WITTENBERG UNIVERSITY

FLEXIBLE BENEFITS PLAN DOCUMENT

Amended and Restated Plan
Effective January 1, 2011
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WITTENBERG UNIVERSITY  
FLEXIBLE BENEFITS PLAN  

Wittenberg University (the "University") hereby adopts, as of the Effective Amendment Date, the following amended and restated flexible benefits plan to permit Eligible Employees to choose between receipt of their full current cash Compensation and the application of a portion of such current Compensation for certain tax-free benefits. The Plan shall be maintained for the exclusive benefit of Eligible Employees. It is intended that this Plan be a cafeteria plan as defined in Code Section 125.

SECTION 1  
DEFINITIONS  

When used in the Plan, the following capitalized words and phrases will have the meanings listed below. Additional words and phrases may be defined in the text of the Plan.

"Account" means the record of a Participant's salary reductions under Section 4.1 and/or Section 5.1.

"Available Benefit" means: (a) a Pre-Tax Premium Benefit for a Policy or Program; (b) a Health Care Flexible Spending Account; and (c) a Dependent Care Flexible Spending Account.

"Code" means the Internal Revenue Code of 1986, as may be amended from time to time.

"Claims Administrator" means the entity to which the University has delegated authority to receive, review, and process claims for benefits from Participants' Health Care Flexible Spending Accounts and Dependent Care Flexible Spending Accounts. The University delegates to the Claims Administrator complete discretionary authority to determine eligibility for benefits, construe the terms of the Plan, make factual determinations, decide claims, and decide appeals of denied claims.

"Compensation" means the total compensation payable to an Eligible Employee by the Employer, including overtime pay, scheduled bonuses, and commissions, but excluding severance, expense allowances and all other extraordinary compensation.

"Dependent" means:

(a) for purposes of a Dependent Care Flexible Spending Account, a qualifying individual (as defined in Code Section 21) who: (i) has not attained age 13; or (ii) is physically or mentally incapable of caring for himself and who has the same principal place of residence as the Participant for more than half the year; and

(b) for purposes of a Health Care Flexible Spending Account, an individual who is eligible to enroll as the Participant's dependent in a medical benefits plan sponsored by the University and for whom medical expenses may be paid under this Plan on a non-taxable basis under Code Section 105.

"Dependent Care Expense" means an expense incurred by a Participant which: (a) is incurred for the care of a Participant's Dependent to enable the Participant to be gainfully employed; and (b) is paid or payable to a Dependent Care Service Provider. The term "Dependent Care Expense" shall not include an expense incurred for services outside the Participant's household for the care of a Dependent unless such Dependent: (i) is under the age of 13; or (ii) regularly spends at least eight hours each day in the Participant's household.

"Dependent Care Reimbursement" means a payment made by the Employer to reimburse a Participant for a Dependent Care Expense to the extent provided in Section 5.

"Dependent Care Service Provider" means a person who provides care or other services described in Code Section 21(b)(2), but does not include: (a) a dependent care center, as defined in Code Section 21(b)(2)(D),
unless the requirements of Code Section 21(b)(2)(C) are satisfied; or (b) a related individual described in Code Section 129(c).

"Earned Income" means earned income, as defined in Code Section 32(c)(2), but such term shall not include any amounts paid by the Employer as a Dependent Care Reimbursement.

"Effective Amendment Date" means January 1, 2011.

"Eligible Employee" means an "Employee" within the meaning of the Wittenberg University Welfare Benefit Plan who is either:

(a) faculty or adjunct faculty with rank, administrative staff, or an hourly person who:
- is employed by the University on other than a part-time or temporary basis, or for less than a one year appointment; and
- is regularly scheduled to work for the University for at least a full-time teaching equivalency or 40 hours a week during the academic year, or 1,560 or more hours annually; and
- elects to participate in the Plan; or

(b) any person participating in the "Shared Faculty Positions" Program who:
- is employed by the University on other than a temporary basis; and
- is regularly scheduled to work for the University in combination with another person in at least a Full-Time Teaching Equivalency; and
- elects to participate in the Plan.

Notwithstanding the foregoing, an individual may not participate in the Plan if prohibited under Prop. Treas. Reg. 1.125-1.

"Employer" means the University.

"Enrollment Election" means an agreement between a Participant and the Employer pursuant to which the Employer reduces the Participant's current Compensation and applies the reduction to an Available Benefit.


"Forfeiture" means any remaining credit to (a) a Participant's Health Care Flexible Spending Account after all claims approved by the Claims Administrator for reimbursement for a given Plan Year have been paid; and/or (b) a Participant's Dependent Care Flexible Spending Account after all claims approved by the Claims Administrator for reimbursement for a given Plan Year have been paid.

"Health Care Expense" means an expense incurred for medical care (as defined in Code Section 213(d)) except that, effective for expenses incurred on or after January 1, 2011, expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

"Health Care Expense Reimbursement" means a payment made by the Employer to reimburse a Participant for a Health Care Expense to the extent provided in Section 4.2.

"Highly-Compensated Employee" means any individual described in Code Section 414(q) or, to the extent applicable, any individual described in Code Section 125(e).

