CAFETERIA PROGRAM

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CAFETERIA PROGRAM

INTRODUCTION

The purpose of this Cafeteria Program is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Cafeteria Program was first effective on August 1, 1991.

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

Except as otherwise set forth herein, capitalized terms shall have the definition assigned to them under the main plan document of the OSI Restaurant Partners, LLC Employee Benefit Plan or the Summary Plan Description.

ARTICLE I
DEFINITIONS

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

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

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

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

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

1.6 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.1 and has not for any reason become ineligible to participate further in the Plan.

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

1.8 **"Program"** means the Cafeteria Program, as amended from time to time.

1.9 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.2. These contributions shall be allocated to the funds or accounts established under the Program pursuant to the Participants' elections made under Article V.

1.10 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his or her 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 Program and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

ARTICLE II
PARTICIPATION

2.1 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Program shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Plan Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his or her Benefit elections pursuant to Section 5.3 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he or she wishes to participate in this Program. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Program, who is covered by the Employer's insured or self-funded Benefits under the Plan, and who has sufficient Compensation to participate in this Program shall automatically become a Participant to the extent of the Premiums for such insurance or Benefits, unless otherwise limited by law.

2.2 TERMINATION OF PARTICIPATION

Except as provided in Section 2.3(c) below, a Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.3;

(b) **Death.** The Participant's death, subject to the provisions of Section 2.4; or

(c) **Termination of the Plan or this Program.** The termination of the Plan or this Program, subject to the provisions of Section 10.2.

2.3 TERMINATION OF EMPLOYMENT

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

(a) **Self-Funded/Insurance Benefit.** With regard to Benefits provided under Section 4.1, the Participant's participation in the Plan shall cease, subject to the Participant's right to COBRA coverage under any insurance contract or self-funded Benefit as addressed in the "COBRA" Section of the Summary Plan Description.

(b) **Dependent Care Flexible Spending Account.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Program shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred up to the date of termination and submitted within 90 days after termination, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **COBRA applicability for Health Care Flexible Spending Account.** With regard to the Health Care Flexible Spending Account, the Participant may submit claims within 90 days after termination for expenses that were incurred during the portion of the Plan Year before the date of termination. Thereafter, the Health Care Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B, as addressed in the "COBRA" Section of the Summary Plan Description.

(d) **Health Savings Account.** With regard to the Health Savings Account, a Health Savings Account continues to be the Participant's Health Savings Account, even if a Participant's employment with the Employer is terminated. The Participant can elect to roll their Health Savings Account into another Health Savings Account.

2.4 DEATH

If a Participant dies, his or her participation in this Program shall cease. However, such Participant's Spouse or Dependents may submit claims for expenses or benefits under the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account incurred through the date on which the Participant dies. In no event may reimbursements be paid to someone who is not a Spouse or Dependent. Code Section 4980B shall apply for purposes of the Health Care Flexible Spending Account, as addressed in the COBRA Section of the Summary Plan Description.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

A Participant's Compensation will be reduced in an amount equal to the cost of Benefits he or she elected under Section 4.1. Such reduction shall be his or her Salary Redirection, which the Employer will use on his or her behalf to pay for the Benefits he or she elected. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect to have Salary Redirections applied to one or more of the Benefits set forth in this Section 4.2 through 4.8 or, as applicable, to pay the employee contributions or premiums for such Benefits set forth in this Section 4.2 through 4.8.

4.2 HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant who is enrolled in a non-high deductible health plan sponsored by the Employer may elect to participate in the Health Care Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

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

4.4 MEDICAL COVERAGE

Each Participant may elect to be covered under medical coverage offered by the Employer for the Participant, his or her Spouse, and his or her Dependents.

4.5 DENTAL COVERAGE

Each Participant may elect to be covered under the dental coverage offered by the Employer for the Participant, his or her Spouse, and his or her .

4.6 VISION COVERAGE

Each Participant may elect to be covered under the vision coverage offered by the Employer for the Participant, his or her Spouse, and his or her Dependents .

4.7 OTHER INSURANCE BENEFITS

Each Participant who is eligible under the applicable Incorporated Document may elect to participate in the following coverages allowed under Code Section 125:

(a) Supplemental Life Insurance for the Participant;

(b) Supplemental Accidental Death & Dismemberment Insurance for the Participant;

(c) Buy-Up Short Term Disability Insurance for the Participant; or

(d) Buy-Up Long Term Disability Insurance for the Participant.

