or change in election and or coverage.
"Employer" has the meaning given in the Recitals.
"Employer Account" means an account established and maintained in the name of the Employer for payment of Plan benefits.
"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.
"Effective Date" has the meaning given in Section 1.1.
"Electronic PHI" has the meaning assigned to such term under HIPAA.
"Health Care FSA" has the meaning given in the Recitals.
"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.
"IRS" means Internal Revenue Service
"Named Fiduciary" means the named fiduciary as defined in ERISA § 402(a)(1).
"Participant" has the meaning given in section 1.2.
"Plan Administrator" means the administrator as defined in ERISA § 3(16)(A).
"Plan" has the meaning given in the Recitals.
"Protected Health Information" or "PHI" has the meaning assigned to such term under HIPAA.
"Quarterly Audit Reports" have the meaning described in Section 3.7.
"Required Balance" shall have the meaning as described in Article 5.2.

Article II. Employer Responsibilities

2.1 Sole Responsibilities

(a) General. Employer has the sole authority and responsibility for the Plan and its operation, including the authority and responsibility for administering, construing and interpreting the provisions of the Plan and making all determinations thereunder. Employer gives Administrative Agent the authority to act on behalf of Employer in connection with the Plan, but only as expressly stated in this Agreement or as mutually agreed in writing by Employer and Administrative Agent. Final determinations as to a Participant's entitlement to Plan benefits shall, if legally required (or otherwise in Administrative Agent's discretion) be made by Employer or its designee, including any final internal determinations upon appeal of a denied claim for Plan benefits. Employer will enter into all legally required contracts between the Plan and independent review organization s (IROs) for the purpose of performing any required external appeals for Plan benefits. Employer is the Plan Administrator and Named Fiduciary of the Plan benefits for purposes of ERISA.

(b) Responsibilities. Without limiting Employer's responsibilities described herein, it shall be Employer's sole responsibility (as Plan Administrator) and duty to: ensure

compliance with COBRA; ensure required nondiscrimination testing are completed; ensure the Plans are amended as necessary to ensure ongoing compliance with applicable law; ensure any required tax or governmental returns (including Form 5500 returns) relating to the Plan are filed; determine if and when a valid election change has occurred; in certain circumstances handle Participant final internal claim appeals; if applicable, ensure that the plan complies with the external claims procedures imposed by the Patient Protection and Affordable Care Act (PPACA) to include standard external reviews, expedited external reviews, and contracting between the plan and an independent review organizations (IROs);
ensure required Plan and claim documentation are retained; and when appropriate take all other steps necessary to maintain and operate the Plan in compliance with applicable provisions of the Plan, ERISA, HIPAA, the Code and other applicable federal and state laws.

2.2 Service Charges; Funding

Employer shall pay Administrative Agent the service charges set forth in the Appendices hereto, as described in Article V Employer shall provide Administrative Agent with funds as necessary to make payment of Plan benefits.

2.3 Information to Administrative Agent

Employer shall furnish the information requested by Administrative Agent as determined necessary to perform Administrative Agent's functions hereunder, including information concerning the Plan and the eligibility of individuals to participate in and receive Plan benefits. Such information shall be provided to Administrative Agent in the time and in the manner agreed to by Employer and Administrative Agent. Administrative Agent shall have no liability with regard to benefits paid in error due to Employer's failure to timely update such information, accurately and in the format agreed to by Employer and Administrative Agent.

a. Enrollment
   Employer shall notify Administrative Agent of new plan year enrollment in an approved electronic format fifteen (15) business days prior to the beginning of the plan year. Administrative Agent will process enrollment according to Section 3.6 of this agreement. Delayed or incorrect information provided to Administrative Agent may result in erroneous payment(s) and Employer will bear any risk of any loss that was a result of delayed or incorrect information sent by the Employer or an approved representative of the Employer.
b. Eligibility Changes
   Employer shall notify Administrative Agent of Eligibility changes in an agreed upon electronic format. Administrative Agent will process changes according to Section 3.6 of this agreement. Delayed or incorrect information provided to Administrative Agent may result in erroneous payment(s) and Employer will bear any risk of any loss that was a direct result of delayed or incorrect information sent by the Employer or an approved representative of the Employer.
c. Compliance
   It is the plans responsibility to initiate any corrective action required in the event the Plan becomes discriminatory or otherwise fails to meet any requirements for favorable tax treatment for itself or any participant.

2.4 Plan Documents

Employer is responsible for the Plan's compliance with all applicable federal and state laws and regulations and shall provide Administrative Agent, with all relevant documents, including but not limited to, the executed Plan documents and any executed Plan amendments. Employer is responsible for working with its legal counsel to develop and distribute all other legal documents and notices that may be required for plan administration. Employer will notify Administrative Agent of any changes to the Plan at least thirty (30) days before effective date of such changes. Employer acknowledges that Administrative Agent is not providing tax or legal advice and that Employer shall be solely responsible for determining the legal and tax status of the Plan.

2.5 Liability for Claims

Employer is responsible for payment made pursuant to, and the benefits to be provided by, the Plan. Administrative Agent does not insure or underwrite the liability of Employer under the Plan. Employer is financially responsible for any payment to be made pursuant to, and the benefits to be provided by, the Plan. Except for expenses specifically assumed by Administrative Agent in this Agreement, Employer is responsible for all expenses related to the Plan. In the event of employee fraud against the Plan, it is the Employer's responsibility to make the Plan whole and pursue appropriate remedies from the employee.

2.6 Indemnification

Employer shall indemnify Administrative Agent and hold it harmless from and against all loss, liability, damage, expense, (including reasonable attorneys' fees) or other obligation, resulting from, or arising out of or in any way connected with, any act or omission by Employer in connection with the Plan or claim, demand or lawsuit by Plan Participants and beneficiaries against Administrative Agent in connection with benefit payments or services performed hereunder, except to the extent that any such loss, liability, damage, expense, attorney's fees or other obligations result from, or arise out of, the negligence, willful misconduct or breach of this Agreement by Administrative Agent. In addition, Employer shall indemnify Administrative Agent and hold it harmless from and against any liability, expense, demand, or other obligation, resulting from, or out of any premium charge, tax or similar assessment (federal or state), for which the Plan or Employer is liable.

2.7 HIPAA Privacy

Employer shall provide Administrative Agent with the Health Care FSA's Notice of Privacy Practices (prepared by Employer), as well as any subsequent changes to such notices. Employer shall provide Administrative Agent with certification that the Health Care FSA plan document has been amended as required by the privacy rule to permit disclosures of PHI to Employer for plan administration purposes and that Employer agrees to the conditions set forth in that plan amendment; if Employer receives them, copies of any authorizations of Participants or Beneficiaries to use to disclose PHI (and any later changes to or revocation of such authorization); notice of any restrictions on the use or disclosure of PHI that Employer agrees to under the privacy rule; and notice of any request that communications be sent to a Participant or Beneficiary by an alternative means or at an alternative location that Employer agrees to under the privacy rule. Employer shall not request Administrative Agent to use or disclose PHI in any manner that would not be permissible under the privacy rule if done by Employer, except that Administrative Agent may use or disclose PHI for purposes of data aggregation and the management and administrative activities of Administrative Agent.