"Key Employee" means any individual described in Code Section 416(i).

"Participant" means an Eligible Employee who meets the eligibility requirements and submits an Enrollment Election under Section 2.

"Plan" means the Wittenberg University Flexible Benefits Plan, as set forth in this document.
“Plan Year” means the 12-month period ending on December 31.

“Policy” means an insurance policy providing group health, disability, or life insurance benefits designated in the Summary Plan Description as available under the Plan.

“Pre-Tax Premium Benefit” means the payment of premiums for Policies and/or Programs from the Participant's Compensation prior to the deduction of federal taxes and, where permitted, state and local taxes.

“Program” means a self-insured group health plan designated in the Summary Plan Description as available under the Plan.

“Protected Health Information” is health information that identifies a Participant and relates to the medical care he or she receives, or the amounts paid for that care, that is created or obtained by the Plan in connection with the Participant's receipt of benefits from his or her Health Care Flexible Spending Account. Protected Health Information does not include information created or obtained in connection with a Participant's Dependent Care Flexible Spending Account.

“Spouse” means the Participant's spouse in a marriage between one man and one woman.

“Summary Plan Description” means the summary plan description(s) for the University's group health plan(s), as from time to time amended and/or restated. Any reference to the Summary Plan Description includes changes announced in annual enrollment materials and other summaries of material modifications. The Summary Plan Description, including any summaries of material modifications, is incorporated herein by reference.

“University” means Wittenberg University. For purposes of ERISA and with respect to the matters for which the University is responsible under the Plan or any Policy or Program, the University is the Plan administrator and named fiduciary.

SECTION 2
PARTICIPATION

2.1 Enrollment Elections. An Eligible Employee will become a Participant by making an Enrollment Election with respect to an Available Benefit:

(a) within the enrollment period in connection with first becoming an Eligible Employee. The Enrollment Election will be effective on the first day of the month coinciding with or following the date he or she (i) became an Eligible Employee; or, if later, (ii) submitted an Enrollment Election.

(b) within the enrollment period in connection with the addition of an Available Benefit. The Enrollment Election will be effective on the first day of the month coinciding with or following the date (i) of the addition of the new Available Benefit; or, if later, (ii) the Eligible Employee submitted an Enrollment Election.

(c) during the annual enrollment period prior to the beginning of each Plan Year. The Enrollment Election will be effective as of the first day of the Plan Year.

(d) during the enrollment period in connection with an event listed in Section 2.3. In the case of a birth, adoption, or placement for adoption, the Enrollment Election will be effective as of the date of the birth, adoption, or placement for adoption. In all other cases, the Enrollment Election will be effective on the first day of the month coinciding with or following the date (i) of the event; or, if later, (ii) the Eligible Employee submitted an Enrollment Election.

The Summary Plan Description will establish the dates and/or length of the enrollment periods. Notwithstanding the length of the enrollment period for other events, the enrollment period for an Eligible Employee who has a right to special enrollment due to: (i) the loss of eligibility for Medicaid or a state children's health insurance program (SCHIP); or (ii) the start of eligibility for premium assistance under Medicaid or SCHIP, is the 60 days after
the date of the event. Upon making an Enrollment Election, the Participant will automatically be bound by all the
terms and conditions of the Plan and any amendments thereto.

2.2 Failure to Elect. An Eligible Employee who fails to make an initial Enrollment Election on or
before the due date specified by the Summary Plan Description shall be deemed to have elected to receive his or
her full current Compensation in cash. A Participant who has made an Enrollment Election for a prior Plan Year,
but who fails to make an Enrollment Election during the enrollment period for the subsequent Plan Year, shall be
deemed to have elected, with respect to the Pre-Tax Premium Benefit, to continue the previous year's election
and, with respect to the Health Care Flexible Spending Account and the Dependent Care Flexible Spending
Account, to receive his or her full Compensation in cash for such subsequent Plan Year.

2.3 Irrevocability of Elections. An Enrollment Election (and the failure to make an Enrollment Election)
shall be irrevocable until:

(a) the end of the applicable Plan Year.

(b) for the Pre-Tax Premium Benefit used for group health plan coverage, an event giving rise
to a right to special enrollment in a group health plan under Code Section 9801.

(c) a change in status that impacts eligibility for benefits, provided the revocation and new
election are on account of and consistent with the change in status. For this purpose, a change in status is:

(i) a change in the Participant's marital status, including marriage, death of a Spouse,
divorce, legal separation, or annulment;

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

(iii) a change in the employment status of the Participant, Spouse, or Dependent,
including a termination or commencement of employment, a strike, a lockout, a change in worksite, or other change in
employment status that results in a gain or loss of eligibility;

(iv) a Dependent satisfying or ceasing to satisfy the requirements for coverage due to
attainment of age or similar circumstances as provided in the group health plan; or

(v) a change in the place of residence of the Participant, Spouse, or Dependent that
affects eligibility.

The University shall apply Internal Revenue Service standards to determine whether a revocation of
an election and a new election are on account of and consistent with a change in status. Notwithstanding the
forgoing, no election for a Health Care Flexible Spending Account can be revoked or made in connection with a
change in status if, as a result, projected contributions to the Health Care Flexible Spending Account for the Plan
Year would be less than year-to-date reimbursements from the Health Care Flexible Spending Account.