The rights and conditions with respect to the Benefits above payable from any Insurance Contract shall be determined therefrom, as set forth in Addendum A to the Summary Plan Description.

4.8 HEALTH SAVINGS ACCOUNT BENEFIT

Each Participant enrolled in a high-deductible health plan sponsored by the Employer and who is otherwise eligible to make contributions to a Health Savings Account may elect to have Salary Redirections contributed to a Health Savings Account, as defined in Code Section 223, subject to an annual limit set by the Plan Administrator and communicated to Participants during the Election Period. The amounts contributed shall be subject to the terms of the Health Savings Account as established. A Participant who has elected to make elective contributions under such arrangement may modify or revoke the election prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder.

4.9 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Program to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be

discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

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

(c) **Adjustment to avoid test failure.** If the Plan 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 Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Plan 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 the highest amount of non-taxable Benefits for the Plan Year shall have his or her non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his or her non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has 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 Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among self-funded 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 Eligible Employee may elect to participate in this Plan for all or the remainder of such Plan Year, provided he or she elects to do so on or before his or her effective date of participation.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Program and who is covered by the Employer's insured or self-funded benefits under the Plan shall automatically become a Participant to the extent of the Premiums for such insurance, unless otherwise limited by law.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, in whatever manner required by the Plan Administrator, which

spending account Benefit options he or she wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) Except for elections for the Dependent Care Flexible Spending Account, the Health Care Flexible Spending Account and the Health Savings Account, the initial elections made by a Participant or Employee, or a Participant's or Employee's failure to elect to participate, will continue from Plan Year to Plan Year unless the Participant or Employee elects different or new Benefits under the Plan during the Election Period.

(b) A Participant must make an affirmation election each Election Period if he or she wants to contribute to the Dependent Care Flexible Spending Account, the Health Care Flexible Spending Account and/or the Health Savings Account for the Plan Year following the Election Period.

(c) A Participant or Employee who elects under subsection (a) not to participate for the Plan Year following the Election Period or a Participant or Employee who fails to make an affirmation election in subsection (b) will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.3.

5.3 CHANGE IN STATUS

Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury and provided for under the Section "Qualified Changes in Status" in the Summary Plan Description. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

ARTICLE VI
HEALTH CARE FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Care Flexible Spending Account is intended to qualify as a medical reimbursement program under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. Except as provided in Section 6.7, all amounts reimbursed shall be periodically paid from amounts allocated to the Health Care Flexible Spending Account. Periodic payments reimbursing Participants from the Health Care Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

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

(a) **"Health Care Flexible Spending Account"** means the account established for Participants pursuant to the Plan to which he or she may allocate Salary Redirection and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

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

(1) one of the 5 highest paid officers;

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

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

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

A Participant may not be reimbursed for the cost of 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 or her Spouse or Dependent.

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

6.3 FORFEITURES

Any balance remaining in the Participant's Health Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and the Participant shall have no further claim to such amount for any reason. However, if the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his or her account until the claim appeal procedures set forth in Section 8.1 have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held shall be forfeited.

6.4 LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Care Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Care Flexible Spending Account by a Participant in or on account of any Plan Year will be set out in the materials

provided during the Election Period. However, in no event shall the amount of salary redirections on the Health Care Flexible Spending Account exceed the amount permitted under Code Section 125(i).

6.5 NONDISCRIMINATION REQUIREMENTS

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

(b) **Adjustment to avoid test failure.** If the Plan Administrator deems it necessary to avoid discrimination under this Health Care Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Plan 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 Flexible Spending Account 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 Section 105 who has elected the second highest contribution to the Health Care Flexible Spending Account 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.

6.6 HEALTH CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the portion of the Plan Year in which the Participant was participating shall be reimbursed for that Plan Year subject to Section 2.3, even though the submission of such a claim occurs after his or her participation hereunder ceases, but provided that the Medical Expenses were incurred during the applicable portion of the Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Plan Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Salary Redirection which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts that are not otherwise reimbursed by the Plan, another program or any third party.

(c) **Payments.** Except as provided in Section 6.7, reimbursement payments under this Plan shall be made directly to the Participant or, if requested by the Participant, directly to the service provider. The application for reimbursement shall be made to the Plan Administrator in any form approved by the Plan Administrator within a reasonable time of paying for the service. The application shall include a written statement or invoice from the provider stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Flexible Spending Account, such amount will not be claimed as a tax deduction.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Plan Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment.