Article III. Administrative Agent Responsibilities

3.1 Sole Responsibilities

Administrative Agent's sole responsibilities shall be described in this Agreement. Administrative Agent provides reimbursement and recordkeeping services.

3.2 Customer Service

Administrative Agent shall provide customer service personnel during normal business hours as determined by Administrative Agent by telephone and shall provide electronic administrative services. To the extent that any Services use Internet, wireless or related electronic or telephonic services to transport data or communications, Administrative Agent will take reasonable security precautions, but Administrative Agent disclaims any liability for interception of any such data or communications. Administrative Agent shall not be responsible for, and makes no warranties regarding, the access, speed or availability of such services. Administrative Agent shall not be deemed in default of this Agreement, nor held responsible for, any cessation, interruption, or delay in the performance of its obligations hereunder due to causes beyond its reasonable control, including, but not limited to, natural disaster, act of God, labor controversy, civil disturbance, disruption of the public markets, war or armed conflict, or the inability to obtain sufficient material or services required in the conduct of its business, including Internet access, or any change in or the adoption of any law judgment or decree.

3.3 Claims

Administrative Agent shall process participant claims and Card substantiation requests in accordance with the Plan document and IRS regulations within three (3) business days of receipt. Administrative Agent acts as "agent of the Plan Administrator" when making claim determinations and will defer unusual and/or legally unclear cases to the Employer for determination. Administrative Agent will post payroll contribution data and respective funds as soon as administratively possible within two (2) business days of receipt.

3.4 Claims Appeals

Administrative Agent shall, if legally required, or otherwise in its discretion refer to Employer or its designee, for final internal review and, if applicable to the plan, standard or expedited external review determination, any claim for benefits or coverage that is appealed after initial rejection by Administrative Agent or any class of claims that Employer may specify, including: (a) any question of eligibility or entitlement of the claimant for coverage under the Plan; (b) any question with respect to the amount due; or (c) any other appeal.

3.5 Reimbursements

Administrative Agent will provide check or direct deposit reimbursements on all business days. If a holiday or other event impacts bank processing on a scheduled disbursement date, payment is issued the next business day. If the Employer account is not sufficiently funded, the disbursements will be delayed until funding is sufficient to process such reimbursements.

3.6 Eligibility Changes

Administrative Agent shall process enrollment, eligibility changes and Card status requests from the information received from the Employer. Administrative Agent will post eligibility change data soon as administratively possible within two (2) business days of receipt.

3.7 Quarterly Audit Reports

From time to time thereafter, but no less frequently than quarterly, Administrative Agent shall provide Employer with updated reports summarizing the eligibility data and projected Participant account balances for the Plan Year based on information that has been provided by Employer (Quarterly Audit Reports) by electronic medium unless otherwise agreed by the parties. The Quarterly Audit Reports shall specify the effective date for each Participant who is added to or terminated from participation in the Plan as well as projected account balances for verification purposes.

3.8 Plan Compliance Services

Services include compliance with discrimination testing requirements and IRS Form 5500 filing. Administrative Agent will provide a completed IRS Form 5500(s) if required and requested by the Employer. Administrative Agent is not responsible for the accuracy of any information provided by Employer with regard to the annual Form 5500 and the discrimination testing nor shall Administrative Agent be responsible for determining the level of compliance required by the Plan. The Employer must provide the Administrative Agent with the necessary non-discrimination test data consistent with the Employer records in a timely fashion at the end of each contracted Plan Year and at other times during the plan year if additional testing is requested or required. Employer remains responsible to implement corrective actions required by testing results. If Administrative Agent will not be providing some or all of the compliance services listed above, the Employer agrees to complete the requirements according to the IRS regulations. The Employer agrees to report any required adjustments found during testing on a timely basis to the Administrative Agent. The Employer remains responsible to implement any corrective action required by the testing results.

3.9 Bonding

To the extent required under applicable law, Administrative Agent will have and maintain a fidelity bond for all persons involved in collecting money or making claim payments, and all officers of the Administrative Agent. Such bond, if necessary, will cover the handling of Employer's and Participants' money and protect such money from losses by dishonesty, theft, forgery or alteration, and unexplained disappearance.

3.10 Reporting

Administrative Agent shall make available to Employer each month via electronic medium (unless otherwise agreed by the parties) a master report showing the payment history and status of Participant claims and the amounts and transactions of Participant accounts during the preceding month. For purposes of Employer's Health Care FSA, Employer must provide certification that the Plan document requires the Employer to comply with applicable privacy and security rules under HIPAA before Administrative Agent will make available the reports provided for in this Section to Employer. Administrative Agent shall also make available to Participants via electronic medium a report showing their individual payment history and status of claims and the amounts and transactions in their individual accounts.

3.11 Plan Document

A Section 125 plan document reflecting plan terms must be adopted prior to administration. Employer maintains all documents. When Administrative Agent drafted document is elected by Employer all future regulatory amendments and restatements will be provided at no charge. Administrative Agent prototype Plan document reflects Administrative

Agent's administrative processes for administration and allows for limited Plan modifications such as addition or changes with standard benefit options. Adoption of the plan document is required prior to service/implementation. Administrative Agent prototype plan document includes a summary plan description and a corporate resolution.

3.12 Recordkeeping

Administrative Agent shall maintain, for the duration of this Agreement, the usual and customary books, records and documents, including electronic records that relate to the Plan and its Participants that Administrative Agent has prepared or that have otherwise come within its possession (collectively "Documents"). These Documents are the property of Employer, and Employer has the right to continuing access to them during normal business hours at Administrative Agent's offices with reasonable prior notice. If this Agreement terminates, Administrative Agent may deliver at Employer's request, if Administrative Agent determines it is feasible, Documents to Employer, subject to Administrative Agent's right to retain copies of any Documents it deems appropriate. Employer shall be required to pay Administrative Agent reasonable charges for transportation or duplication of such records, provided, however, that upon termination of this Agreement, Administrative Agent will, if it is feasible in the Administrative Agent's opinion to do so and Employer so requests, destroy or return to Employer all PHI, including PHI that is in the possession of subcontractors or agents of Administrative Agent. To the extent Administrative Agent retains any PHI, Administrative Agent shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Administrative Agent retains such PHI. Administrative Agent shall pay all storage charges for any such PHI for so long as Administrative Agent retains such PHI.

3.13 Standard of Care; Erroneous Payments

Administrative Agent shall use reasonable care in the exercise of its powers and the performance of its duties under this Agreement. If Administrative Agent makes any payment under this Agreement to an ineligible person, due solely to Administrative Agents error, or if more than the correct amount is paid, Administrative Agent shall make a diligent effort to recover any payment made to or on behalf of an ineligible person or any overpayment. However, Administrative Agent will not be liable for such payment, unless Administrative Agent would otherwise be liable under another provision of this Agreement.