(d) for the Pre-Tax Premium Benefit used for group health plan coverage or the Health Care
Flexible Spending Account, a change is needed to comply with a qualified medical child support order. A Participant
may cancel a Dependent's coverage in connection with a qualified medical child support order to enroll a Dependent
in another employer's group health plan only if the Dependent becomes covered by the other employer's group health
plan.

(e) for the Pre-Tax Premium Benefit used for group health plan coverage or the Health Care
Flexible Spending Account, an Eligible Employee may elect:

(i) to revoke coverage of the Participant, Spouse, or Dependent in connection with that
individual's enrollment in Medicare or Medicaid.
(ii) coverage for the Participant, Spouse, or Dependent in connection with that individual's loss of eligibility for Medicare or Medicaid.

(f) for the Pre-Tax Premium Benefit, a cost increase that the University determines is significant. In connection with a significant cost increase, a Participant may elect to increase his or her contributions to maintain coverage or switch to other similar coverage. A Participant may elect to eliminate coverage in connection with a significant cost increase only if (i) the Employer does not offer similar coverage; or (ii) the Participant elects similar coverage under another employer's plan. The University may in its sole discretion adjust a Participant's salary reduction contribution for a Pre-Tax Premium Benefit to accommodate a cost increase that the University determines is not significant.

(g) for the Pre-Tax Premium Benefit, a cost decrease that the University determines is significant. In connection with a significant cost decrease, a Participant may elect the coverage for which contributions were decreased or switch from similar coverage to the coverage for which contributions were decreased. The University may in its sole discretion adjust a Participant's salary reduction contribution for a Pre-Tax Premium Benefit to accommodate a cost decrease that the University determines is not significant.

(h) for the Pre-Tax Premium Benefit, a change in available coverage. A Participant may elect:

(i) to switch to a new benefit package in connection with the addition of a new benefit package;

(ii) to switch to another benefit package in connection with the elimination of a benefit package;

(iii) to switch to another benefit package in connection with a significant improvement to that benefit package;

(iv) to enroll in coverage or to revoke coverage in connection with the opposite election for a similar benefit under a plan sponsored by the Spouse's employer; or

(v) to enroll in coverage in connection with a loss of group health coverage sponsored by a governmental or educational institution.

(i) for a Dependent Care Flexible Spending Account, the Participant may elect to change his or her contributions in connection with a cost change imposed by a Dependent Care Service Provider (who is not a relative) or in connection with a change in Dependent Care Service Providers.

This Section shall be interpreted and administered in accordance with Internal Revenue Service rules.

2.4 Paid Leaves of Absence. If a Participant receives Compensation through the Employer's regular payroll during a leave of absence, the Participant's Enrollment Election will continue in effect during the leave. If an Eligible Employee receives Compensation during a leave of absence other than through the Employer's regular payroll system, the leave shall be treated as paid unless the University determines it is not administratively practicable to apply the Participant's Enrollment Election to such Compensation.

2.5 Unpaid FMLA Leaves. If a Participant takes an unpaid FMLA leave of absence:

(a) the Employer shall provide the Participant with written notice of the terms of the payment of contributions for coverage during FMLA leave;

(b) the Eligible Employee must make contributions in accordance with instructions provided by the University in order to maintain coverage during the leave; and
(c) if the Employer notifies the Eligible Employee at least 15 days in advance of the expiration of a 30-day grace period for the payment of contributions and the Eligible Employee fails to make contributions by the expiration of the grace period, coverage will lapse as of the first date for which the Eligible Employee failed to make contributions.

2.6 Other Unpaid Leaves of Absence. In the event of an unpaid leave of absence that is not an FMLA leave:

(a) the Eligible Employee must make contributions in accordance with instructions provided by the University in order to maintain coverage during the leave; and

(b) if the Eligible Employee fails to make contributions by the expiration of a 30-day grace period, coverage will lapse as of the first date for which the Eligible Employee failed to make contributions.

2.7 Return from Unpaid Leave.

(a) If the Eligible Employee who has taken an unpaid leave of absence returns to active employment in the same Plan Year, contributions and coverage shall continue (or, if coverage lapsed, resume) in accordance with the Eligible Employee's Enrollment Election for the Plan Year. If an Eligible Employee's coverage under his or her Health Care Flexible Spending Account ceased during a leave, the Eligible Employee may elect to: (i) be reinstated at the same coverage level as in effect before the leave (with increased contributions); or (ii) at the same level of contributions as in effect before the leave (with a reduced coverage level), provided that projected contributions to the Health Care Flexible Spending Account for the Plan Year cannot be less than year-to-date reimbursements from the Health Care Flexible Spending Account.

(b) Notwithstanding anything in the Plan to the contrary, no election for a Health Care Flexible Spending Account can be revoked, changed, or made during a Plan Year if, as a result, projected contributions to the Health Care Flexible Spending Account for the Plan Year would be less than year-to-date reimbursements from the Health Care Flexible Spending Account.