6.7 DEBIT AND CREDIT CARDS

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

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

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued upon its expiration date if the Participant remains a Participant in the Health Care Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Care Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.

(d) **Card use.** The cards shall only be used for Medical Expense purchases at qualified locations with IIAS certification. If an entity does not accept the card despite the card being used for a Medical Expense, you can pay for the Medical Expense and then file for reimbursement as explained under Section 6.6.

(e) **Substantiation.** Such purchases by the cards may be subject to substantiation by the Plan Administrator or its delegate, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Plan Administrator will follow all requirements set by the IRS for substantiation. Purchases that require substantiation will be conditional pending confirmation and substantiation.

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

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

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

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

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

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account. This Dependent Care Flexible Spending Account is not subject to ERISA.

7.2 DEFINITIONS

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

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which he or she may allocate Salary Redirection and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

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

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

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

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

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

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

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

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

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Plan Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects Salary Redirection to be allocated to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

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

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.11 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

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

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Plan Administrator or its delegate 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

Any balance remaining in a Participant's Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for any Plan Year shall be forfeited and the Participant shall have no further claim to such amount for any reason. However, if the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his or her account until the claim appeal procedures set forth in Section 8.1 have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held shall be forfeited.

7.9 LIMITATION ON PAYMENTS

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

7.10 NONDISCRIMINATION REQUIREMENTS

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

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

(c) **Adjustment to avoid test failure.** If the Plan 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 Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Plan 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 Flexible Spending 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 Flexible Spending 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 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

Except as provided in Section 7.12, the Plan Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Plan Administrator of documentation of such expenses in a form satisfactory to the Plan Administrator. However, the Participant may request that payments may be made directly to the service provider. In its discretion in administering the Plan, the Plan Administrator or its delegate may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the request for payment or reimbursement shall include a written statement or invoice from the provider as proof that the expense has been incurred during the Plan Year and the

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

(a) The Dependent or Dependents for whom the services were performed;

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

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

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

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

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

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

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

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

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

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

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

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

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Plan Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment.

7.12 DEBIT AND CREDIT CARDS

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

(a) **Card only for dependent care expenses.** Each Participant issued a card shall certify that such card shall only be used for Employment-Related Dependent Care Expenses. The Participant shall also certify that any Employment-Related Dependent Care Expense paid with the card has not already been reimbursed by any other plan covering dependent care benefits and that the Participant will not seek reimbursement from any other plan covering dependent care benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued upon its expiration date if the Participant remains a Participant in the Dependent Care Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Dependent Care Flexible Spending Account.

(c) **Card Use.** The cards may not be accepted by all service providers. The cards shall only be used for Employment-Related Dependent Care Expenses from these providers. If an entity does not accept the card despite the card being used for an Employment-Related Dependent Care Expenses, the Participant can pay for the Employment-Related Dependent Care Expenses and then file for reimbursement under Section 7.11.

(d) **Substantiation.** Such purchases by the cards may be subject to substantiation by the Plan Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Plan Administrator will follow all requirements set by the IRS for substantiation. Purchases that require substantiation will be conditional pending confirmation and substantiation. The Plan Administrator will follow all requirements set by the IRS for substantiation.

(e) **Correction methods.** If such purchase is later determined by the Plan Administrator to not qualify as an Employment-Related Dependent Care Expense, the Plan Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Plan Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

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

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

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

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

ARTICLE VIII
MISCELLANEOUS

8.1 CLAIMS AND APPEALS FOR FLEXIBLE SPENDING ACCOUNT BENEFITS

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

(1) specific references to the pertinent Plan provisions on which the denial is based;

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

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

(b) **Dependent Care Flexible Spending Account Appeals.** Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Plan Administrator or its delegate for a full and fair review. The claimant or his or her duly authorized representative may:

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

(2) review pertinent documents; and

(3) submit issues and comments in writing.

A decision on the review by the Plan Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing, in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Plan Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by

the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(c) **Health Care Flexible Spending Account Claims.** If a Participant fails to submit a claim under the Health Care Flexible Spending Account within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Plan Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 90 days after termination of employment. Once a claim is submitted, the following timetable for claims and appeals below apply:

Notification of whether claim is approved or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Time to file an appeal of the denied Claim	180 days
Review of Appeal	60 days

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

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

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

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

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

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol,

or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

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

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

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

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

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

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

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

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

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

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

8.2 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.