3.14 Non-Discretionary Duties; Additional Duties

Administrative Agent and Employer agree that the duties to be performed hereunder by Administrative Agent are non-discretionary duties. Administrative Agent and Employer may agree to additional duties in writing as may be specified in the Appendices from time to time.

Article IV Flexible Benefits Card

4.1 The Flex Benefits Card

The BMO Qualified Expense Card (Card) permits employees who are a Participant in the Plan, from the time of the Participant's enrollment is received by Administrative Agent until Employer notifies Administrative Agent that the Participant's participation has been terminated, to use a VISA® debit card for payment of Eligible Expenses. Bank will issue the Cards to a Participant upon enrollment in the plan by the Participant. By electing a Card, a Participant can

pay for Eligible expenses by using the Card rather than by submitting receipts and waiting for reimbursement. Each transaction using the Card will be paid if authorized through the VISA® authorization system.

4.2 Compliance

Although Employer, as Plan Administrator, is ultimately responsible for determining whether that each transaction is for a Eligible Expense and that the Card and each transaction complies with the terms of the applicable Plan, applicable law and regulations, Employer delegates Administrative Agent ministerial, non-fiduciary responsibilities to make this determination in accordance with IRS guidance and releases and the Administrative Agent accepts such delegation on the same terms as provided for elsewhere in this Agreement. Employer should consult its legal counsel concerning whether the Card Program complies with ERISA, the Health Insurance Portability and Accountability Act and other applicable laws and regulations. No Third Party is responsible for such compliance or certification.

4.3 Issuance of Cards

Employer chooses to issue Cards to all Participants; the Card will be issued to each Participant that enrolls in the Plan. The Participant may request additional Cards for qualified individuals. Each Card will be accompanied by and subject to a Cardholder Agreement between the Bank and the Participant. Notwithstanding Employer's issuance of the Card to a Participant, the Participant must affirmatively elect to activate the Card before use which confirms acceptance of the cardholder terms and agreements. Fees for additional, replacement and lost or stolen Cards will be deducted from the Participant's election.

4.4 Authorization for Transactions

Each time the Card is used, the transaction is sorted into the correct participant election based on information about the type of VISA® merchant that accepted the Card. The Card can be used only at certain types of merchants, as provided in IRS Revenue Ruling 2003-43, as amended from time to time or as otherwise authorized by the Employer or the IRS. An "authorization" through the VISA® system is required for processing of most transactions. When an authorization is required, the authorization will be granted for a proposed transaction only if there are funds available to the Participant in the appropriate election being accessed. Authorization may be denied if the transaction amount exceeds available funds in the applicable election, if Bank or Administrative Agent believes that the proposed transaction is not for a Eligible Expense, or if the transaction limits for a single transaction or for outstanding transactions are exceeded. Transaction limits are established from time to time and implemented by Bank for security purposes.

4.5 Funding of Transactions

Each day, Bank will settle for all transactions through the VISA® system. The Employer Account will reimburse the Bank for the settled transactions each day. Settled transactions initiated by Employer's Participants will be deducted that day from the balances that have been deposited on Employer's behalf in the Employer Account. The Employer must maintain the Required Balance in the Employer Account. As a result, the Employer must reimburse the Employer Account in the amount of settled transactions initiated by Employer's Participants. Employer's obligation to reimburse the Employer Account in the amount of settled transactions and to maintain the Required Balance is absolute, unconditional and not subject to offset or defense of any kind. If for any reason the Employer does not maintain the Required Balance in

the Employer Account or fails to reimburse the Employer Account in the amount of all settled transactions, the Administrative Agent has authority to suspend all Cards in use until the Employer Account is sufficiently funded.

4.6 Review of Expenses

The Card may only be used for the payment of Eligible Expenses and all transactions are subject to review. Some transactions will be reviewed and adjudicated automatically: for example, transactions equal to the Participant's office visit co-pay amount generated by a merchant which is a medical practice will be automatically adjudicated, and no further verification will be required. An e-mail will be sent to each Participant no less often than monthly which will direct the Participant to the Administrative Agent's website which includes a statement showing all of the Participant's transactions. The Participant will be requested to review all receipts and reimburse the Employer for use of the Card for any amounts that were not for Eligible Expenses. The Participant will be directed to supply receipts for all remaining transactions that were not adjudicated automatically within sixty (60) days of the transaction date. The Employer is responsible for the review of all transactions to determine if each transaction was for Eligible Expenses. Employer delegates this responsibility to the Administrative Agent and the Administrative Agent accepts such delegation on the same terms as provided for elsewhere in this agreement. If the Participant does not supply suitable receipts within sixty (60) days, the Participants' Card will be suspended and they must reimburse the Employer for the amount of the transaction.

4.7 Reimbursement for Ineligible Expenses.

At the time of each Participant's enrollment in the Card Program and acceptance of the Cardholder Agreement, the Participant agrees to reimburse the Employer for the amount of any transaction that was not for an Eligible expense. The Employer is obligated to review transactions and to determine whether all transactions were for eligible expenses. Employer delegates this responsibility to the Administrative Agent and the Administrative Agent accepts such delegation on the same terms as provided for elsewhere in this Agreement basing such determination on IRS guidelines and releases and directing other issues back to the employer. For transactions determined by the Participant, Employer or the Administrative Agent to be for ineligible expenses, the Participant will be notified of a balance due to the Plan by email, their online account or direct mail informing him or her of the amount due. If the Participant does not repay the Plan, the Employer will be responsible for repayment to the Plan. If the claim still remains outstanding, the Employer must offset the amount thereof against future claims under the Plan. Employer delegates this responsibility to the Administrative Agent and the Administrative Agent accepts such delegation on the same terms as provided for elsewhere in this Agreement. The Employer must also take action to ensure that further violations do not occur; including denial of access to the Card. Employer delegates this responsibility to the Administrative Agent and the Administrative Agent accepts such delegation on the same terms as provided for elsewhere in this agreement. In the event the amount cannot be collected from the Participant, the Employer must nevertheless pay such amount back to the Plan and treat the amount due as the Employer would any other business indebtedness. Employer should consult a tax advisor on how to handle uncollectible accounts. Generally, the Employer is required to include the amount due as income on the Participant's W-2 form for the year in which the Employer has exhausted collection efforts and has determined the amount to be uncollectible.

4.8 Transactions that are Ineligible

When the Card is used to pay for items that are not Eligible Expenses, the IRS requires repayment from the Participant. A transaction is considered ineligible (" Ineligible Expense") when either: (1) the Administrative Agent, Employer or Participant determines that a portion of a Card transaction is not an Eligible Expense or (2) the Participant does not respond to a request for "receipt verification" within Ninety (90) days. At this time, the Participant's card access is or will remain suspended (Section 4.6) and the amount of the transaction is added to the Ineligible Expense balance. The IRS requires that this debt be collected by the Employer from the Participant and, in general, handled like any other indebtedness between an Employer and its Participant. The Employer may request the Administrative Agent to reinstate the Card when the indebtedness is resolved.