2.8 Nondiscrimination Requirements. If the University determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to either Key Employees or Highly-Compensated Employees, the University shall take such action as the University deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of the Enrollment Elections of Highly-Compensated Employees or Key Employees with or without the consent of such Participants. The University shall notify each affected Participant of such actions.

2.9 Termination of Participation. A Participant will cease to be a Participant in this Plan upon the earlier of: (a) the termination of this Plan; or (b) the date on which the employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Termination of participation in this Plan will automatically revoke the Participant's elections. Notwithstanding the foregoing, if a Participant terminates his or her employment for any reason and then is rehired within 30 days after the date of a termination of employment and within the same Plan Year, then the employee will be reinstated with the same elections that such individual had before termination.

SECTION 3
PRE-TAX PREMIUM BENEFIT

3.1 Designation of Policies and Programs. The University will designate (and from time to time change) in its Summary Plan Description the Policies and/or Programs available under the Plan. A Participant shall be entitled to receive only the benefits to which such Participant is entitled under any Policy or Program. The types and amounts of benefits available, the requirements for participation, and the other terms and conditions of coverage under Policies and Programs are as set forth from time to time in the relevant documents governing the Policies and Programs. Each Participant shall be entitled to look only to any Policies for payment of any insured benefits and
shall not have any right, claim, or demand therefore against the Employer or any employee, officer, or director of the Employer.

3.2 Salary Reduction Contributions. The University will designate (and from time to time change) in its Summary Plan Description or enrollment materials the amount of salary reduction contributions for each Policy and Program available under the Plan to be made by an Eligible Employee electing a Pre-Tax Premium Benefit. The salary reduction contributions may be a dollar amount or a formula and may vary by class of Eligible Employees.

3.3 Bonuses. In lieu of or in addition to salary reduction contributions, the University may designate (and from time to time change) in its Summary Plan Description a dollar amount of taxable bonus payable to Eligible Employees electing to waive coverage under one or more Policies or Programs.

3.4 Claims and Appeals. For claims and appeals under Policies and Programs for which the Pre-Tax Premium Benefit is used, see the certificate of coverage or Summary Plan Description of the applicable Policy or Program.

SECTION 4
HEALTH CARE EXPENSE REIMBURSEMENT BENEFIT

4.1 Establishment of Health Care Flexible Spending Account. Any amount elected by a Participant for Health Care Expense Reimbursement benefits shall be credited to the Participant's Health Care Flexible Spending Account. Amounts credited to a Participant's Health Care Flexible Spending Account shall be used by the University to reimburse the Participant for Health Care Expenses as provided in this Section.

4.2 Health Care Expense Limitations. The following limitations shall apply to the Health Care Expense Reimbursement benefits:

(a) The maximum amount of Health Care Expense Reimbursements that any Participant may elect to receive for a Plan Year shall be $3,000 (or such greater or lesser amount as may be established by the University in the Summary Plan Description or enrollment materials before the first day of the Plan Year). Notwithstanding the foregoing, effective for Plan Years starting on or after January 1, 2013, the maximum amount a Participant may elect to receive for a Plan Year is $2,500, as indexed for inflation for Plan Years starting on and after January 1, 2014. The minimum amount of Health Care Expense Reimbursements that any Participant may elect to receive for a Plan Year shall be $100 (or such greater or lesser amount as may be established by the University in the Summary Plan Description before the first day of the Plan Year).

A Participant may submit claims for reimbursement of Health Care Expenses that are incurred by the Participant, the Participant's Spouse, and/or the Participant's Dependents.

(b) The Plan will reimburse or pay Health Care Expenses only in the event and to the extent that such reimbursement or payment is: (i) not provided for or reimbursable under any insurance policy, whether the premium on such policy is paid by the Employer or the Participant; and (ii) not provided for or reimbursable under any other group health plan or policy maintained by the Employer.

(c) Amounts credited to the Participant's Health Care Flexible Spending Account during a Plan Year will be credited to the Account and made available for the payment of Health Care Expense Reimbursement benefits on the first day of the Plan Year. Payment shall not be conditioned, either as to eligibility or timing, on the making of contributions by or the continued employment of the Participant. Notwithstanding the foregoing, the University and the Plan shall comply with any rules or limitations on reimbursement of benefits relating to when a reimbursable expense is deemed to accrue or the period to which any reimbursable expense is deemed to relate.

(d) The Health Care Expense Reimbursement benefits shall not discriminate in favor of Highly-Compensated Employees as to eligibility to participate or as to benefits provided.
4.3 **Run Out Period.** All Health Care Expenses incurred by a Participant during the Plan Year must be submitted for reimbursement no later than the following March 31, except that Participants who terminate employment with the Employer (or COBRA coverage ends) during the Plan Year must submit all Health Care Expenses by the last day of the month in which they terminate employment (or your COBRA coverage ends). Any remaining balance credited to a Participant's Health Care Flexible Spending Account after the reimbursement of claims submitted by such date shall be forfeited. The University may elect to apply forfeitures to the payment of administrative expenses, the provision of benefits to all Participants, or the reduction of contributions from all Participants.

4.4 **Claims Procedures.** Claims for benefits shall be submitted to the Claims Administrator in accordance with the procedures established by the University. The University will institute procedures for making claims for reimbursement, including but not limited to the time that reimbursements will be made to Participants and the minimum dollar amount of such reimbursements. The Participant shall provide all information, verification, documents, or forms as may be required by the Claims Administrator to appropriately process such claim. The Claims Administrator may, at the direction of the Participant, pay any amounts directly to a service provider in lieu of reimbursement to the Participant.

4.5 **Debit Cards.**

(a) A Participant may use the Health Care Expense debit card to pay for Health Care Expenses directly from his or her Health Care Flexible Spending Account, provided the expenses are incurred: (i) at a merchant with an inventory approval system that identifies items as Health Care Expenses; or (ii) at a provider with a health care-related merchant code.

(b) When a Participant uses a Health Care Expense debit card provided by the Claims Administrator, use of the card at a health care provider is considered a claim for benefits. However, if the transaction using the card is declined, it is considered a denial of a claim only if the reason for denial is that the nature of expenditure was either indeterminable or determined not to be an eligible Health Care Expense. Other reasons, such as merchant terminal failures, are not considered a denial of a claim. In such cases, the Participant may submit a written claim for reimbursement to the Claims Administrator.

(c) The Claims Administrator may require that the Participant submit a detailed receipt to show that the debit card was used for eligible expenses. If the Participant fails to show the debit card was used for eligible expenses:

   (i) The debit card will be de-activated until the amount of the improper payment is recovered. During the period the debit card is de-activated, the Participant must submit written claims for reimbursement of Health Care Expenses;

   (ii) The University will demand that the Participant repay the Plan the amount of the improper payment;

   (iii) If the Participant fails to repay the amount of the improper charge, the Employer will withhold the amount of the improper charge from the Participant's pay or other compensation, to the full extent allowed by applicable law;

   (iv) If any portion of the improper payment remains outstanding, the reimbursement for a later substantiated expense claim will be reduced by the amount of the improper payment; and

   (v) If, after applying all the procedures described in this paragraph, the Participant remains indebted to the Employer for improper payments, the Employer, consistent with its business practice, will treat the improper payment as it would any other business indebtedness.
4.6  Claims Processing.

(a)  The Claims Administrator will make a decision on a Participant's claim within a reasonable time, not to exceed thirty (30) days. The Claims Administrator may extend the thirty (30) day period one time for up to fifteen (15) days, provided the Claims Administrator determines the extension is necessary due to matters beyond the control of the Plan and notifies the Participant prior to the expiration of the initial thirty (30) day period. Such notification shall include the reason for the delay, specific description of information required if the delay is due to the failure of the Participant to submit required information, and the date the Claims Administrator expects to decide the claim. The Participant shall have forty-five (45) days from receipt of the notice to provide any required information that is the cause of the delay.

(b)  If a claim is approved, the Claims Administrator will issue a benefit payment.

(c)  If a claim is wholly or partially denied, the Claims Administrator will provide to the Participant a written notice setting forth:

(i)  the specific reason or reasons for denial;

(ii)  specific reference to the pertinent Plan provisions on which the denial is based;

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

(iv)  an explanation of the Plan's claim review procedure; and

(v)  any internal rule, guideline, protocol, or other similar criterion relied on in making the adverse determination or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request.

4.7  Appeals.

(a)  A Participant whose claim for benefits has been denied may submit an appeal to the Claims Administrator, may review and copy pertinent documents upon request free of charge, and may submit issues and comments in writing along with other information not included in the initial claim. The Participant's appeal must be submitted, in writing, to the Claims Administrator within one hundred eighty (180) days after receipt by the Participant of written notification of the denial of a claim. The review on appeal will not afford deference to the initial adverse benefit determination and will be conducted by an individual or entity who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual. Any determination that is based in whole or in part on medical judgment shall be done only after consulting with an appropriately trained and experienced health care professional not involved in the original determination and not a subordinate of a health care professional involved in the original determination. A decision by the Claims Administrator shall be made promptly, and not later than sixty (60) days after its receipt of an appeal. Upon request, the Claims Administrator will disclose to the Participant the identity of medical or vocational experts whose advice was obtained on behalf of the Plan without regard to whether the advice was relied upon in making the adverse determination.

(b)  If, after review, the denial of benefits is wholly or partially upheld, the Claims Administrator shall provide to the Participant written notice setting forth:

(i)  the specific reason or reasons for the adverse determination;

(ii)  specific reference to the pertinent Plan provisions on which the adverse determination is based;
(iii) a statement that the Participant 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 Participant's claim for benefits; 

(iv) a statement of the Participant's right to bring an action under Section 502(a) of ERISA; and 

(v) any internal rule, guideline, protocol, or other similar criterion relied on in making the adverse determination or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request.

(c) A Participant cannot bring a lawsuit until after the date of the decision on appeal. Further, no lawsuit can be brought at all unless it is commenced within one year (or shorter period specified in the Summary Plan Description) after the decision on appeal.

4.8 Termination of Eligibility. If a Participant ceases to be an Eligible Employee, such Participant shall be entitled to continue to receive reimbursement under this Section for Health Care Expenses incurred prior to the date on which his or her employment or eligible status is terminated.