Article V Benefit Plan Payment; Employer's Funding Responsibility

5.1 Payment of Benefits

Employer authorizes Administrative Agent to pay Plan benefits directly or indirectly from funds set aside in an Employer Account.

5.2 Funding of Benefits

Funding for any payment on behalf of the Participants under the Plan, including but not limited to, all benefits to Participants in accordance with the Plan, is the sole responsibility of Employer, and Employer agrees to accept liability for, and provide sufficient funds to satisfy, all payments to Participants under the Plan, including claims for reimbursement for covered expenses, if such expenses are incurred and the claims are presented for payment during the term of this Agreement. Employer is required to fund 5% of the annual elections, the Required Balance, before the start of the Plan Year and required to maintain an account balance equal to the 5% of the annual elections at all times. If nevertheless the account becomes overdrawn due to timing of electronic Card transactions and/or receipt of deposits or any other cause beyond Administrative Agent's control, Employer may be charged an overdraft fee of up to $30.00 each day the account remains overdrawn. The Employer understands that it shall be solely responsible for any and all overdraft charges associated with this account and no such charges shall be allocated to the account or participants in violation of any applicable federal or state laws.

Article VI. Administrative Agent Compensation

6.1 Service Charges

The amounts of the monthly service charges of Administrative Agent are described in the Appendices. Administrative Agent may change the amount of such charges by providing at least sixty (60) days written or electronic notice to Employer before the beginning of the next Plan Year. Administrative Agent may also change the monthly service charges as of the date any change to services provided is made to the Plan by the Employer.

6.2 Billing of Charges

All service charges of Administrative Agent, whether provided for in this or any other Section, shall be billed separately from other amounts paid or payable by the Employer.

6.3 Payment of Charges

All charges under this Article VI shall be determined by Administrative Agent and billed to Employer monthly. All fees are invoiced monthly, Participant monthly fees are charged from the month coverage begins through the end of the plan year. Employer shall make payment to Administrative Agent within thirty (30) business days of receipt of notice of the amount due, or such amount will be deducted from the account maintained by Employer as described in Article V.

Article VII General Provisions

7.1 Severability; Headings

If a court declares any term of this Agreement invalid, the same will not affect the validity of any other provision, provided that the basic purposes of this Agreement are achieved through the remaining valid provisions. The headings of Sections and subsections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

7.2 Compliance; Non-Waiver

Failure by Employer or Administrative Agent to insist upon strict performance of any provision of this Agreement will not modify such provision, render it unenforceable, or waive any subsequent breach. No waiver or modification of any of the terms or provisions of this Agreement shall be valid unless in each instance the waiver or modification is accomplished pursuant to the amendment provisions of Section 7.3

7.3 Assignment; Amendment

Neither Employer nor Administrative Agent can assign Agreement (other than with the other party's written consent.) This Agreement may be amended only by written agreement of duly authorized officers of Employer and Administrative Agent.

7.4 Audits

Each party shall be authorized to perform audits of the records of payment to all Participants and other data specifically related to performance of the parties under this Agreement upon reasonable prior written notice to the other. Audits shall be performed during normal working hours. An agent of either party may perform audits provided such agent signs an acceptable confidentiality agreement. Each party agrees to provide reasonable assistance and information to the auditors. Employer acknowledges and agrees that if it requests an audit, it shall bear the costs of the audit, including but not limited to Administrative Agent's reasonable expenses, including copying and labor costs, in assisting Employer to perform the audit. Each party also agrees to provide such additional information and reports as the other party shall reasonably request.

7.5 Arbitration

Any controversy or claim arising out of or relating to this Agreement between Employer and Administrative Agent, or the breach thereof, shall be subject to non-binding arbitration prior to the filing of a complaint in a court of law; provided, however, that such arbitration shall be final and binding and may be enforced in any court with the requisite jurisdiction if the parties agree in advance, in writing, that such arbitration shall have final, binding effect. All arbitration, whether binding or non-binding, shall be conducted in accordance with the Commercial

Arbitration Rules of the American Arbitration Association. The arbitration shall take place in Milwaukee, Wisconsin.

7.6 Termination of Agreement

(a) Automatic. This Agreement shall automatically terminate as of the earliest of the following: (1) the effective date of any legislation which makes the Plan and/or this Agreement illegal; (2) the date Employer or Administrative Agent becomes insolvent, or bankrupt, or subject to liquidation, receivership, or conservatorship; or (3) the termination date of the Plan, subject to any agreement between Employer and Administrative Agent regarding payment of benefits after the Plan is terminated.

(b) Optional. This Agreement may be terminated as of the earliest of the following: (1) by Administrative Agent upon the failure of Employer to pay any charges within ninety (90) business days after they are due and payable as provided in Article V; (2) by Administrative Agent upon the failure of Employer to perform its obligations in accordance with this Agreement, unless such failure is substantially cured within 20 days of the notice by the aggrieved party; (3) by Employer upon the failure of Administrative Agent to perform its obligations in accordance with this Agreement, including the provisions of Section 3.10; or (4) by either Employer or Administrative Agent, as of the end of the term of this Agreement, by giving the other party ninety (90) days written notice.

(c) Limited Continuation After Termination. If the Plan is terminated, Employer and Administrative Agent may mutually agree in writing that this Agreement shall continue for the purpose of payment of any Plan benefit, expense, or claims incurred prior to the date of Plan termination. In addition, if this Agreement is terminated while the Plan continues in effect, Employer and Administrative Agent may mutually agree in writing that this Agreement shall continue for the purpose of payment of any claims for which requests for reimbursements have been received by Administrative Agent before the date of such termination. If this Agreement is continued in accordance with this subsection (c), Employer shall pay the unreduced monthly service charges incurred during the period that this Agreement is so continued. This Agreement shall continue as provided by and subject to Section 3.8 if the return or destruction of PHI is determined to be infeasible.

(d) Survival of Certain Provisions. Termination of this Agreement shall not terminate the rights or obligations of either party arising out of a period prior to such termination. The indemnity, confidentiality, privacy, and security provisions of this Agreement shall survive its termination.

7.7 Miscellaneous

Employer represents and warrants that as of the date of this Agreement that the person submitting this Agreement on Employer's behalf has full power and authority to bind Employer to the terms of this Agreement, that the Employer sponsors a Plan and the Plan is in compliance with all applicable Internal Revenue Service regulations and rulings, including without limitation, requirements related to the use of debit or stored value cards and that no contractual obligations exist that would prevent Employer from entering into and performing this Agreement.

7.8 Complete Agreement; Governing Law

This Agreement (including the Appendices) is the full Agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements and representations between the parties. This Agreement shall be construed, enforced and governed by the laws of the State of Wisconsin.