4.9 COBRA Continuation of Coverage. To the extent required by COBRA (Part 6 of Title I of ERISA), a qualified beneficiary (as defined in Section 607 of ERISA) who would cease to be eligible to receive a Health Care Expense Reimbursement benefit under the Plan upon the occurrence of a qualifying event (as described in Section 603 of ERISA) will be permitted to continue such Health Care Expense Reimbursement benefit under the Plan by electing to pay the applicable premium, on an after-tax basis, in accordance with procedures established by the University that are consistent with Part 6 of Title I of ERISA and any regulations promulgated under that part. COBRA continuation coverage of a Health Care Flexible Spending Account will not continue past the last day of the Plan Year in which the initial qualifying event occurred.

4.10 Erroneous Payments. In the event that aggregate payments made pursuant to this Section to a Participant exceed the amount available under the Participant's Health Care Flexible Spending Account for the Plan Year, such excess shall be considered a debt owed by the Participant to the Employer. In the event that any payment made to a Participant pursuant to this Section is for a Health Care Expense for which the Participant receives a reimbursement from some other source (including any insurance policy or group plan) or for which the Participant fails to provide adequate substantiation, such Participant will be required to refund such reimbursement to the Plan. The amount returned to the Plan shall again be credited to the Participant's Health Care Flexible Spending Account.

4.11 Unclaimed Reimbursements. In the event a Participant fails to cash a check issued for a Health Care Expense Reimbursement within one year of the date of the check's issuance, such monies shall be a Forfeiture. A Participant shall have no right to request or receive a re-issuance of the Forfeited amount.

4.12 Protected Health Information. The Plan may disclose Protected Health Information to the University's human resources department and other employees of the University who are appointed in writing by the Plan's Privacy Officer to perform specific tasks on behalf of the Plan (collectively, the "Health Plan Administration Staff"), provided that the University will:

(a) only use Protected Health Information received from the Plan for assisting Participants with benefits questions, problems, and appeals; financial planning and controls; monitoring the performance of third parties; and oversight and assistance with the administration of the Plan;

(b) not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law or permitted by a Participant's authorization;
(c) ensure that any agents (including a subcontractor) to whom the University provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the University with respect to such information;

(d) not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any non-health benefits under the Plan or another employee benefit plan of the University, except as authorized by a Participant;

(e) report to the Plan's Privacy Officer any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for of which the University becomes aware;

(f) make a Participant's Protected Health Information available to him or her for access, amendment, and accounting in accordance with the federal privacy regulations;

(g) make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with federal regulations;

(h) return Protected Health Information to the Plan (when feasible), destroy Protected Health Information (where return is not feasible and retention is not required by law), or continue to maintain the privacy of all Protected Health Information (where return is not feasible and retention is required by law);

(i) use its best efforts to request only the minimum necessary type and amount of Protected Health Information to carry out the functions for which the information is requested;

(j) ensure adequate separation between the University and the Plan so that Protected Health Information disclosed to the University: (i) will not be disclosed to employees who are not members of the Health Plan Administration Staff; and (ii) will be used by the Health Plan Administration Staff for only permitted purposes; and

(k) provide an effective mechanism for resolving issues of noncompliance through investigation and resolution by the Plan's Privacy Officer and as otherwise provided under ERISA.

The foregoing limits do not apply to disclosures of enrollment information or summary health information by or on behalf of the Plan to the University acting in its capacity as an employer.

4.13 Electronic Security of Protected Health Information. The University agrees that, if the University creates, receives, maintains, or transmits any electronic Protected Health Information on behalf of the Plan, it will:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) ensure that the adequate separation between the University and the Plan (described above) is supported by reasonable and appropriate security measures;

(c) ensure that any agents (including subcontractors) to which it provides such electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect such electronic Protected Health Information; and

(d) report to the Plan any security incident of which it becomes aware.

The foregoing limits do not apply to disclosures of enrollment information or summary health information by or on behalf of the Plan to the University acting in its capacity as an employer.
SECTION 5
DEPENDENT CARE REIMBURSEMENT BENEFIT

5.1 Establishment of Dependent Care Flexible Spending Account. Any amount elected by a Participant, pursuant to Section 3.1, to be used to receive Dependent Care Reimbursement benefits shall be credited to an account established for such Participant. Such account shall be designated as the Participant's Dependent Care Flexible Spending Account. Amounts credited to a Participant's Dependent Care Flexible Spending Account shall be used by the University to reimburse the Participant for Dependent Care Expenses incurred by such Participant during the Plan Year.

5.2 Dependent Care Reimbursement Limitations. The following limitations shall apply to Dependent Care Reimbursement benefits:

(a) The maximum amount of reimbursements for Dependent Care Expenses that any Participant may elect to receive in a Plan Year is: (i) $2,500, in the case of a married individual who files a separate return for federal income tax purposes; or (ii) $5,000. The minimum amount of reimbursements for Dependent Care Expenses that any Participant may elect to receive in a Plan Year is $100 (or such greater or lesser amount as may be established in the Summary Plan Description or enrollment materials).

(b) The maximum amount of reimbursements for Dependent Care Expenses that a Participant may receive in a Plan Year is equal to the lesser of: (i) the Participant's Earned Income for the Plan Year (after all reductions in Compensation including the reduction applied to Dependent Care Reimbursement benefits); or (ii) the actual or deemed Earned Income of the Participant's Spouse for the Plan Year. In the case of a Spouse who is either a full-time student at an educational institution or who is physically or mentally incapable of caring for himself, such Spouse is deemed to have Earned Income of not less than $250 per month if the Participant has one Dependent and $500 per month if the Participant has two or more Dependents.

(c) Payments from a Participant's Dependent Care Flexible Spending Account during, or in respect to, a Plan Year to pay Dependent Care Expenses will be limited to the current balance in such Participant's Dependent Care Flexible Spending Account. Requests for payment that are not made due to an insufficient Dependent Care Flexible Spending Account balance may be resubmitted to the University when such balance increases later in the Plan Year.

(d) No reimbursement shall be made to a Participant for any Dependent Care Expense for which such Participant has previously claimed a tax credit under Code Section 21.

(e) Dependent Care Reimbursement benefits shall not be provided in a manner that would discriminate in favor of Highly-Compensated Employees or their dependents (as defined in Code Section 152).

5.3 Special Limitation for Certain Participants.

(a) No more than twenty-five percent (25%) of the total Dependent Care Reimbursement benefits during any Plan Year may be paid to a class of Participants who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than five percent (5%) of the stock or of the capital or profits interest in the Employer.

(b) The average Dependent Care Reimbursement benefits provided to Participants who are not Highly-Compensated Employees shall equal at least 55 percent (55%) of the average Dependent Care Reimbursement benefits provided to Participants who are Highly-Compensated Employees. For purposes of satisfying the requirements of this paragraph, individuals described in Code Sections 129(d)(8)(B) and 129(d)(9) shall be excluded from consideration.

(c) If the University believes that the limitations contained in either paragraph (a) or (b) of this Section may be exceeded, it may, in its absolute discretion, limit the amount of Dependent Care Reimbursement benefits that may be paid to such Participants, provided that any such limitation imposed by the University shall
apply on a uniform basis pursuant to rules applicable equally to all Participants who are members of the class whose benefits are limited by this Section.

5.4 Forfeitures. All Dependent Care Expenses incurred by the Participant during a Plan Year must be submitted for reimbursement to the University no later than the following March 31, except that Participants who terminate employment with the Employer during the Plan Year must submit all Dependent Care Expenses by the last day of the month in which they terminate employment. If, during a Plan Year, a Participant fails or is unable to fully utilize the amount credited to his or her Dependent Care Flexible Spending Account, such unused amount shall be a Forfeiture. The University may elect to apply Forfeitures to the payment of administrative expenses, the provision of benefits to all Participants, or the reduction of contributions from all Participants.

5.5 Claims Procedures. Claims for benefits shall be submitted to the Claims Administrator in accordance with the procedures established by the University. The University will institute procedures for making claims for reimbursement, including but not limited to the time that reimbursements will be made to Participants and the minimum dollar amount of such reimbursements. The Participant shall provide all information, verification, documents, or forms as may be required by the Claims Administrator to appropriately process such claim. The Claims Administrator may, at the direction of the Participant, pay any amounts directly to a service provider in lieu of reimbursement to the Participant.

5.6 Claims and Appeals.

(a) When a claim for reimbursement of an expense is denied, the Participant will receive a written notification of the denial within sixty (60) days from the date on which the claim was submitted. The notice will explain:

(i) the reason for the denial;

(ii) any additional material or information needed to make the claim acceptable and the reason it is necessary; and

(iii) the procedure for requesting a review of the claim.

(b) If a claim is approved, the Claims Administrator shall issue a benefit payment.

(c) Within thirty (30) days of receiving the denial, the Participant or the Participant's representative may appeal the denial of the claim. The appeal must be in writing. In connection with the appeal, the Participant may request copies of relevant documents and submit additional written information related to the claim. A decision on the appeal will be made within sixty (60) days after the appeal is received. The Participant will receive a copy of the decision, in writing, including any specific reasons for it and references to the Plan provisions on which it is based.

5.7 Termination of Eligibility. If a Participant ceases to be an Eligible Employee, such Participant shall be entitled to continue to receive reimbursement under this Section, to the extent of the balance in his or her Dependent Care Flexible Spending Account, for Dependent Care Expenses incurred prior to the date on which his or her employment or eligible status is terminated.

5.8 Erroneous Payments. In the event that aggregate payments made pursuant to this Section to a Participant exceed the balance of the Participant's Dependent Care Flexible Spending Account, such excess shall be considered a debt owing by such Participant to the Employer and may be, if permitted by applicable law, collected by the Employer by payroll deduction or otherwise. In the event that any payment made to a Participant pursuant to this Section is for a Dependent Care Expense for which the Participant previously claimed a tax credit under Code Section 21, such Participant will be required to refund such reimbursement to the Plan. The amount returned to the Plan shall again be credited to the Participant's Dependent Care Flexible Spending Account.