The person submitting this Agreement on Employer's behalf has full power and authority to bind Employer to the terms of this Agreement. Employer sponsors a Plan and the Plan is in compliance with all applicable Internal Revenue Service regulations and rulings, including without limitation, requirements related to the use of debit or stored value cards. No contractual obligations exist that would prevent Employer from entering into and performing this Agreement.

IN WITNESS WHEREOF, Employer and Administrative Agent have caused this Agreement to be executed in their names by their undersigned officers, the same being duly authorized to do so.

Date: _____ By: _____

City of Menasha

Date: _____ By: _____

Marshall & Ilsley Trust Company N.A.

Appendix A
Plan Fees & Services

Initial Plan Document and Elective Full Restatements	**$750.00**
Elective Plan Amendments	**$250.00**
Participant Monthly Charge	**$4.00**
Monthly Minimum	**$260.00**

Monthly Participant charge includes:
Participation in one or all of the spending accounts
Contributions made by the Employer or Participant (through pre-tax payroll deduction)
Two (2) BMO Qualified Expense Cards issued to all Participants
90-day standard run-off period following last day of plan year (for renewing plans)
Optional 2 1/2 month grace period following plan year for HCFSA & DCFSA
2 1/2 month run-off period following optional grace period (for renewing plans)

BMO Qualified Expense Card

Optional Co-Branded Card Fee (Requires 120 day lead time prior to Plan Year start)	**$750.00**
Additional Card Requests*	**$5.00**
Reissue/Lost or stolen Card Fee*	**$5.00**

*Fees for additional Cards, replacements of lost or stolen or additional Cards will be deducted from the Participant's available balance.

Form 5500 Preparation	**Included**
Non-Discrimination Testing Service includes up to two tests per Plan year.	**Included**
Additional Non-Discrimination Tests	**$300.00**

Appendix B
Communication Services

On-line Enrollment	**Included**
Educational Meetings* - Group meetings - Benefit Fair Attendance - One-on-one Counseling	**$350.00 for an 8-hour day**
PowerPoint FSA Presentation	**Included**
Electronic FSA Information Booklet - PDF version. - Employer distributes/directs Participants to electronic location	**Included**
FSA Information Booklet - Hard copy version - Employer distributes	**$30 / pack of 25 + shipping**
FSA Informational Insert	**$20 / pack of 100 + shipping**
FSA Poster	**$15 /pack of 10 + shipping**
Customized Materials	**Cost plus 10% + shipping**

Materials and services are invoiced at the time of request or the first month of the plan year.

***Travel and lodging costs are additional**

BMO A part of BMO Financial Group

M&I Institutional Trust Services, a division of Marshall & Ilsley Trust Company, N.A., offers products and services through various affiliates of BMO Financial Corp., including M&I Investment Management Corp., M&I Financial Advisors, Inc. (member FINRA/SIPC, maintaining its principal offices at 111 E. Kilbourn Ave., Milwaukee, WI 53202), North Star Trust Company and Taplin, Canida & Habacht, LLC. © 2011 BMO Financial Corp.

Investment products are: Not FDIC Insured | No Bank Guarantee | May Lose Value

M&I | Marshall & Ilsley Trust Company N.A.

PLAN SPONSOR'S AUTHORIZATION

As a Fiduciary with respect to the plan(s) designated below, I hereby acknowledge that M&I provides investment advice to the Marshall Money Market Fund with respect to the plan, and I am independent of and unrelated to M&I.

On the basis of the prospectus for the Marshall Money Market Fund and other information provided, I hereby authorize and approve the initial and ongoing investment of the assets of the plan in the Fund and the payment of the fees incident to such investment as described in the prospectus and your letter including the payment of advisory fees to M&I.

On Behalf of the Following: City of Menasha

Account #: 98L128018 In the Name of: City of Menasha

Signature: _____ Date: _____

Title: _____

The above named Company declines the option to have funds from the above referenced account invested in the Marshall Money Market Fund. As a result funds will not earn any interest while on account at M&I.

Signature: _____ Date: _____

Title: _____

BMO A part of BMO Financial Group

M&I Institutional Trust Services, a division of Marshall & Ilsley Trust Company, N.A., offers products and services through various affiliates of BMO Financial Corp., including M&I Investment Management Corp., M&I Financial Advisors, Inc. (member FINRA/SIPC, maintaining its principal offices at 111 E. Kilbourn Ave., Milwaukee, WI 53202), North Star Trust Company and Taplin, Canida & Habacht, LLC. © 2011 BMO Financial Corp.

Investment products are: Not FDIC Insured | No Bank Guarantee | May Lose Value

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BA Agreement"), effective February 17, 2010 ("BA Agreement Effective Date"), is entered into by and between MARSHALL & ILSLEY TRUST COMPANY N.A. ("Business Associate") and CITY OF MENASHA CAFETERIA PLAN ("Covered Entity) (collectively, "the Parties").

I. Definitions

(a) *Breach.* "Breach" shall have the same meaning as the term "breach" in 45 CFR Section 164.402.

(b) *Business Associate.* "Business Associate" shall mean MARSHALL & ILSLEY TRUST COMPANY N.A.

(c) *Covered Entity.* "Covered Entity" shall mean CITY OF MENASHA CAFETERIA PLAN.

(d) *Electronic Health Record.* "Electronic Health Record" shall have the same meaning as the term "electronic health record" in American Recovery and Reinvestment Act of 2009, Section 13400(5).

(e) *Electronic Protected Health Information.* "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 CFR Section 160.103.

(f) *Electronic Transactions Rules.* "Electronic Transactions Rule" shall mean the final regulations issued by HHS concerning standard transactions and code sets under 45 CFP Parts 160 and 162.

(g) *HHS.* "HHS" shall mean the Department of Health and Human Service.

(h) *Privacy Rule.* "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, subparts A and E.

(i) *Protected Health Information.* "Protected Health Information" shall have the same meanings as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

(j) *Required By Law.* "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

(k) *Security Incident.* "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR Section 164.304.

(l) *Security Rule.* "Security Rule" shall mean the Security Standards and Implementation Specifications at 45 CFR Parts 160 and 164, subpart C.

(m) *Transaction.* "Transaction" shall have the meaning given the term "transaction" in 45 CFR Section 160.103.

(n) *Unsecured Protected Health Information.* "Unsecured protected health information" shall have the meaning given the term "unsecured protected health information" in 45 CFR Section 164.402.

II. Safeguarding Privacy and Security of Protect Health Information

(a) **Permitted uses and Disclosures.** Business Associate is permitted to use and disclose Protected Health Information that it creates or receives on Covered Entity's behalf or receives from Covered Entity (or another business associate of Covered Entity) and to request Protected Health Information on Covered Entity's behalf (collectively, "Covered Entity's Protected Health Information") only:

(i) **Functions and Activities on Covered Entity's Behalf.** To perform the services specified under the services agreement between Covered Entity and Business Associate.