5.9 Unclaimed Reimbursements. In the event a Participant fails to cash a check issued for a Dependent Care Reimbursement, such monies shall be escheated pursuant to applicable state laws governing
unclaimed property; provided, however, that such Participant may request and receive a re-issuance of such check until such time as such monies are actually escheated to the state.

5.10 Report to Participants. On or before January 31 of each year, the University shall furnish to each Participant a written statement showing the amount of contributions made during the previous calendar year with respect to the Participant.

SECTION 6
ADMINISTRATION

6.1 Plan Administrator. The administration of the Plan shall be the responsibility of the University. It shall be the principal duty of the University to make certain that the Plan is administered, in accordance with its terms, for the exclusive benefit of the Participants and their beneficiaries.

6.2 Powers and Duties. The University, in its absolute discretion, shall have such authority as may be necessary to discharge its responsibilities under the Plan, including without limitation the following:

(a) to adopt rules and regulations for the administration of the Plan and, from time to time, to amend or supplement such rules and regulations;

(b) to interpret any provision of the Plan;

(c) to determine eligibility and validity of reimbursement requests for both Health Care Expenses and Dependent Care Expenses;

(d) to correct any defect, supply any omission, or reconcile any inconsistency in the Plan in such a manner and to such extent to carry out the intentions of the Plan;

(e) to determine all questions that may arise under the Plan, including questions submitted by a Participant;

(f) to perform the duties and exercise the powers and discretion given to it pursuant to the provisions of the Plan; and

(g) to employ such counsel and agents in such clerical, medical, accounting, and other services as it may require to carry out the provisions of the Plan.

6.3 Delegation of Responsibility. The University may delegate the claims administration and/or record keeping portion of its responsibilities to administer the Plan to any person or entity. The University has delegated discretionary authority for the administration of claims and appeals to the Claims Administrator. All usual and reasonable expenses of the person or entity appointed pursuant to this Section may be paid, in whole or in part, out of Forfeitures or by the Employer.

6.4 Facility of Payment. Whenever, in the University's opinion, a Participant entitled to receive any payment under the Plan is under legal disability or is incapacitated in any way so as to be unable to manage his or her personal financial affairs, the University may make such payment to the Participant's legal representative or relative for the Participant's benefit. Any payment of a benefit or installment thereof to such representative or relative in accordance with the provisions of the Plan shall be a complete discharge of any liability for the making of such payment.

6.5 Information to be Furnished. Participants shall provide the University with such information and evidence and shall sign such documents as may reasonably be requested from time to time for the purpose of the administration of the Plan. When making a determination or calculation, the University shall be entitled to rely upon information furnished by the Participant.
6.6 **Reasonable Care.** The University shall discharge its duties with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

6.7 **Nondiscriminatory Exercise of Authority.** Whenever, in the administration of the Plan, any discretionary action by the University is required, the University shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

6.8 **Indemnification.** Any employee of the Employer to whom the University assigns responsibilities pursuant to Section 6.2 shall be indemnified by the Employer against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim relating thereto.

**SECTION 7**

**AMENDMENT AND TERMINATION**

7.1 **Amendments.** The University reserves the right to make, from time to time, any amendment(s) to this Plan, including an amendment that may reduce or discontinue benefits previously provided under the Plan.

7.2 **Termination.** The University may terminate the Plan, or any portion of the Plan, at any time. In the event of the dissolution, merger, consolidation, or reorganization of the University, the Plan shall terminate, unless it is continued by a successor to the University.

7.3 **Action Upon Plan Termination.** Upon the termination of the Plan, the rights to reimbursement of all Participants affected thereby shall become payable as the University may direct. Such direction may include a continuation of the Plan in order to pay account balances in accordance with Sections 4 and 5.

**SECTION 8**

**MISCELLANEOUS**

8.1 **Non-Alienation of Benefits.** Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable under the Plan shall be void. The Employer shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits under the Plan.

8.2 **No Employment Contract.** Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any Eligible Employee or as a right of any Eligible Employee to be continued in the employment of the Employer or as a limitation of the right of the Employer to discharge any of its Eligible Employees, with or without cause.

8.3 **Rights to Employer's Assets.** No Eligible Employee, Participant, or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such Eligible Employee, Participant, or beneficiary. All payments of benefits provided for in this Plan shall be made solely out of the assets of the Employer.

8.4 **Benefits Provided Through Third Parties.** In the case of any benefit provided through a third party, such as an insurance company or another employee benefit plan, pursuant to a contract, policy, or plan document, if there is any conflict or inconsistency between the description of benefits contained in this Plan and such contract, policy, or plan document, the terms of such contract, policy, or plan document shall control.
8.5 **Exclusive Benefit of Employees.** This Plan shall be maintained for the exclusive benefit of the Eligible Employees and its terms shall be legally enforceable.

8.6 **Gender and Number.** Any references in the masculine gender herein shall be deemed to also include the feminine gender, unless expressly provided otherwise. Wherever appropriate, any reference in this document in the singular shall include the plural and any reference in the plural shall include the singular.

**IN WITNESS WHEREOF,** the University has caused this amended and restated Plan to be executed by its duly authorized representative.

WITTENBERG UNIVERSITY

Date: _________________

By: _______________________

Print Name: ____________________

Title: __________________________