(ii) **Business Associate's Operation.** For Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities, provided that, with respect to disclosure of Covered Entity's Protected Health Information, either:

(A) The disclosure is Required by Law; or

(B) Business Associate obtains reasonable assurance from any person or entity to which Business Associate will disclose Covered Entity's Protected Health Information that the person or entity will:

(1) Hold Covered Entity's Protected Health Information in confidence and use or further disclose Covered Entity's Protected Health Information only for the purpose for which Business Associate disclosed Covered Entity's Protected Health Information to the person or entity or as Required by Law; and

(2) Promptly notify Business Associate (who will in turn notify Covered Entity in accordance with the breach notification provisions) of any instance of which the person or entity becomes aware in which the confidentiality of Covered Entity's Protected Health Information was breached.

(iii) **Minimum Necessary.** Business Associate will, in its performance of the functions, activities, services, and operations specified above, make reasonable efforts to use, to disclose, and to request only the minimum amount of Covered Entity's Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure, or request, except that Business Associate will not be obligated to comply with this minimum-necessary limitation if neither Business Associate nor Covered Entity is required to limit its use, disclosure or request to the minimum necessary. Business Associate and Covered Entity acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), passed as part of the American Recovery and Reinvestment Act of 2009, and government guidance on the definition.

(b) **Prohibition on Unauthorized Use or Disclosure.** Business Associate will neither use nor disclose Covered Entity's Protected Health Information, except as permitted or required by this Agreement or in writing by Covered Entity or as Required by Law. This Agreement does not authorize Business Associate to use or disclose Covered Entity's Protected Health Information in a manner that will violate the Privacy Rule if done by Covered Entity.

(c) **Information Safeguards.**

(i) **Privacy of Covered Entity's Protected Health Information.** Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of Covered Entity's Protected Health Information. The safeguards must reasonably protect Covered Entity's Protected Health Information from any intentional or unintentional use or disclosure in violation of the Privacy Rule and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement.

(ii) **Security of Covered Entity's Electronic Protected Health Information.** Business Associate will develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health

Information that Business Associate creates, receives, maintains, or transmits on Covered Entity's behalf as required by the Security Rule.

(d) **Subcontractors and Agents.** Business Associate will require any of its subcontractors and agents, to which Business Associate is permitted by this Agreement or in writing by Covered Entity to disclose Covered Entity's Protected Health Information and/or Electronic Protected Health Information, to provide reasonable assurance that such subcontractor or agent will comply with the same privacy and security safeguard obligations with respect to Covered Entity's Protected Health Information and/or Electronic Protected Health Information that are applicable to Business Associate under this Agreement.

(e) **Prohibition on Sale of Records.** Business Associate shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an individual.

(f) **Penalties for Noncompliance.** Business Associate acknowledges that it is subject to civil and criminal enforcement for failure to comply with the privacy rule and security rule, as amended by the HITECH Act.

III. Compliance with Electronic Transactions Rule. If Business Associate conducts in whole or part electronic Transactions on behalf of Covered Entity for which HHS has established standards, Business Associate will comply, and will require any subcontractor or agent it involves with the conduct of such Transactions to comply, with each applicable requirement of the Electronic Transactions Rule. Business Associate shall also comply with the National provider Identifier requirements, if and to the extent applicable.

IV. Individual Rights.

(a) **Access.** Business Associate will, within 20 calendar days following Covered Entity's request, make available to Covered Entity or, at Covered Entity's direction, to an individual (or the individual's personal representative) for inspection and obtaining copies Covered Entity's Protected Health Information about the individual that is in Business Associate's custody or control, so that Covered Entity may meet its access obligations under 45 CFR Section 164.524. Effective as of the date specified by HHS, if the Protected Health Information is held in an Electronic Health Record, then the individual shall have a right to obtain from Business Associate a copy of such information in an electronic format. Business Associate shall provide such a copy to Covered Entity or, alternatively, to the individual directly, if such alternative choice is clearly, conspicuously, and specifically made by the individual or Covered Entity.

(b) **Amendment.** Business Associate will, upon receipt of written notice from Covered Entity, promptly amend or permit Covered Entity access to amend any portion of Covered Entity's Protected Health Information, so that Covered Entity may meet its amendment obligations under 45 CFR Section 164.526.

(c) **Disclosure Accounting.** To allow Covered Entity to meet its disclosure accounting obligations under 45 CFR Section 164.528:

(i) **Disclosures Subject to Accounting.** Business Associate will record the information specified below ("Disclosure Information") for each disclosure of Covered Entity's Protected Health Information, not excepted from disclosure accounting as specified below, that Business Associate makes to Covered Entity or to a third party.

(ii) **Disclosures Not Subject to Accounting.** Business Associate will not be obligated to record Disclosure Information or otherwise account for disclosures of Covered Entity's Protected Health Information if Covered Entity need not account for such disclosures.

(iii) **Disclosure Information.** With respect to any disclosure by Business Associate of Covered Entity's Protected Health Information that is not excepted from

disclosure accounting, Business Associate will record the following Disclosure Information as applicable to the type of accountable disclosure made:

(A) **Disclosure Information Generally.** Except for repetitive disclosures of Covered Entity's Protected Health Information as specified below, the Disclosure Information that Business Associate must record for each accountable disclosure is (i) the disclosure date, (ii) the name and (if known) address of the entity to which Business Associate made the disclosure, (iii) a brief description of Covered Entity's Protected Health Information disclosed, and (iv) a brief statement of the purpose of the disclosure.

(B) **Disclosure Information for Repetitive Disclosures.** For repetitive disclosures of Covered Entity's Protected Health Information that Business Associate makes for a single purpose to the same person or entity (including Covered Entity), the Disclosure Information that Business Associate must record is either the Disclosure Information specified above for each accountable disclosure, or (i) the Disclosure Information specified above for the first of the repetitive accountable disclosures; (ii) the frequency, periodicity, or number of the repetitive accountable disclosures; and (iii) the date of the last of the repetitive accountable disclosures.

(iv) **Availability of Disclosure Information.** Business Associate will maintain the Disclosure Information for at least six years following the date of the accountable disclosure to which the Disclosure Information relates (three years for disclosures related to an Electronic Health Record, starting with the date specified by HHS). Business Associate will make the Disclosure Information available to Covered Entity within 30 calendar days following Covered Entity's request for such Disclosure Information to comply with an individual's request for disclosure accounting. Effective as of the date specified by HHS, with respect to disclosures related to an Electronic Health Record, Business Associate shall provide the accounting directly to an individual making such a disclosure request, if a direct response is requested by the individual.

(d) **Restriction Agreements and Confidential Communications.** Business Associate will comply with any agreement that Covered Entity makes that either (i) restricts use or disclosure of Covered Entity's Protected Health Information pursuant to 45 CFR Section 164.522(a), or (ii) requires confidential communication about Covered Entity's Protected Health Information pursuant to 45 CFR Section 164.522(b), provided that Covered Entity notifies Business Associate in writing of the restriction or confidential communication obligations that Business Associate must follow. Covered Entity will promptly notify Business Associate in writing of the termination of such restriction agreement or confidential communication requirement and, with respect to termination of any such restriction agreement, instruct Business Associate whether any of Covered Entity's Protected Health Information will remain subject to the terms of the restriction agreement. Effective February 17, 2010 (or such other date specified as the effective date by HHS), Business Associate will comply with any restriction request if: (i) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (ii) the Protected Health Information pertains solely to a health care item or service for each the heath care provider involved has been paid out-of-pocket in full.

V. Breaches and Security Incidents.

(a) **Reporting.**

(i) **Privacy or Security Breach.** Business Associate will report to Covered Entity any use or disclosure of Covered Entity's Protected Health Information not permitted by this Agreement along with any Breach of Covered Entity's Unsecured Protected Health Information. Business Associate will treat the Breach as being discovered in accordance with 45 CFR Section 164.410. Business Associate will make the report to Covered Entity's Privacy Official not more than 10 calendar days after Business Associate learns of such non-permitted use or disclosure. If delay is requested by a law-enforcement official in accordance with 45 CFR Section 164.412, Business Associate may delay notifying Covered Entity for the applicable time period. Business Associate's report will at least:

(A) Identify the nature of the Breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;

(B) Identify Covered Entity's Protected Health Information that was subject to the non-permitted use or disclosure or Breach (such as whether full name, social security number, date of birth, home address, account number or other information were involved) on an individual basis;

(C) Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;

(D) Identify what corrective or investigational action Business Associate took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;

(E) Identify what steps the individuals who were subject to a Breach should take to protect themselves;

(F) Provide such information, including a written report, as Covered Entity may reasonably request.

(ii) Security Incidents. Business Associate will report to Covered Entity any attempted or successful (A) unauthorized access, use, disclosure, modification, or destruction of Covered Entity's Electronic Protected Health Information or (B) interference with Business Associate's system operation in Business Associate's information systems, of which Business Associate becomes aware. Business Associate will make this report once per month, except if any such security incident resulted in a disclosure not permitted by this Agreement or Breach of Covered Entity's Unsecured Protected Health Information, Business Associate will make the report in accordance with the provisions set forth in the paragraph above.

VI. Term and Termination.

(a) **Term.** The term of this Agreement shall be effective as of February 17, 2010, and shall terminate when all Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this section.

(b) **Right to Terminate for Cause.** Covered Entity may terminate Agreement if it determines, in its sole discretion, that Business Associate has breached any provision of this Agreement, and upon written notice to Business Associate of the breach, Business

Associate fails to cure the breach within 10 calendar days after receipt of the notice. Any such termination will be effective immediately or at such other date specified in Covered Entity's notice of termination.

(i) **Return or Destruction of Covered Entity's Protected Health Information as Feasible.** Upon termination or other conclusion of Agreement, Business Associate will, if feasible, return to Covered Entity or destroy all of Covered Entity's Protected Health Information in whatever form or medium, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of Covered Entity's Protected Health Information. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Business Associate. Further, Business Associate shall require any such subcontractor or agent to certify to Business Associate that it be returned to Business Associate (so that Business Associate may return to the Covered Entity) or destroyed all such information which could be returned or destroyed. Business Associate will complete these obligations as promptly as possible, but not later than 30 calendar days following the effective date of the termination or other conclusion of Agreement.

(ii) **Procedure When Return or Destruction is Not Feasible.** Business Associate will identify any of Covered Entity's Protected Health Information, including any that Business Associate has disclosed to subcontractors or agents as permitted under this Agreement, that cannot feasibly be returned to Covered Entity or destroyed and explain why return or destruction is infeasible. Business Associate will limit its further use and disclosure of such information to those purposes that make return or destruction of such information infeasible. Business Associate will complete these obligations as promptly as possible, but not later than 30 calendar days following the effective date of the termination or other conclusion of Agreement.

(iii) **Continuing Privacy and Security Obligation.** Business Associate's obligation to protect the privacy and safeguard the security of Covered Entity's Protected Health Information as specified in this Agreement will be continuous and survive termination or other conclusion of this Agreement.

VII. General Provisions

(a) **Definitions.** All terms that are used but not otherwise defined in this Agreement shall have the meaning specified under HIPAA, including its statute, regulations and other official government guidance.

(b) **Inspection of Internal Practices, Books, and Records.** Business Associate will make its internal practices, books, and records relating to its use and disclosure of Covered Entity's Protected Health Information available to Covered Entity and to HHS to determine compliance with the Privacy Rule.

(c) **Amendment to Agreement.** Upon the compliance date of any final regulation or amendment to final regulation promulgated by HHS that affects Business Associate or Covered Entity's obligations under this Agreement, this Agreement will automatically amend such that the obligations imposed on Business Associate or Covered Entity remain in compliance with the final regulation or amendment to final regulation.

(d) **No Third-Party Beneficiaries.** Nothing in this Agreement shall be construed as creating any rights or benefits to any third parties.

(e) **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit Covered Entity and Business Associate to comply with the applicable requirements under HIPAA.

(f) **Indemnification.** Business Associate agrees to indemnify and hold harmless Covered Entity and City of Menasha its agents, directors, and employees against any and all losses, damages, liabilities and expenses (including reasonable attorneys fees) to the extent such result from Business Associate's negligence, willful misconduct, or failure to follow the terms of this Agreement. In addition, CITY OF MENASHA, WISCONSIN agrees to indemnify and hold harmless Business Associate, its agents, directors, and employees against any and all losses, damages, liabilities and expenses (including reasonable attorneys fees) to the extent such result from CITY OF MENASHA, WISCONSIN's and/or Covered Entity's negligence, willful misconduct, or failure to follow the terms of this Agreement.

(g) **Notices.** Any notices or reports given hereunder shall be delivered to named Privacy Officials/Contacts. Current Privacy Officials/Contacts are identified on the attached "Schedule A". The Parties shall provide prompt written notification of any change of Privacy Official/Contact.

CITY OF MENASHA, WISCONSIN and
CITY OF MENASHA CAFETERIA PLAN, Covered Entity

Dated:

_____

By:
Title:

_____

By:
Title:

MARSHALL & ILSLEY TRUST COMPANY N.A.,
Business Associate:

Dated:

_____

By: Sheila Vetrone
Benefits Services Manager

_____

By: Pam Ganzen
Officer, Flexible Benefits Specialist

Amendment and Adoption for the City of Menasha Flexible Spending Plan

The undersigned, by executing this Amendment and Adoption Agreement ("Amendment") makes the following elections and amends the City of Menasha Flexible Spending Plan (the "Plan"). The undersigned further directs that the appropriate employees take such actions deemed necessary and proper in order to implement the Amendment and Adoption.

SECTION I
AMENDMENT

1. **Effective Date**. The amendment shall be effective January 1, 2011, unless otherwise defined herein. (*Regulations permit retroactive coverage to March 30, 2010*)

2. **Coverage for Adult Children Under Age 27.** The definition of Dependent is amended to include any child (as defined in Code §152(f)(1) §152(f)(1) of the Participant who as of the end of the taxable year has not attained age 27) ("Adult Child") with respect to the following components of the Plan:
   ☒ Premium Conversion Plan under Code Section 106
   ☐ Medical Reimbursement Plan under Code Section 105 (*Optional for "excepted" benefits under the HIPAA Portability Rules*)

3. **Notwithstanding the Election(s) in #2 Above, Coverage Exceptions for Adult Children Under Age 27:**
   ☒ No exclusions apply
   ☐ Coverage is excluded for an Adult Children eligible for similar group health coverage through his/her employer *(Permitted option for "excepted" benefit, as well as "non-excepted" benefits that maintain grandfathered status.)*

4. **Special Enrollment.**
   ☒ N/A (excepted benefit plan)
   ☐ Applies (non-excepted benefit plan). Each eligible Adult Child must be given an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period. The special enrollment period may run concurrent with or following annual open enrollment. This enrollment opportunity and a written notice must be provided not later than the first day of the first plan year beginning on or after September 23, 2010. The requirement does not otherwise change the enrollment period or start of the plan year. The special enrollment for this Plan will begin and end (*will generally run concurrent with special enrollment for group health insurance*).

5. **Notwithstanding the Election(s) in #2 Above, the Coverage End Date for Adult Children Under Age 27 shall be:**
   ☐ The Adult Child's 26th birthday.
   ☐ The last day of the month in which the Adult Child turns age 26.
   ☒ The last day of the calendar year in which the Adult Child turns age 26.
   ☐ Other, describe: (*Income must be imputed for coverage extended beyond the last day of the calendar year in which the Adult Child reaches age 26 if the Adult Child does not qualify as a tax dependent.*)

6. **Definition of Medical Expenses**: Effective January 1, 2011 "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations there under, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. Medical Expenses for purposes of providing coverage for an Adult Child under age 27 who does otherwise qualify as the Participant's tax dependent are included to the extent adopted in numbers 2, 3, and 5 of this Amendment. Over-the-counter medicines and drugs are included if prescribed meeting the prescription requirements of applicable state law to treat (or due to) a specific medical condition. Limited Health Care Reimbursement Plan (Limited FSA) coverage, to the extent it is included as a Benefit in this Plan, covers only those health care expenses considered to be for dental or vision expenses, as allowed under Code Section 223. 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. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

SECTION II
ADOPTION

The undersigned hereby certifies that the following resolutions were duly adopted by:

- ☐ The Board of Directors on , 2010.
- ☐ Other governing body (describe:) on , 2010
- ☒ Individual authorized to act on behalf of the governing body
- ☐ Committee authorized to act on behalf of the governing body
- ☐ Other form of adoption (provide detail):

(*Attach a copy of the Minutes or Authorization if applicable. Maintain the original with plan sponsor files for audit purposes.*)

Date:

City of Menasha, Wisconsin

_____

By:
Title:

Business Associate Agreement
Addendum

This document is an addendum to and is incorporated into the existing Business Associate Agreement entered into between Marshall & Ilsley Trust Company N.A. ("Business Associate") and the INSERT PLAN NAME ("Covered Entity"). The purpose of this addendum is to identify:

1) Privacy Officials of the Covered Entity and Business Associate;
2) Covered Entity personnel authorized to access or transmit information for plan administration purposes; and,
3) Other business associates of the Covered Entity authorized to access or transmit information for plan administration purposes.

Information requested from or transmitted to the parties listed must be limited to the "Minimum Necessary" for plan administration functions and may include Health Information, Individually Identifiable Health Information (IIHI), Protected Health information (PHI), or Electronic Protected Health Information (ePHI) subject to the HIPAA Privacy, Security and HITECH Rules. Where individuals are identified by name and title, authorization to access is extended to successors in title. The Parties shall provide prompt written notification for all other changes.

NAMED PRIVACY OFFICIALS/CONTACTS

If to Business Associate:

Ms. Sheila Vetrone
M&I Benefits Services Manager
Marshall & Ilsley Trust Company, N.A.
221 West College Avenue
Appleton, WI 54911
Sheila.Vetrone@micorp.com
800-236-3539

If to Covered Entity:

(Name)
(Title)
(Company)
(Street)
(City, State, Zip)
(Email)
(Telephone)

COVERED ENTITY PERSONNEL AUTHORIZED ACCESS TO INFORMATION FOR PLAN ADMINISTRATION PURPOSES

, (Title); , (Name)

, (Title); , (Name)

, (Title); , (Name)

, (Title); , (Name)

-or-

(Detailed description of employees (e.g. by department) authorized access to PHI for plan administration purposes.)

BUSINESS ASSOCIATES AUTHORIZED ACCESS INFORMATION FOR PLAN ADMINISTRATION PURPOSES

List all other business associates authorized to receive information from (or to transmit information to) M&I Benefits Services.

, (Company); , (Department); , (Title); , (Name);
Have you entered into a Business Associate Agreement with this provider?

, (Company); , (Department); , (Title); , (Name);
Have you entered into a Business Associate Agreement with this provider?

, (Company); , (Department); , (Title); , (Name);
Have you entered into a Business Associate Agreement with this provider?

INSERT COMPANY NAME
and on behalf of
INSERT PLAN NAME, Covered Entity

Dated: _____

_____
By:
Title:

_____
By:
Title:

MARSHALL & ILSLEY TRUST COMPANY N.A.,
Business Associate:

Dated: _____

_____
By: Sheila Vetrone
Benefits Services Manager

_____
By:

BMO | A part of BMO Financial Group

M&I Institutional Trust Services, a division of Marshall & Ilsley Trust Company, N.A., offers products and services through various affiliates of BMO Financial Corp., including M&I Investment Management Corp., M&I Financial Advisors, Inc. (member FINRA/SIPC, maintaining its principal offices at 111 E. Kilbourn Ave., Milwaukee, WI 53202), North Star Trust Company and Taplin, Canida & Habacht, LLC. © 2011 BMO Financial Corp.

Investment products are: Not FDIC Insured | No Bank Guarantee | May Lose Value

CERTIFICATE OF ADOPTION

The undersigned being duly authorized by the City Council of City of Menasha (the "City"), hereby certifies that the amended and restated plan document attached hereto is duly adopted.

The proper officers of the City are hereby authorized and directed to execute said Amendment(s). The appropriate officers of the City shall be instructed to take such actions deemed necessary and proper in order to implement the Amendment(s) and to set up adequate accounting and administrative procedures to provide benefits as provided under the Plan.

The City hereby agrees to indemnify and to hold Marshall & Ilsley Trust Company harmless from and against all claims, expenses (including reasonable attorney fees), liabilities, damages, actions or other charges incurred by or assessed against Marshall & Ilsley Trust Company as a direct or indirect result of anything done or omitted by Marshall & Ilsley Trust Company in reliance upon the directions, or absence of directions, of the Plan Administrator, the City, or any participant in the Plan or any prior service provider.

_____

Name:
Title:
Date: