bebe stores, inc. Section 125 and Welfare Benefits Plan

Amended and Restated Effective July 1, 2012
(except as otherwise specified)

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bebe stores, inc.

SECTION 125 AND WELFARE BENEFITS PLAN

ARTICLE I

PURPOSE AND ESTABLISHMENT OF PLAN

1.1 Purpose. The purpose of this Plan is to provide Eligible Employees of bebe stores, inc. and the other Employers with a choice among certain employee benefits programs.

1.2 Section 125 and Welfare Benefits Plan. This Plan is intended to qualify as a cafeteria plan with health care and dependent care reimbursement features under Code Sections 105, 125 and 129, and to be a welfare plan as defined in Section 2510.3-1 of the Department of Labor Regulations.

1.3 Separate Plan Documents. The Benefits offered under this Plan may be the subject of separate trust agreements, group insurance policies, or administrative services contracts, as each may be in effect from time to time. Such other agreements, policies, and contracts, as listed on Appendix A, may be amended from time to time and are incorporated herein by reference.

1.4 Applicability to Benefits. The provisions of this Plan shall apply to all Benefits, except to the extent such provisions are inconsistent with the particular terms and conditions of the affected Benefit, in which case the terms and conditions of the group insurance policy, administrative services contract, or other document governing the specific Benefit shall apply to determine the eligibility of any person for benefits and the amount and kind of benefits available. The eligibility requirements set forth in this Plan are intended to reflect minimum requirements for eligibility.

ARTICLE II

DEFINITIONS

The following words and phrases shall have the following meanings:

2.1 Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such determination that is based on eligibility under the Plan or particular Benefit or that results from any utilization review, a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational or not medically necessary or appropriate, as well as a Rescission of Coverage.

2.2 Authorization means a document signed by an Individual authorizing disclosure of Protected Health Information and complying with the requirements of the Privacy Rule.

2.3 Benefit means any of the health and welfare options that may be offered and/or purchased under this Plan.

2.4 Board or Board of Directors means the Board of Directors of the Company.

2.5 Change in Status shall have the meaning set forth in Article XI.

2.6 Child means (1) a natural child of an Employee and/or the Employee's Spouse or Domestic Partner, (2) a step-child by legal marriage of an Employee and/or the Employee's Spouse or Domestic Partner pursuant to the Company's procedures, (3) a child who has been placed with the Employee (and/or the Employee's Spouse or Domestic Partner) for adoption by a U.S. court of competent jurisdiction, and (4) a child for whom legal guardianship has been awarded by a U.S. court of competent jurisdiction to the Employee and/or his or her Spouse or Domestic Partner; provided, however, that the child must reside with the Employee in a parent-child relationship and be primarily dependent on the Employee for maintenance or support, or the child must be the subject of a qualified medical child support order ("QMCSO") pursuant to ERISA.

2.7 Claims Administrator means the Plan Administrator or, if applicable, the entity to which the Plan Administrator has delegated or assigned responsibility for administration of Benefit claims.

2.8 COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and the regulations issued thereunder.

2.9 Code means the Internal Revenue Code of 1986, as amended from time to time, and the regulations issued thereunder.

2.10 Company means bebe stores, inc., or any successor by merger, consolidation, or purchase of substantially all of its assets.

2.11 Compensation means an Employee's wages within the meaning of Code Section 3401(a) in connection with income tax withholding reportable on Internal Revenue Service Form W-2 and all other remuneration paid to the Employee by the Employer for which the Employer is required to furnish the Employee with a written statement under Code Sections 6041(d), 6051(a)(3) and 6052, determined without regard to exclusions based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in Code Section 3401(a)(2)). Compensation shall include only that compensation which is actually paid or made available to the Employee during the portion of the Plan Year that the Employee was a Participant. Compensation shall include any amount that is contributed by the Employer pursuant to a salary deferral agreement and that is not includable in the gross income of the Employee under Code Section 125, 132(f)(4), 402(e)(3), 402(g)(3), 402(h), 408(o) or 457. The determination of the amount of Compensation shall be made by the Employer in accordance with the records of the Employer.

2.12 Covered Dependent means an Eligible Dependent for whom a Participant elects, or is deemed to elect, Benefits in accordance with Section 3.1.

2.13 Deemed Exhaustion shall have the meaning set forth in Article XIII.

2.14 Dependent means any individual who is tax dependent of the Participant, as defined in Code Section 152, determined without regard to Code Sections 152(b)(1) and (b)(2), that contain certain exceptions to the definition of dependent, and without regard to Code Section 152(d)(1)(B), that contains a gross income limitation for a qualifying relative; provided, however, that for purposes of the Dependent Care Reimbursement Program, a "dependent" means a Qualifying Individual. For purposes of accident and health coverage, including the Health Care Reimbursement Program, any Child to whom Code Section 152(e) applies (regarding a child of divorced parents, where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a Dependent of both parents for that calendar year.

2.15 Dependent Care Expenses means employment-related expenses under Code Section 21(b)(2), that is, expenses for the care of a Qualifying Individual that are necessary for gainful employment of the Employee and Spouse, and expenses for incidental household services paid for by the Employee to obtain Qualified Dependent Care Services, to the extent not reimbursable under any insurance plan, contract, or arrangement. Dependent Care Expenses shall not include amounts paid to an individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant, his or her Spouse, a Participant's Child who is under nineteen (19) years of age at the end of the calendar year in which the expenses were incurred, or a parent of a Participant's qualifying child, as defined in Code Section 152(c)

who is under thirteen (13) years of age. Expenses incurred by a Participant's Domestic Partner who is not otherwise a Dependent are not eligible as Dependent Care Expenses under the Plan.

2.16 Dependent Care Reimbursement Account means a component Benefit providing a flexible spending account for the reimbursement of Dependent Care Expenses pursuant to Code Section 129. A Dependent Care Reimbursement Account is commonly referred to as a "Dependent Care Flexible Spending Account" or "Dependent FSA".

2.17 Domestic Partner means an individual designated by the Participant as his or her domestic partner in such manner and in such form as required by the Company. If a Domestic Partner constitutes a Dependent, then he or she shall be treated as a Dependent for all purposes hereunder. Coverage for a Domestic Partner who is not a tax dependent of a Participant within the meaning of Code Section 152 shall not be treated as provided under Code Section 125. Employer Contributions for coverage of such Domestic Partner shall be deemed imputed income to the Participant and Participant contributions for coverage of such Domestic Partner shall be made on an after-tax basis.

2.18 Earned Income means all income derived from wages, salaries, tips, self-employment, and other Compensation, but only if such amounts are includible in gross income for the taxable year. Earned Income shall not include any amounts received pursuant to the Dependent Care Reimbursement Program, or amounts excluded from income under Code Section 32(c)(2).

2.19 Effective Date means the date upon which the Employer originally established this Plan, specifically, August 1, 1993. This Plan was subsequently restated or amended on a number of occasions, including effective as of December 1, 1998, August 1, 2003, August 1, 2004, August 1, 2007, July 1, 2008, July 1, 2009, July 1, 2011, and is hereby restated in its entirety, effective as of July 1, 2012 (except as otherwise stated herein or as required by law).

2.20 Electronic Media means:

(a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; and

(b) Transmission media used to exchange information already in electronic storage media including, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

2.21 Electronic Protected Health Information or ePHI means PHI that is created, received, maintained or transmitted in Electronic Media by or on behalf of the Plan.

2.22 Eligible Dependent means a Dependent who meets the eligibility and participation criteria set forth in the applicable certificate of insurance booklet, group service agreement, or other governing document, as listed in Appendix A. At a minimum, an Eligible Dependent must be: (a) a Spouse of a Participant, (b) a Domestic Partner of a Participant, (c) a Child of a Participant if such Child is under the age of twenty-six (26), (d) an unmarried Child of a Participant if such Child is incapable of self-sustaining employment by reason of mental or physical disability that commenced before age twenty-six (26), and who is primarily dependent on the Employee for support and maintenance, or (e) only to the extent required by any applicable state insurance laws, a Grandchild of a Participant. The Employer reserves the right to require, at its expense, an independent medical, psychiatric, or psychological evaluation in connection with any annual review of the Child's disabled status.

2.23 Eligible Employee means an Employee who is a resident of the U.S., Puerto Rico or the Virgin Islands and is regularly-scheduled to work for the Employer thirty-seven and one-half (37½) hours per week or more, or an Employee who is regularly-scheduled to work for the Employer twenty (20) hours per week or more in Hawaii, excluding the following:

(a) an individual who is classified by the Employer as a leased employee (e.g., an individual who is not an employee who provides services to the Employer under the primary direction or control of the Employer on a substantially full-time basis pursuant to an agreement with the Employer expected to last for a period of at least one (1) year);

(b) an individual classified by the Employer as a contract worker, independent contractor, casual employee or intern for the period of time during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the Internal Revenue Service or any other government agency or tribunal, on a prospective or retroactive basis, to be a common-law employee of the Employer for such period;

(c) an individual who is classified as a "temporary" or "seasonal" employee whether he or she is paid by a temporary agency, other such staffing agency or by the Employer, whether or not any such individual is on the Employer's W-2 payroll or is determined by the Internal Revenue Service or any other government agency or tribunal, on a prospective or retroactive basis, to be a common-law employee of the Employer during such period;

(d) an Employee in a classification or job represented by a collective bargaining representative and whose terms and conditions of employment are determined under a collective bargaining agreement, unless the collective bargaining agreement contains a written provision extending Plan coverage to these Employees;

(e) an Employee who is a non-resident alien (as defined under Code Section 7701(b)(1)(B)) who has no U.S.-sourced income (e.g., an individual who performs services based outside of the United States and who does not earn compensation from the Employer for services provided under an authorization to work in the United States); or

(f) an individual who is party to an agreement with the Employer that provides that such individual shall not be eligible to participate in the Plan.

2.24 Employee means any person who renders services to the Employer for Compensation.

2.25 Employer means the Company, and shall also include its affiliates and all allied, owned, associated, subsidiary companies, corporations, organizations, entities, joint ventures, limited liability companies and partnerships that have been approved by the Board, or its authorized delegate, to participate in the Plan and which shall have taken all action deemed necessary or appropriate by the Board, or its authorized delegate, to participate. Currently, such entities shall include the Company, bebe Management, Inc. and bebe Studio Inc.

2.26 Enrollment Form and Compensation Redirection Agreement means the form or other mechanism provided by the Plan Administrator for allowing an Eligible Employee to elect Benefits and authorize the Employer to make salary reductions to pay for the Eligible Employee's participation in the Plan.

2.27 Entry Date means the first day of the month following the date that an Eligible Employee first satisfies any requirements for participation set forth in Section 3.1 and subsequently on July 1 of each calendar year thereafter unless otherwise specified with respect to a Benefit.

2.28 ERISA means the Employee Retirement Income Security Act of 1974, as amended, from time to time and the regulations issued thereunder.

2.29 External Review means a review of a final decision under the Plan's internal claims and appeals procedures conducted pursuant to an applicable external review process pursuant to Sections 13.8 through 13.11.

2.30 FLSA means the Fair Labor Standards Act, as amended from time to time, and the regulations issued thereunder.

2.31 FMLA means the Family Medical Leave Act of 1993, as amended from time to time and the regulations issued thereunder, and to the extent required, any applicable state law that requires continued health coverage for up to twelve (12) weeks in a rolling twelve (12)-month period for any other family or medical leave.

2.32 FMLA Leave means a qualifying leave under the FMLA.

2.33 Grandchild means a Child of an Eligible Dependent where such Child would be an Eligible Dependent if his or her parent were an Eligible Employee.

2.34 Health Care Expenses means health care expenses incurred by a Participant and/or his or her Spouse and/or Dependent(s), to the extent permitted by the Code. Health Care Expenses include expenses only to the extent that such expenses are not reimbursable through any plan, contract or arrangement. Expenses incurred for over-the-counter medicines and drugs, except for insulin, are not Health Care Expenses eligible for reimbursement under the Plan, unless purchased pursuant to a prescription. For this purpose, a "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a

prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

2.35 Health Care Operations means any of the following activities of the Plan: (a) conducting quality assessment and improvement activities, including outcome evaluations and development of clinical guidelines specific to the Plan; (b) population-based activities related to improving health or reducing care costs, protocol development, case management and care coordination, contacting Health Care Providers and patients with information about treatment alternatives, and related functions that do not involve treatment; (c) reviewing the competence or qualification of health care professionals, evaluating practitioner or provider performance, training of students or practitioners in which the students or practitioners learn under supervision to practice or improve their professional skills, training non-health care professionals, and accreditation, certification, licensing or credentialing activities; (d) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a health insurance contract (or similar) or health benefits, as well as ceding, securing or placing a stop-loss or excess risk insurance contract relating to health claims (as long as the requirements of the Privacy Rule are met); (e) conducting or arranging for medical review, legal services and auditing functions, including but not limited to fraud and abuse detection and compliance programs; (f) business planning and development, such as conducting cost-management and planning which pertain to running the Plan, including but not limited to developing and administering formularies and administering, developing or improving methods of payment or coverage policies; and (g) business management and general Plan administrative activities, including but not limited to: (i) management activities related to HIPAA privacy compliance; (ii) customer service, including providing data analysis for plan sponsors, as long as PHI is not disclosed in the process; (iii) resolution of internal grievances; (iv) merger or consolidation of the Plan with another health plan, and due diligence related to the merger or consolidation; and (v) consistent with the requirements of the Privacy Rule, creating de-identified health information or a limited data set.

2.36 Health Care Expense Arrangement means a health care expense arrangement program pursuant to Article X.

2.37 Health Care Provider means a provider of services, including a provider of medical or health services, as defined in the Social Security Act, and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business.

2.38 Health Care Reimbursement Program means a component Benefit providing a flexible spending account for reimbursement of Health Care Expenses pursuant to Code Section 105. A Health Care Reimbursement Account is commonly referred to as a "Health Care Flexible Spending Account" or "Health Care FSA".

2.39 Health Information means any information, whether oral or recorded in any form or medium, that: (a) is created or received by a Health Care Provider, health plan, public health authority, employer, life insurer, school, university or health care clearing house; and (b) relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual.

2.40 Health Insurance Issuer means an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state and is subject to that state's law that regulates insurance. The term does not include a group health plan.

2.41 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the regulations issued thereunder.

2.42 HIPAA Group Health Benefit Programs means Benefits governed by HIPAA, currently medical, prescription drug, dental, vision, wellness, and the Employee Assistance Program Premium Benefits, as well as the Health Care Reimbursement Program and Health Care Expense Arrangement.

2.43 HITECH Act means the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. Sections 17921 – 17954 and implementing regulations and guidance, generally effective as of February 17, 2010 (such references herein is deemed to be effective as of the applicable date(s) specified therein).

2.44 Independent Review Organization means the entity that performs independent external reviews of Adverse Benefit Determinations and renders final decisions with respect to Adverse Benefit Determinations under state or federal, as applicable, external review procedures.

2.45 Individual or Individuals means the person(s) who is (are) the subject of PHI.

2.46 Individually Identifiable Health Information means Health Information, including demographic information, taken from an Individual that either identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

2.47 Information System means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

2.48 Leave of Absence means any absence of an Employee authorized by the Employer under the Employer's policies, provided that the Employee returns to active service with the Employer at, or prior to, the expiration of his or her Leave of Absence.

2.49 Loss of Coverage means the elimination of a Benefit Election Option. In addition, the Employer shall treat the following as a Loss of Coverage: (a) a substantial decrease in the medical care providers available under a Benefit Election Option; (b) a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse, Domestic Partner or Dependent is currently in a course of treatment; or (c) any other similar fundamental loss of coverage.

2.50 Minimum Benefits means those Premium Benefits offered under the Plan for which no Participant Contributions are required and for which no affirmative enrollment by the Participant is required.

2.51 Open Enrollment Period means the period designated by the Company during which an Eligible Employee may make elections for Benefits to be effective as of the first day of the next Plan Year.

2.52 Participant means an Eligible Employee who elects, or is deemed to elect, Benefits in accordance with Section 3.1.

2.53 Participant Contributions means the amount determined by the Employer that a Participant must pay as his or her share of the cost for the Benefits, as more fully described in Article IV.

2.54 Payment means (a) the activities of the Plan (or another health plan) to obtain premiums or to determine or fulfill its responsibility for coverage or providing benefits; or (b) the activities of the Plan or a Health Care Provider to obtain or provide reimbursement for providing health care. Examples of Payment activities include, but are not limited to: (i) determination of eligibility or coverage, including coordination of benefits or determining cost sharing amounts; (ii) determining subrogation of health claims; (iii) risk adjusting amounts due based on an Individual's health status and demographic characteristics; (iv) billing, claims management, collection activities, obtaining payment under a stop-loss or excess risk insurance policy (or the like), and related health care data processing; (v) review of health care services to determine medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; (vi) utilization review activities, including precertification or preauthorization of claims and concurrent or retrospective review of services; and (vii) disclosure to consumer reporting agencies of any of the following information relating to collection of premiums or reimbursement: (A) name and address; (B) date of birth; (C) social security number; (D) payment history; (E) account number; and (F) name and address of the Plan or of a Health Care Provider.

2.55 Period of Coverage means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year starting with the date participation commences and ending with the last day of the Plan Year in which such participation commenced; (b) for Employees who terminate participation, it shall mean the portion of the Plan Year starting with the first day of the Plan Year in which termination occurs and ending with the date participation terminates; (c) a combination of (a) and (b); or (d) as the Code provides, if different than the Plan Year.

2.56 Plan means this bebe stores, inc. Section 125 and Welfare Benefits Plan, as amended from time to time.

2.57 Plan Administrator means, effective as of July 26, 2010 (or such other date as approved by the Company's Board of Directors), the bebe Benefits Committee.

2.58 Plan Year means the consecutive twelve (12)-month period commencing on July 1 and ending on the following June 30.

2.59 Premium Benefit means medical, prescription drug, dental, vision, life, long term disability, short term disability, accidental death and dismemberment, wellness and, the Employee Assistance Program, but excluding the Dependent Care Expense Reimbursement Program, the Health Care Reimbursement Program, the Health Incentive Arrangement and the Health Care Expense Arrangement.

2.60 Price means the Participant Contributions needed to purchase a Benefit for the Plan Year, whether with pre-tax or after-tax payments.

2.61 Privacy Rule or Rules means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, Subparts A and E, as amended by the HITECH Act and as further amended from time to time, as applicable.

2.62 Protected Health Information means Individually Identifiable Health Information, excluding information contained in employment records of the Employer, that is transmitted or maintained in any form or medium.

2.63 Qualifying Dependent Care Services means services that relate to the care of a Qualifying Individual, to enable the Participant and his or her Spouse (if such Spouse is not a Qualifying Individual) to remain gainfully employed during Plan Year, and are performed in the Participant's home or outside the Participant's home for the care of a Participant's Dependent who is under age thirteen (13) or the care of any other Qualifying Individual who regularly spends at least eight (8) hours per day in the Participant's household.

2.64 Qualifying Individual means a Participant's Dependent who is under the age of thirteen (13) and who is the Participant's qualifying child as defined in Code Section 152(c), a Participant's Dependent who is mentally or physically incapable of self-care and who has the same principal place of abode as the Participant more than half of the Participant's taxable year, or a Participant's Spouse who is mentally or physically incapable of self-care and who has the same principal place of abode as the Participant more than half of the Participant's taxable year. In the case of divorced parents, the Child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code Section 152(e)(1) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

2.65 QMCSO means any "qualified medical child support order" including any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (a) provides for child support with respect to a child of an Employee under the Plan or provides for health benefit coverage to such a child pursuant to a state domestic relations law (including a community property law) and relates to benefits under the Plan; or (b) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan. The term QMCSO also includes a National Medical Support Notice promulgated pursuant to section 401(b) of the Child Support and Performance Incentive Act of 1998.

2.66 Rescission of Coverage means cancellation or discontinuance of coverage that has a retroactive effect, whether or not there is an adverse effect to any particular Benefit at

the time. Rescission of Coverage does not, however, include cancellation or discontinuance of coverage due to a failure by the Participant or other covered individual to timely pay required premiums or contributions.

2.67 Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an Information System.

2.68 Security Manual means the written policies and procedures adopted by the Company to comply with the security rules under HIPAA.

2.69 Security or Security Measures means all Administrative, Physical and Technical Safeguards (as defined in HIPAA) in an Information System.

2.70 Security Standards means the security standards set forth in Sections 164.306 (regarding general security standards), 164.308 (regarding Administrative Safeguards), 164.310 (regarding Physical Safeguards), 164.312 (regarding Technical Safeguards), 164.314 (regarding organizational requirements), and 164.316 (regarding policies and procedures and documentation requirements) of HIPAA, individually or collectively, as the context requires.

2.71 Spouse means the legal husband or wife of an individual as determined under the Code, including Code Section 21(e). An individual legally separated from the Participant under a decree of divorce or of separate maintenance shall not be considered a Spouse.

2.72 Summary Health Information means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses, or type of claims experienced by Individuals under the Plan, as such term is described in Section 164.504 of the HIPAA regulations.

2.73 Termination of Employment means the termination of a Participant's employment as an Employee resulting from a change in job classification, discharge, layoff, voluntary termination, disability, retirement, death, or otherwise.

2.74 Urgent Care Claim means a claim for medical care or treatment if the time period for making non-urgent care determinations could seriously jeopardize the claimant's life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an Urgent Care Claim.

2.75 USERRA means the Uniformed Services Employment and Reemployment Rights Act, as amended, and the regulations issued thereunder.

2.76 USERRA Leave means a leave commenced for purposes of commencing active duty in the "Uniformed Services" (as that term is defined in USERRA) pursuant to active duty orders.

ARTICLE III

ELIGIBILITY FOR PARTICIPATION

3.1 General Eligibility Considerations.

(a) An Eligible Employee may commence participation in the following Benefits as of the Entry Date and annually on the first day of each Plan Year, that is, on July 1, thereafter, subject in each case to the acceptance and processing of his or her enrollment by the Plan Administrator:

(1) an Eligible Employee (who is not regularly-scheduled to work in Puerto Rico or Hawaii) may participate in any Premium Benefit other than disability coverage; or

(2) an otherwise Eligible Employee who is regularly-scheduled to work in Puerto Rico, is eligible only to participate in the coverage specified in Appendix A; or

(3) an otherwise Eligible Employee who is regularly-scheduled to work in Hawaii for at least twenty (20) hours per week is eligible only to participate in the coverage specified in Appendix A.

(b) An Eligible Employee may participate in the short-term and long-term disability program Benefits under the Plan as of the first day of the month following twelve (12)-consecutive months of employment with the Employer and annually thereafter, subject in each case to the acceptance and processing of his or her enrollment by the Plan Administrator. The twelve (12)-month service requirement does not apply to mandatory State disability programs to the extent required by law.

(c) An Eligible Employee may participate in the Health and Dependent Care Reimbursement Programs (or FSAs) as of the Entry Date and annually on the first day of each Plan Year, that is, on July 1 thereafter, subject in each case to the acceptance and processing of his or her enrollment by the Plan Administrator.

(d) An Eligible Employee who has elected to participate in the Plan may enroll his or her Eligible Dependent(s) for coverage under this Plan, in accordance with the terms of this Plan and the applicable policy, contract or Benefit program listed in Appendix A or as described in the Plan's enrollment materials from time-to-time. Notwithstanding the foregoing, the Plan Administrator shall comply with a QMCSO, within the meaning of ERISA Section 609(a), but only to the extent required by and under the conditions specified in ERISA Section 609(a).

(e) Notwithstanding the foregoing, all Eligible Employees shall be eligible to participate in the Employee Assistance Program ("EAP") as of the first day of employment with the Employer.

3.2 Termination of Participation. Eligibility to participate in this Plan and/or a Benefit, as applicable, shall terminate upon the first of the following: (a) the Participant ceases to meet eligibility requirements for the Plan or a Benefit, (b) the Participant revokes his or her election to participate or fails to timely make the required premium payments pursuant to the terms of the enrollment agreement or Plan, (c) the Period of Coverage for which the Participant has elected to participate expires and no default election applies, (d) the Benefit is terminated, or (e) this Plan is terminated.

3.3 Participation Following Termination of Employment or Loss of Eligibility. In the event of a Participant's loss of status as an Eligible Employee and subsequent return to Eligible Employee status within thirty (30) days of the loss of Eligible Employee status, then the Eligible Employee will be reinstated as a Participant with the same elections that he or she had before the loss of Eligible Employee status; provided, however, that such Participant must notify the designated representative of the Company of his or her change of status. If a former Participant returns to Eligible Employee status more than thirty (30) days following his or her loss of Eligible Employee status, then the former Participant shall be treated as a new hire for purposes of eligibility and enrollment under the Plan.

3.4 FMLA Leave or USERRA Leave. A Participant on an FMLA Leave or a USERRA Leave shall continue to be treated as an Eligible Employee and a Participant, and the Employer will continue to maintain the Participant's health benefits for the period of the FMLA Leave or USERRA Leave on the same terms and conditions as if the Participant were still an active Eligible Employee, generally for the period of the FMLA Leave or the first thirty-one (31) days of the USERRA Leave. That is, if the Participant elects to continue his or her health benefits coverage while on leave, then the Employer will continue to pay its share of the premium for the period required by law, and thereafter, the Participant shall be required to pay the full premium plus any administrative fee permitted under applicable law for the remainder of such leave. If the Participant elects to continue health benefits coverage while on leave, then the Participant shall, as determined by the Company, pay his or her Participant Contributions in one of the following ways:

(a) pursuant to his or her Enrollment Form and Compensation Redirection Agreement to the extent the FMLA Leave or USERRA Leave is a paid leave that is sufficient to cover the costs of the full premium and any applicable expense, or otherwise with after-tax dollars, by remitting monthly payments to the designated representative of the Company by the due date established by the Company from time-to-time;

(b) by pre-paying all or a portion of the premium for the expected duration of the leave out of pre-leave or other acceptable terms of Compensation. To pre-pay the premium, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available. The payment may be pre-tax to the extent permitted by applicable law (limited to premium cost for continued coverage for the remainder of the Plan Year in which the leave commences, except that no pre-tax payments may be made to provide Benefits for a Participant's Domestic Partner who is not otherwise eligible for pre-tax contribution or premium payments) in the event that the amount of prepayment is insufficient to cover Benefits for the full period of the leave, such remainder shall be paid in accordance with one of the other options specified in this Section; or

(c) under another arrangement agreed upon between the Participant and the Company, as consistent with applicable law, including the payment of "catch-up" amounts through salary withholding upon the Participant's return.

If a Participant's health coverage ceases while on FMLA Leave or USERRA Leave for failure to pay the Participant's share of premium cost, then the Participant will be permitted to re-enter the Plan upon return from such leave on the same basis with respect to health benefit coverage as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA or USERRA and subject to such adjustments to his or her elections with respect to the Health Care Reimbursement Program as may be required or permitted by the FMLA or USERRA and this Plan. A Participant may not retroactively elect coverage for claims incurred during the period when coverage was terminated.

If a Participant commences an FMLA Leave or USERRA Leave, then the Participant's entitlement to non-health Premium Benefits and Dependent Care Reimbursement Program benefits during the leave shall be determined by the Company's policy for providing such Benefits when the Participant is on a leave that is not an FMLA Leave or a USERRA Leave, as described in Section 3.5. A Participant returning from an FMLA Leave or USERRA Leave shall be eligible to re-enroll in any Benefit component offered under the Plan in accordance with the requirements of the FMLA or USERRA, as applicable, or as otherwise required by applicable law, and in addition, as otherwise permitted under the terms of the applicable Benefit.

3.5 Leaves of Absence Other Than FMLA Leave or USERRA Leave. If a Participant commences an unpaid Leave of Absence other than an FMLA Leave or a USERRA Leave, the Participant's coverage under the Plan will terminate as of the commencement of the leave or otherwise in accordance with the component Benefit.

ARTICLE IV

PARTICIPANT CONTRIBUTIONS

4.1 Participant Contributions. The Company shall determine the amount of Participant Contributions required for coverage under any Benefit. Participant Contributions shall be elected and authorized through the Enrollment Form and Compensation Redirection Agreement or other procedure specified by the Company from time-to-time. Participant Contributions shall be deducted from the Participant's Compensation in substantially equal amounts each pay period throughout the Plan Year or, if applicable, other Period of Coverage. Participant Contributions shall not exceed the aggregate Price of the Benefits selected.

4.2 Premium Payment Program - Pretax Conversion. Participant Contributions shall be made on a pre-tax basis to the extent permitted by applicable law unless otherwise elected by the Eligible Employee. Participant Contributions for Benefits provided to a Participant's Domestic Partner under the Plan shall be made on an after-tax basis, unless the Participant provides reasonable assurance, in the form and manner required by the Company, that the Domestic Partner qualifies as his or her Dependent. In the event that a Participant incurs a Termination of Employment, the Participant Contribution for any coverage extending through the end of the month in which such Termination of Employment occurs shall be deducted from the Participant's final paycheck.

4.3 Cessation of Required Participant Contributions. Nothing in this Plan shall prevent the cessation of coverage or any Benefits under the Plan described in Article V, in accordance with the terms of such offered Benefit and to the extent permitted by applicable law, including, without limitation, on account of a failure to pay the cost of such coverage or Benefit through Participant Contributions.

ARTICLE V

BENEFITS UNDER THE PLAN

5.1 Generally. Subject to the requirements of Article IX regarding Minimum Benefits and Article XI regarding elections, each Participant may elect to purchase any of the Benefits offered under this Plan.

5.2 Benefits. The Price of each Benefit and Benefit Election Option shall be determined by the Company, and may be adjusted during the Plan Year. The Company shall be able to, at any time and without prior notice, to the extent permitted by law, to add, delete or change any component Benefit and/or Benefit Election Option offered under the Plan, to change any provider of benefits or administrative services or to change the price of any component Benefit or Benefit Election Option offered under the Plan.

ARTICLE VI

HEALTH CARE REIMBURSEMENT PROGRAM

6.1 Health Care Reimbursement Program. The Health Care Reimbursement Program is intended to constitute a self-insured medical reimbursement plan under Code Section 105, and the health care expenses reimbursed thereunder are intended to be eligible for exclusion from Participants' gross income under Code Section 105. The Price for the Health Care Reimbursement Program shall be equal to the annual dollar amount of coverage elected by the Participant under the Health Care Reimbursement Program for the Plan Year. Such election may be any whole dollar amount of coverage between a minimum of $260 for that Plan Year (which is intended to be an amount equal to $10 per paycheck during the Plan Year) and a maximum of $2,500 for that Plan Year, or such other minimum and maximum dollar limits as may be established by the Company from time to time.

6.2 Eligibility. Eligibility for the Health Care Reimbursement Program, under this Article shall be limited to an Eligible Employee who has not elected to receive benefits under a Health Savings Account ("HSA") as defined in Code Section 223.

6.3 Timing of Health Care Expenses. Under the Health Care Reimbursement Program, a Participant may receive reimbursement for Health Care Expenses incurred during the Period of Coverage for which an election is in force. A Health Care Expense is incurred at the time the service giving rise to the Expense is furnished, and not when the Participant is formally billed for, is charged for, or pays for the health service; unless otherwise permitted by law and specified by the Plan Administrator.

6.4 Dollar Limits for Reimbursement. The maximum dollar amount elected by the Participant for reimbursement of Health Care Expenses incurred during the Period of Coverage (reduced by prior reimbursements during such Period of Coverage) shall be available at all times during such Period of Coverage, regardless of the actual amounts credited to the Participant's Health Care Reimbursement Account.

6.5 Health Care Reimbursement Program Account. The Plan Administrator shall establish and maintain a Health Care Reimbursement Program account for each Participant who has elected to participate in the Health Care Reimbursement Program which shall constitute a recordkeeping entry, but will not create a separate fund or otherwise segregate assets for this purpose. If any balance remains in the Participant's Health Care Reimbursement Account for a Plan Year after all reimbursements have been made for the Plan Year, such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Plan Year. All forfeitures under this Plan and any Health Care Reimbursement Program benefit payments that are unclaimed (e.g., uncashed benefit checks) by the end of the close of the Plan Year following the Plan Year in which the health expense was incurred shall be forfeited and applied as determined by the Company.

6.6 Claims for Reimbursement. A Participant who has elected to receive Health Care Reimbursement Program benefits for a Plan Year may apply for reimbursement by

submitting an application in such form and manner as the Plan Administrator may prescribe from time to time. A Participant (or the authorized representative of Participant's estate or an individual who has a valid Power of Attorney) may claim reimbursement for any Health Care Expenses incurred during the Plan Year, provided that the Participant (or the Participant's estate) files a claim by the end of the third month following the close of the Plan Year (or such other date as specified by the Company and pursuant to the Code) in which the Health Care Expense was incurred.

ARTICLE VII

DEPENDENT CARE REIMBURSEMENT PROGRAM

7.1 Dependent Care Reimbursement Program. The Dependent Care Reimbursement Program is intended to qualify as a dependent care assistance plan under Code Section 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from Participants' gross income under Code Section 129(a). The Price for the Dependent Care Reimbursement Program shall be equal to the dollar amount of coverage elected by the Participant under the Dependent Care Reimbursement Program for the Plan Year. Such election may be any whole dollar amount of coverage between a minimum of $260 for a Plan Year (which is intended to be an amount equal to $10 per paycheck during the Plan Year) and a maximum of $5,000 for a Plan Year, or such other minimum and maximum dollar limits as may be established by the Company from time to time; provided, however, that such election shall not exceed the least of:

(a) the Participant's Earned Income for a calendar year;

(b) the Earned Income of the Participant's Spouse for a calendar year; or

(c) either:

(1) $5,000 for a calendar year if: (A) the Participant is married and files a joint return; (B) the Participant is married but (i) furnishes more than one-half (1/2) the cost of maintaining the Dependent for whom the Participant is eligible to receive reimbursements under the Dependent Care Reimbursement Program; (ii) the Participant's Spouse maintains a separate residence for the last six (6) months of the calendar year and the Participant files a separate tax return; and (iii) the Participant files a separate tax return; or (C) the Participant is single or is the head of the household for tax purposes; or

(2) $2,500 if, for the calendar year, the Participant is married and resides with the Spouse, but files a separate federal income tax return.

7.2 Timing of Dependent Care Expenses and Services. Under the Dependent Care Reimbursement Program, a Participant may receive reimbursement for Dependent Care Expenses and services incurred during the Period of Coverage for which an election is in force. A Dependent Care Expense is incurred at the time the service giving rise to the Expense is furnished, and not when the Participant is formally billed for, is charged for, or pays for the service.

7.3 Dollar Limits for Reimbursement. The maximum amount available for reimbursement of Dependent Care Expenses shall be the amount withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Plan Year (subject to Section 7.1) less any prior reimbursements for Dependent Care Expenses incurred during the Plan Year.

7.4 Dependent Care Reimbursement Program Account. The Plan Administrator will establish and maintain a Dependent Care Reimbursement Program account for each Participant who has elected to participate in the Dependent Care Reimbursement Program which will constitute a recordkeeping entry, but will not create a separate fund or otherwise segregate assets for this purpose. If any balance remains in the Participant's Dependent Care Reimbursement Account for a Plan Year after all reimbursements have been made for the Plan Year, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. All forfeitures under this Plan and any Dependent Care Reimbursement Program payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Dependent Care Expense was incurred shall be forfeited and applied as determined by the Company.

7.5 Claims for Reimbursement. A Participant who has elected to receive benefits under the Dependent Care Reimbursement Program for a Plan Year may apply for reimbursement by submitting an application to the Plan Administrator in such form and manner as the Plan Administrator may prescribe. A Participant (or the authorized representative of the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Plan Year provided that the Participant (or the authorized representative of the Participant's estate) files a claim by the end of the third month following the close of the Plan Year (or such other date as specified by the Company and pursuant to the Code) in which the Health Care Expense was incurred.

7.6 Breaks in Participation.

(a) In the event that a Participant ceases participation in the Dependent Care Reimbursement Program on Termination of Employment or loss of Eligible Employee status and is rehired and/or returns to Eligible Employee status within thirty (30) days and during the same Plan Year, such former Participant shall be reinstated upon rehire and/or return to Eligible Employee status, as applicable, at the same benefit level elected prior to the break in participation less an adjustment for prior reimbursements plus an adjustment to his or her premium payments to include premiums missed during the break in participation; provided, however, that such Eligible Employee so notifies the designated representative of the Company.

(b) In the event that a former Participant is rehired and/or returns to Eligible Employee status more than thirty (30) days following a break in participation, or in a later Plan Year, except as otherwise required by other applicable law, such former Participant shall be treated as a new hire, subject to an adjustment to the maximum available benefit level for prior reimbursements if the rehire or return to Eligible Employee status occurs in the same Plan Year as the Plan Year in which the break in participation occurred.

7.7 Statement of Expenses. On or before the January 31 following each Plan Year, the Company shall furnish to each Participant who elected to participate in the Dependent Care Reimbursement Program during the prior calendar year a written statement showing Dependent Care Expenses paid during such year with respect to the Participant, and showing the dollar amount of coverage elected for the year for the Dependent Care Reimbursement Program, as the Plan Administrator deems appropriate.

ARTICLE VIII

HEALTH INCENTIVE ARRANGEMENT

8.1 Health Incentive Arrangement. The Health Incentive Arrangement or "HIA" is intended to constitute a self-insured medical reimbursement plan under Code Section 105, and the health care expenses reimbursed thereunder are intended to be eligible for exclusion from Participants' gross income under Code Section 105.

8.2 Eligibility. Eligibility for the Health Incentive Arrangement, under this Article shall be limited to an Eligible Employee, who is a resident of the U.S. or the Virgin Islands, regularly-scheduled to work thirty-seven and one-half (37½) hours per week or more, and who is enrolled in coverage specified in Appendix A. Notwithstanding the forgoing, Eligible Employees who are regularly scheduled to work in Hawaii or Puerto Rico are not eligible for the Health Incentive Arrangement.

8.3 Timing of Health Care Expenses. Under the Health Incentive Arrangement, a Participant may receive reimbursement for Health Care Expenses incurred during the Period of Coverage for which an election is in force. A Health Care Expense is incurred at the time the service giving rise to the Expense is furnished, and not when the Participant is formally billed for, is charged for, or pays for the Health Care Expense.

8.4 Dollar Limits for Reimbursement. The maximum amount available for reimbursement of Health Care Expenses shall be the amount credited by the Employer (at Employer's cost) to Participant's Health Incentive Arrangement Account by the Plan Administrator, up to a maximum of $200 for a Plan Year. Such maximum amount shall be reduced by any prior reimbursements for Health Care Expenses incurred during the Plan Year

8.5 Health Incentive Arrangement Account. The Plan Administrator shall establish and maintain a Health Incentive Arrangement account for each Participant who has elected to participate in the Health Incentive Arrangement which shall constitute a recordkeeping entry, but will not create a separate fund or otherwise segregate assets for this purpose. If any balance remains in the Participant's Health Incentive Arrangement for a Plan Year after all reimbursements have been made for the Plan Year, such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Plan Year. All forfeitures under this Plan and any Health Incentive Arrangement benefit payments that are unclaimed (e.g., uncashed benefit checks) by the end of the close of the Plan Year following the Plan Year in which the Health Care Expense was incurred shall be forfeited and utilized as determined by the Company.

8.6 Claims for Reimbursement. A Participant who has elected to receive Health Incentive Arrangement benefits for a Plan Year may apply for reimbursement by submitting an application in such form and manner as the Plan Administrator may prescribe from time to time. A Participant (or the Participant's estate) may claim reimbursement for any Health Care Expenses incurred during the Plan Year, provided that the Participant (or the Participant's estate) files a claim by the end of the third month following the close of the Plan Year (or such

other date as specified by the Company and pursuant to the Code) in which the Health Care Expense was incurred. A Participant will also have access to funds credited to his or her Health Incentive Arrangement Account through a Visa debit card. Purchases of over-the-counter medicines or drugs using Visa debit cards at drug stores and pharmacies, at non-health care merchants that have pharmacies and at mail order and web-based vendors that sell prescription drugs must be considered fully substantiated at the time and point of sale in accordance with IRS Notices 2010-59 and 2011-5 (and applicable subsequent guidance).

8.7 Coordination with Health Care Reimbursement Program. A Participant who has elected to receive benefits under the Health Care Reimbursement Program (Article VI), shall neither be eligible to seek, nor shall be provided with reimbursements for Health Care Expenses under the Health Incentive Arrangement until having exhausted the maximum dollar amount elected by such Participant for reimbursement under the Health Care Reimbursement Program.

ARTICLE IX

MINIMUM BENEFITS

9.1 Election Required. An Eligible Employee who fails to make a proper election under this Plan during an Open Enrollment Period with respect to the next Plan Year shall be deemed to not have elected coverage under either the Premium Benefits or under the Health Care Reimbursement Program or the Dependent Care Reimbursement Program.

9.3 Minimum Benefits. Notwithstanding the foregoing, an Eligible Employee who has satisfied the requirements of Section 3.1 shall, at minimum, be deemed to have elected to participate in the Plan and to enroll in any Premium Benefit for which no Participant Contributions are required and for which no affirmative Participant enrollment is required, unless the Participant, upon first becoming eligible for coverage under the Plan, provides a written waiver of coverage in such form and manner as required by the Plan Administrator from time to time.

ARTICLE X

SPECIAL PROVISIONS RELATING TO HEALTH CARE

EXPENSE ARRANGEMENTS

10.1 Health Care Expense Arrangement. The Health Care Expense Arrangement ("HCEA", also commonly referred to as an "HRA") is intended to meet the criteria set out in the San Francisco Health Care Security Ordinance ("HCSO"). If the provisions of the HCSO are modified or eliminated, it is the intent of the Company that this Article be interpreted from time to time so as to provide the minimum coverage and benefits required by the HCSO. The HCEA is paid for solely by Employer on behalf of HCEA Eligible Employees (as defined in Section 10.2 below). Employee contributions to the HCEA are not permitted.

10.2 Eligibility. Eligibility for the HCEA under this Article shall be limited to an Employee who meets the following criteria ("HCEA Eligible Employee"):

(a) the Employee: (i) is not eligible for any other Company-sponsored medical coverage hereunder; (ii) is covered by a Company-sponsored medical program under the Plan, but his or her Employer contribution is less than the amount required under the HCSO; or (iii) he or she has waived medical coverage under the Plan, but has not completed the HCSO waiver form;

(b) he or she has completed ninety (90) days of employment with the Employer;

(c) he or she works an average of eight (8) or more hours per week within the geographic boundaries of the City and County of San Francisco during the calendar quarter immediately preceding the Benefit Period as defined in Section 10.4(b) below;

(d) he or she earns less than $40.41 per hour in 2012; and

(e) he or she is not eligible for Medicare or TRICARE/CHAMPUS.

10.3 Cessation of Participation. An Employee will cease to participate in the HCEA on the earliest of the following:

(a) the date the Employee's employment terminates;

(b) the date the Employee's eligible class under the HCSO terminates; or

(c) the date the HCEA terminates (including, without limitation, the date that the Employer is not obligated to comply with the HCSO).

10.4 HCEA Funding and Reimbursement.

(a) Each quarter, the Employer will set aside amounts to the HCEA on behalf of each HCEA Eligible Employee for the calendar quarter in which he or she meets the eligibility

requirements pursuant to Section 10.2. For 2012, the maximum amount shall be $2.20 per hour for all hours worked by an HCEA Eligible Employee in the City in the calendar quarter immediately preceding the Benefit Period as defined in Section 10.4(b) below. The Company reserves the right to modify or terminate amounts set aside at any time for any reason.

(b) The Benefit Period begins on the first day following each calendar quarter for HCEA Eligible Employees who meet the eligibility requirements under Section 10.2 in the calendar quarter immediately preceding the first day of the Benefit Period.

(c) HCEA Eligible Employees may seek reimbursement for eligible medical expenses by submitting an application in such form and manner as the Plan Administrator may prescribe from time to time. The Company will make available to an HCEA Eligible Employee, upon request, a list of eligible medical expenses. An HCEA Eligible Employee may submit requests for reimbursement while employed by the Employer for a period of twenty-four (24) months after the Employer has set aside amounts in the HCEA for that HCEA Eligible Employee, as long as there are amounts remaining on behalf of that HCEA Eligible Employee. An HCEA Eligible Employee may submit requests for reimbursement for a period of ninety (90) days after termination of employment with the Employer, as long as there are amounts remaining on behalf of that HCEA Eligible Employee.

ARTICLE XI

ELECTION PROCEDURES

11.1 Annual Elections and Initial Election. Each Eligible Employee shall make an election of Benefits during the Open Enrollment Period. Each Eligible Employee shall make an election for the Plan Year or the remainder thereof pursuant to such procedures as the Plan Administrator shall prescribe from time to time. Any Eligible Employee who fails to make a proper election under this Plan shall, nevertheless, be a Participant in this Plan and shall be deemed to have elected and purchased the Minimum Benefits described in Article IX of the Plan. An Employee who first becomes eligible to participate in the Plan during a Plan Year may commence participation on the Entry Date, provided that an Enrollment Form and Compensation Redirection Agreement are submitted to the Plan Administrator within such period prescribed by the Plan Administrator. Election of Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit.

11.2 HIPAA Special Enrollment.

(a) An Eligible Employee or the Eligible Dependent of an Eligible Employee, may enroll in HIPAA Group Health Benefit Programs within thirty (30) days after an event described under Code Section 9801(f), including: (1) loss of eligibility for other coverage in place at the time the Eligible Employee or the Eligible Dependent declined coverage under the Plan, where such loss of coverage is due to death, termination of employment, reduction in hours, exhaustion of the maximum COBRA period, or because such other coverage was non-COBRA coverage and employer contributions for such coverage were terminated or, in the case of an Eligible Employee, Spouse or Dependent and not a Domestic Partner, loss of coverage is due to legal separation or divorce; or (2) acquiring a new Spouse or Dependent as a result of marriage, birth, adoption or placement for adoption or acquiring a new Domestic Partner as determined by the Plan Administrator. Coverage based on enrollment on account of acquiring a new Eligible Dependent by birth, adoption or placement for adoption shall be effective on the date of the birth, adoption or placement for adoption.

(b) Pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP"), an Eligible Employee or the Eligible Dependent of an Eligible Employee may enroll in HIPAA Group Health Benefit Programs within sixty (60) days after one of the following events described under Code Section 9801(f) if: (1) such Employee is covered under a State Medicaid plan under Title XIX of the Social Security Act, or child health assistance under a State child health plan under Title XXI of the Social Security Act (a "Medicaid Plan" or a "State Child Health Plan", respectively), and coverage is terminated as a result of loss of eligibility for such coverage and the Employee requests coverage under the Plan not later than sixty (60) days after the date of termination of such coverage; or (2) the Employee becomes eligible for assistance, with respect to coverage under the Plan, under the Medicaid or State Child Health Plan (including under any waiver or demonstration project conducted under or in relating to such plan), and the Employee requests coverage under the Plan not later than sixty

(60) days after the date that the Employee is determined to be eligible for such assistance. The special enrollment rights of the provision also apply to a Dependent of the Employee if such Dependent is eligible, but not enrolled, for coverage under the terms of the plan and the Dependent satisfies one of the above-specified requirements.

11.3 Acceptance of Elections. An election submitted by an Eligible Employee is subject to acceptance, modification, or rejection by the Plan Administrator.

11.4 Election Modifications Required by Plan Administrator. The Plan Administrator can, at any time, require any Participant or class of Participants to amend the Enrollment Form and Compensation Redirection Agreement if the Plan Administrator determines that such action is appropriate to satisfy any of the Code's requirements, prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of Benefits hereunder than would otherwise be recognized, or satisfy other limitations applicable to the Employer's other plans.

11.5 Revocation and Modification of Elections.

(a) Once a Enrollment Form and Compensation Redirection Agreement election has been accepted by the Plan Administrator, the Participant may not modify or revoke his or her election for the remainder of the Plan Year except where both the revocation or modification and new election are on account of and consistent with an event listed in this Article as determined by the Plan Administrator.

(b) A Participant may modify or revoke his or her Enrollment Form and Compensation Redirection Agreement with respect to Domestic Partner coverage in the same manner and subject to the same requirements applicable to changes that may be made with respect to coverage of a Spouse, as determined by the Plan Administrator.

11.6 Change in Status Events.

(a) Change in Status Events include the following:

(1) Legal Marital Status. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(2) Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular Benefit, including birth, death, adoption, and placement for adoption;

(3) Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependent(s): (A) a termination or commencement of employment; (B) a strike or lockout; (C) a change in worksite; (D) commencement or return from an unpaid leave of absence; (E) if the eligibility conditions of this Plan or other benefit plan of the Participant or his or her Spouse or Dependent(s) depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other benefit plan;

(4) Change in Residence. A change in the place of residence of the Participant or his or her Spouse or Dependent(s) affecting eligibility for a particular Benefit; and

(5) Gain of Coverage Eligibility Under Another Employer's Plan. If a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, then a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan.

(b) Consistency Requirements. A requested election change must satisfy the consistency requirements in order for a Participant to be able to alter his or her election based on the specified change in status. The election change must be on account of and correspond with the Change in Status event.

(1) Special Consistency Rule for Dependent Care Reimbursement Program. With respect to the Dependent Care Reimbursement Program, a Participant may change or terminate his or her election upon a Change in Status if (A) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (B) the election change is on account of and corresponds with a change in status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code Section 129.

(2) Special Consistency Rule for Life, Accident, and Long Term Disability Insurance Benefits. For changes in marital and employment status, a Participant may elect to increase or decrease his or her election for group-term life insurance benefits, accidental death and dismemberment insurance benefits, or long term disability insurance benefits, as applicable.

(3) Loss of Spouse or Dependent Eligibility. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (A) the Spouse involved in the divorce, annulment, or legal separation; (B) the deceased Spouse or Dependent; or (C) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status.

11.7 HIPAA Special Enrollment Rights (Applies to Medical Plan, but Not to Health Care Reimbursement or Dependent Care Reimbursement Programs). If a Participant, Spouse, or Dependent is entitled to special enrollment rights for a HIPAA Group Health Benefit Program as described in Section 11.2(a), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds

with such HIPAA special enrollment right. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent Child shall be considered to be consistent with the special enrollment rights. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of an Eligible Dependent may, subject to the provisions of the underlying HIPAA Group Health Benefit Program, be effective retroactively (up to thirty (30) days).

11.8 Certain Judgments, Decrees and Orders (Applies to Accident or Health Coverage and to Health Care Reimbursement Program Benefits, but Not to Dependent Care Reimbursement Program Benefits). If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody requires accident or health coverage (including an election for Health Care Reimbursement Program Benefits) for an Eligible Dependent Child (including a foster child who is a Dependent of the Participant), a Participant may (a) change his or her election to provide coverage for the Dependent Child (provided that the Order requires the Participant to provide coverage); or (b) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

11.9 Medicare and Medicaid (Applies to Accident or Health Plans, to Health Care Reimbursement Program Benefits as Limited Below, but Not to Dependent Care Reimbursement Program Benefits). If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health Care Reimbursement Program coverage may be canceled (but not reduced). Further, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health Care Reimbursement Program coverage may commence or increase. If an Eligible Employee or Eligible Dependent loses eligibility for coverage under a Medicaid Plan or State Child Health Plan, such Eligible Employee or Eligible Dependent may be entitled to special enrollment rights for a HIPAA Group Health Benefit Program as described in Section 11.2(b).

11.10 Change in Cost (Applies to Premium Payment Benefits, to Dependent Care Reimbursement Program Benefits as Limited Below, but NOT to Health Care Reimbursement Program Benefits).

(a) Insignificant Cost Changes. Participants are required to increase their Participant Contributions to reflect insignificant costs increases in the Benefits, and to decrease their Participant Contributions to reflect insignificant cost decreases in the Benefits. The Plan Administrator will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, and will automatically effectuate this increase or decrease in Participant Contributions.

(b) Significant Cost Increases. The Plan Administrator will decide whether a cost increase is significant in accordance with applicable law. If the Plan Administrator determines that the cost for any Benefit significantly increases during a Plan Year, the Plan Administrator may permit a Participant to elect from the following: (1) make a corresponding increase in Participant Contributions; (2) revoke his or her election for the Benefit, and elect another similar Benefit on a prospective basis; or (3) drop coverage on a prospective basis if there is no similar Benefit available.

(c) Significant Cost Decreases. If the Plan Administrator determines that the cost of any Benefit significantly decreases during a Plan Year, the Plan Administrator may permit Participants to change their election on a prospective basis to elect a Benefit or election therein that has decreased in cost.

(d) Limitation on Change in Cost Provisions for Dependent Care Reimbursement Program. The "Change in Cost" provisions described in this Article apply to Dependent Care Reimbursement Program benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee as defined in Code Sections 152(a)(1) through (8).

(e) Change in Cost Provisions Not Applicable to Health Care Reimbursement Program. The "Change in Cost" provisions described in this Article do not apply to Health Care Reimbursement Program benefits.

11.11 Change in Coverage (Applies to Premium Benefits and Dependent Care Reimbursement Program Benefits, but NOT to Health Care Reimbursement Program Benefits). The Plan Administrator will decide, in accordance with applicable law, whether a curtailment is significant and whether a Loss of Coverage has occurred. Coverage shall be deemed to be significantly curtailed only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally.

(a) Significant Curtailment Without Loss of Coverage. If the Plan Administrator determines that a Participant's coverage under a Benefit Election Option under this Plan (or the Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage during a Plan Year, the Participant may prospectively revoke his or her election for the affected coverage, and instead elect coverage under another Benefit Election Option that provides similar coverage.

(b) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Election Option under this Plan (or the Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Plan Year, the Participant may revoke his or her election, and may either prospectively elect coverage under another Benefit Election Option that provides similar coverage, or drop coverage if no other Benefit Election Option providing similar Coverage is offered by the Employer.

(c) Addition or Significant Improvement of a Benefit Election Option. If, during a Plan Year, the Plan Administrator adds a new Benefit Election Option or significantly

improves an existing Benefit Election Option, the Plan Administrator may permit the following election changes: (1) Eligible Employees who are enrolled in a Benefit Election Option other than the newly-added or significantly improved Benefit Election Option may change their election on a prospective basis to elect the newly-added or significantly improved Benefit Election Option; and (2) Eligible Employees may elect the newly-added or significantly improved Benefit Election Option on a prospective basis, subject to the terms and limitations of the Benefit Election Option. The Plan Administrator will decide whether there has been an addition of, or a significant improvement in, a Benefit Election Option in accordance with applicable law.

(d) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCRIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government as defined in Code Section 7701(a)(40), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Election Option.

(e) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as: (1) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable law; or (2) the Plan permits Participants to make an election for a Plan Year that is different from the plan year under the other cafeteria plan or benefits plan. The Plan Administrator will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with applicable law.

(f) Dependent Care Reimbursement Account Coverage Changes. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant with respect to dependent care service provider. For example: (1) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and (2) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

(g) Change in Coverage Provisions Not Applicable to Health Care Reimbursement Program. The "Change in Coverage" provisions described in this Article do not apply to Health Care Reimbursement Program benefits.

ARTICLE XII

ADMINISTRATION

12.1 Duties and Powers of the Plan Administrator. The Plan Administrator has full discretionary authority to administer, construe and interpret the Plan. Duties, responsibilities and authority with respect to the administration of the Plan shall include but are not limited to the following:

(a) To construe and interpret the Plan, including ambiguous terms, and decide all questions of benefits;

(b) To delegate to an insurer or third party administrator the responsibility, as Claims Administrator, of determining benefit claims with respect to a Premium Benefit offered under the Plan. The Claims Administrator shall have the full discretion and authority of the Plan Administrator to construe and interpret the Plan and decide all questions of eligibility for benefits so delegated to the Claims Administrator;

(c) To prescribe procedures to be followed by Eligible Employees in making elections under the Plan and in filing claims under the Plan;

(d) To prepare and distribute information explaining the Plan to Eligible Employees and Participants;

(e) To require and receive such information as shall be necessary or appropriate for the proper administration of the Plan;

(f) To keep reports of elections, claims, and disbursements for claims under the Plan and other data as necessary or appropriate for proper administration and to meet applicable disclosure and reporting requirements;

(g) To employ such persons, including, but not limited to actuaries, accountants, medical experts, and counsel, as it deems necessary or appropriate to perform such duties as may from time to time be required under ERISA, the Plan, or other applicable law and to render advice upon request with regard to any matters arising under the Plan;

(h) To accept, modify or reject elections under the Plan; and

(i) To take all other steps deemed necessary or appropriate to properly administer the Plan in accordance with its terms and the requirements of applicable law.

12.2 Duties and Powers of the Plan Sponsor. The Company, as Plan Sponsor, has full discretionary authority to administer, construe and interpret the Plan to the extent consistent with its settlor duties and responsibilities, including determination of an Employee's eligibility to participate in the Plan.

12.3 Rules and Decisions. The Plan Administrator or its authorized representative shall interpret the Plan and decide any matters arising hereunder in its sole and absolute discretion. All decisions of the Plan Administrator or its authorized representative shall be conclusive and binding on all persons, entities or parties and shall be given the maximum possible deference allowed by law. The Plan Administrator or its authorized representative shall be entitled to rely upon such information as may be furnished to it by a Participant, the Employer, interested persons, legal counsel, or the administrator or insurer (or entities acting on each of their behalf) of any Benefit.

ARTICLE XIII

CLAIMS AND PROCEDURES

13.1 Disputes Concerning Eligibility and Contributions. Except as set forth in Section 13.1(c) below with respect to claims for eligibility and enrollment that are coincident with claims for benefits, all disputes concerning eligibility to participate in this Plan and all disputes concerning contributions to the Plan (including Employer and Participant premium contributions and salary reductions) shall be resolved in accordance with the procedures set forth in Sections 13.1(a) and 13.1(b) below.

(a) All claims for eligibility or enrollment under the Plan must be submitted no later than the last date of the Plan Year for which the claim is being made.

(b) If an Employee, or a Spouse, Domestic Partner or Child of an Employee believes he or she is eligible to participate in the Plan, or if a Participant has a claim concerning Participant Contributions or amounts retained by the Employer pursuant to his or her Salary Reduction Agreement, then such individual may file a written claim with the Company's Human Resource Department in such form and manner as the Company may prescribe from time to time. The Company's Human Resource Department shall furnish within ninety (90) days after its receipt of the claim (or within one-hundred and eighty (180) days after such receipt if special circumstances require an extension of time) a written notice of decision on the claim. If the Company's Human Resource Department determines that the claim is denied, the written denial of such claim shall be conclusive and binding on all parties.

(c) If an eligibility claim is coincident with a "claim for benefits" as defined in ERISA, the review of the claims by the Company's Human Resource Department will be limited to determining eligibility requirements. If the Company's Human Resource Department determines that the claimant met the eligibility requirements, the Company's Human Resource Department will forward the claim and an explanation directly to the Claims Administrator. An eligibility claim coincident with a "claim for benefits" will be reviewed under the same time periods applicable for health or disability benefit claims, as described below.

13.2 Claims for Group Insurance Benefits. All claims for Premium Benefits shall be resolved by the applicable insurance carrier or administrator, as the Claims Administrator, in accordance with the procedures prescribed under the applicable insurance policy or contract, summary plan description, or other document governing the Premium Benefit listed in Appendix A or as described in the Plan's enrollment materials from time-to-time and in accordance with the applicable time and notice requirements set forth below. To obtain Premium Benefits from an insurer of a component benefit program, or with respect to which the Plan Administrator has delegated claims determination responsibility, as Claims Administrator, to a third party administrator insurance company or other entity under an administrative services contract, a Participant must follow the claims procedures under the applicable insurance policy or the applicable administrative services contract identified in Appendix A or as described in the Plan's enrollment materials from time to time. A claim denied by the insurance carrier may be appealed to the insurance carrier in accordance with the appeals procedures under the applicable

insurance policy or contract, summary plan description, or other document governing the Premium Benefit listed in Appendix A or as described in the Plan's enrollment materials from time-to-time. For purposes of all claims for Group Insurance Benefits, the Plan Administrator has delegated to the applicable insurance carrier or third party administrator, as Claims Administrator, the responsibilities of the Plan Administrator with respect to benefit claims administration for the Group Insurance Benefits provided under the Plan.

13.3 Claims for Health or Disability Benefits. Except to the extent Sections 13.2 and 13.4 apply, claims for health and disability benefits provided under the Plan shall be subject to the following requirements:

(a) Initial Submissions. All claims for health and disability benefits under the Plan must be submitted to the applicable Claims Administrator listed in Appendix A, within one (1) year of the Participant's receipt of service, or onset of illness or injury, whichever is later, and in such form and manner as the Company may prescribe from time to time.

(b) Time Requirements for Initial Decision.

(1) In the case of an Urgent Care Claim, the Claims Administrator will provide the Participant with notice of a decision as soon as possible, taking into account the medical exigencies involved, but no later than within seventy-two (72) hours after it receives the Participant's claim. However, if more information is required, the Claims Administrator will notify the Participant, within twenty-four (24) hours after receipt of the claim, of all the incomplete information needed to correct the claim. The Participant will then have forty-eight (48) hours to provide the requested information to the Claims Administrator. The Participant will be notified of the Claims Administrator's decision on the claim either forty-eight (48) hours after the Claims Administrator receives the required information or ninety-six (96) hours after the Participant received notice that more information is required, whichever occurs first. Notice may be provided to the Participant orally if written or electronic notification is furnished within three (3) days after the oral notification.

(2) In the case of a pre-service health benefits claim, or a claim for health benefits that requires advanced approval, the Participant will receive notice of the Claims Administrator's decision within fifteen (15) days after it receives the Participant's claim. The Claims Administrator may extend this period for up to fifteen (15) days, if it determines that the extension is necessary due to circumstances beyond the control of the Plan. The notification will be sent to the Participant prior to the expiration of the initial fifteen- (15-) day period and will state the reason for the extension and the date when the Participant can expect a decision. If the extension is due to the Participant's failure to supply the necessary information, the notice of extension will describe the required information and the Participant will have forty-five (45) days to provide the requested information. Moreover, the period for making the determination will be delayed from the date the notification of extension was sent out until the Participant responds to the request for additional information, not to exceed the forty-five- (45-) day limit.

(3) In the case of a post-service health benefits claim, or a claim for health benefits that does not require advanced approval (including a claim for reimbursement of health care expenses under the Health Care Reimbursement Program), the Participant will receive notice of the Claims Administrator's decision within thirty (30) days after it receives the claim. The Claims Administrator may extend this period for up to fifteen (15) days, if it determines that the extension is necessary due to circumstances beyond the control of the Plan. The notification will be sent to the Participant prior to the expiration of the initial thirty- (30-) day period and will state the reason for the extension and the date when the Participant can expect a decision. If the extension is due to the Participant's failure to supply the necessary information, the notice of extension will describe the required information and the Participant will have forty-five (45) days to provide the requested information. Moreover, the period for making the determination will be delayed from the date the notification of extension was sent out until the Participant responds to the request for additional information.

(4) In the case of a concurrent health care claim, where a course of health care treatment is reduced or terminated before the end of the period of time or number of treatments previously approved, the Claims Administrator will notify the Participant sufficiently in advance of the reduction or termination to allow the Participant to appeal the decision and have the appeal decided before the benefit is reduced or terminated. If the Participant requests an extension of the treatment beyond the approved period of time or number of treatments, and the claim is an Urgent Care Claim, the Claims Administrator will notify the Participant of its decision on the claim within twenty-four (24) hours after receipt of the claim, as long as the claim is made at least twenty-four (24) hours before the expiration of the prescribed period of time or number of treatments.

(5) In the case of a disability benefits claim, the Participant will receive notice of the Claims Administrator's decision within forty-five (45) days after receipt of the claim. The Claims Administrator may extend this period for up to thirty (30) days if it determines that the extension is necessary due to circumstances beyond its control, and the Claims Administrator may further extend this period for up to an additional thirty (30) days if it determines that the decision cannot be made within the original extended period due to circumstances beyond its control. Any such extension notice provided by the Claims Administrator must be sent to the Participant within the initial decision or extension period, and must explain the standards on which entitlement to a benefit is based, the unresolved issues, any information the Participant must provide to perfect the claim, and when the Participant can expect a decision. If the Participant is required to provide additional information, the notice of extension will describe the required information and the Participant will have at least forty-five (45) days to provide the additional information. Moreover, the period for making the determination will be delayed from the date the notification of extension was sent out until the Participant responds to the request for additional information.

(c) Content of Notice for Initial Decision. If a claim for health or disability benefits results in an Adverse Benefit Determination, the Participant will receive written or electronic notification, which will include:

(1) Information sufficient to identify the claim, including the date of service, health care provider, claim amount, if applicable, and notification of the right to request the diagnosis and treatment codes as well as their meanings, and stating that such request will not be considered an appeal of the Adverse Benefit Determination;

(2) The specific reasons for the Adverse Benefit Determination, including the denial code and corresponding meaning, the Plan's standard, if any, that was used in making the decision, and specific reference to the pertinent Plan provisions on which the denial was based;

(3) A description of any additional information needed from the Participant to perfect the claim and an explanation of why such information is necessary;

(4) The specific rule, guideline, or other criterion relied upon in making the Adverse Benefit Determination, or a statement that a copy of such rule will be provided free of charge to the Participant upon request;

(5) If the claim was denied based on a medical necessity or experimental treatment or similar exclusion or limit, the Participant will be provided either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided to the Participant free of charge upon request;

(6) A description of the applicable claim review procedure (both internal and external), including a statement of the claimant's right to bring civil action under Section 502(a) of ERISA following an appeal of the adverse benefit determination and, in the case of an Urgent Care Claim, a description of the expedited review process applicable to such claims;

(7) Contact information for an applicable office of health insurance consumer assistance or ombudsman; and

(8) If applicable, a culturally and linguistically appropriate notice of the availability of language assistance.

(d) Time for Appeal of Initial Claim and Decision on Appeal.

(1) If a Participant's claim for health or disability benefits under the Plan results in an Adverse Benefit Determination, the Participant may request a review of the denial at any time within one hundred and eighty (180) days following the date the Participant received written notice of the denial of his or her claim.

(2) In the case of an appeal involving an Urgent Care Claim, determination of the appeal will be made and communicated to the Participant within seventy-two (72) hours after the Claims Administrator receives the request for review. The Participant may ask the Claims Administrator for an expedited review process, in which all necessary information will be communicated between the Participant and the Claims Administrator by telephone, facsimile, or other similar method.

(3) In the case of an appeal involving a pre-service health benefits claim, determination of the appeal will be made and communicated to the Participant within thirty (30) days after the Claims Administrator receives the request for review.

(4) In the case of an appeal involving a post-service health benefits claim, determination of the appeal will be made and communicated to the Participant within sixty (60) days after the Claims Administrator receives the request for review.

(5) In the case of an appeal involving a claim for disability benefits, determination of the appeal will generally be made and communicated to the Participant within forty-five (45) days after the Claims Administrator receives the request for review. The forty-five-(45-) -day period may be extended for up to an additional forty-five (45) days if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. Written notice of the extension will be provided to the Participant within the initial forty-five- (45-) day period and will explain the special circumstances requiring the extension of time, the date by which the Claims Administrator expects to render a decision, and any additional information the Participant must provide in order to perfect the appeal.

(e) Appeal Procedure.

(1) The Participant must submit a written request for review to the Claims Administrator to review or appeal an Adverse Benefit Determination of a health or disability claims.

(2) The Participant may examine pertinent documents (other than those that are legally privileged) relating to the Adverse Benefit Determination and submit issues and comments in writing. Upon the Participant's request, the Claims Administrator will identify any medical or vocational expert whose advice was obtained on behalf of the Claims Administrator in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

(3) The Claims Administrator will consider the appeal de novo, or without any deference to the Adverse Benefit Determination. The review will not include any person who participated in the Adverse Benefit Determination or who works under the supervision of a person who participated in the Adverse Benefit Determination.

(4) If the Adverse Benefit Determination was based in whole or in part on a medical judgment, the Claims Administrator will:

(A) Consult with a health care professional who has appropriate training and experience in the area of medicine that is involved in the medical judgment, and who was neither consulted in connection with the initial benefit determination nor works under the supervision of any person who was consulted in connection with that determination; and

(B) Upon notifying the Participant of an adverse determination on review, include in the written notice either an explanation of the clinical basis for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(f) Content of Notice of Decision on Appeal. The Claims Administrator's decision on review shall be furnished to the claimant in written or electronic form and shall include:

(1) Information sufficient to identify the claim, including the date of service, health care provider, claim amount, if applicable, and notification of the right to request the diagnosis and treatment codes as well as their meanings;

(2) The specific reasons for the decision, a discussion of the decision, including the denial code and corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim and specific references to the pertinent Plan provisions on which the decision is based;

(3) A statement that the Participant is entitled to receive, upon request and free of charge, copies of documents (other than those that are legally privileged) relevant to the Participant's claim for benefits, including a statement that such a request will not be considered a request for an External Review;

(4) The specific rule, guideline, or other criterion relied upon in making an adverse determination of the appeal, or a statement that a copy of such rule will be provided free of charge to the Participant upon request;

(5) If the Participant's claim was denied based on a medical necessity or experimental treatment or similar exclusion, the Participant will be provided a statement explaining the decision, which will be provided to the Participant free of charge upon request;

(6) Contact information for an applicable office of health insurance consumer assistance or ombudsman;

(7) A statement describing the Plan's review procedures (both internal and external) and time limits applicable to such procedures, including a statement of the Claimant's right to bring an action under section 502(a) of ERISA, in the case of an Urgent Care Claim, a description of the expedited review process applicable to such claims;

(8) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;"

(9) If applicable, a culturally and linguistically appropriate notice of the availability of language assistance; and

(10) If, in reaching the decision on appeal, the Claims Administrator considered, relied upon, or generated new or additional evidence in connection with the claim, such evidence will be provided, as well as any new or additional rationale for the denial. The Claims Administrator will also provide you with a reasonable opportunity to respond to such new evidence or rationale.

13.4 Procedures for Health Care Expense Reimbursement Claims.

(a) Claims for reimbursement of Health Care Expenses must be filed by the end of the third month following the close of the Plan Year (or such other date as specified by the Company and pursuant to the Code) in which the Health Care Expense was incurred.

(b) Health Care Expense claims under the Health Care Expense Reimbursement shall be processed as post-service claims in accordance with Section 13.3(b)(3), 13.3(c) through 13.3(f), 13.6 and 13.7. Notwithstanding the forgoing, Health Care Expense claims under the Health Care Expenses Reimbursement are not eligible for External Review or Deemed Exhaustion.

13.5 Procedures for Dependent Care Expense Reimbursement Claims.

(a) A Participant shall submit his or her Dependent Care Expense Reimbursement benefit claims to the Claims Administrator. The Participant will receive notice of the Claims Administrator's decision within ninety (90) days after it receives the Participant's claim. The Claims Administrator may extend this period for up to another ninety (90) days, if it determines that the extension is necessary due to circumstances beyond the control of the Plan. The notification will be sent to the Participant prior to the expiration of the initial ninety- (90-) day period and will state the reason for the extension and the date when the Participant can expect a decision. If the extension is due to the Participant's failure to supply the necessary information, the notice of extension will describe the required information and the date by which the Participant must provide such information. The decision of the Claims Administrator will be furnished to the Participant in written or electronic form, and if adverse, shall include:

(1) The specific reasons for the denial and specific reference to the pertinent Plan provisions on which the denial was based;

(2) A description of any additional information needed from the Participant to perfect the claim and an explanation of why such information is necessary;

(3) The specific rule, guideline, or other criterion relied upon in making an adverse determination of the appeal, or a statement that a copy of such rule will be provided free of charge to the Participant upon request; and

(4) An explanation of the Plan's claims review procedure and time limits and a statement of the Participant's rights to bring a civil action under Section 502(a) of ERISA following a denial of benefits on review.

(b) Appeal Procedure. A Participant may appeal the denial of a claim for reimbursement under the Dependent Care Expense Reimbursement benefit programs by filing a written request for review with the Claims Administrator within sixty (60) days of receipt of the initial denial of the Participant's claim. The Claims Administrator will consider the appeal de novo, or without any deference to the initial benefit denial. The review will not include any person who participated in the initial benefit denial or who works under the supervision of a person who participated in the initial benefit denial. The Claims Administrator will provide a decision on appeal within sixty (60) days of receipt of the Participant's request for review. The decision on appeal will be furnished to the Participant in written or electronic form and if adverse, shall include:

(1) The specific reasons for the decision and specific reference to the pertinent Plan provisions on which the decision is based;

(2) A statement that the Participant is entitled to receive, upon request and free of charge, copies of documents (other than those that are legally privileged) relevant to the Participant's claim for benefits;

(3) The specific rule, guideline, or other criterion relied upon in making an adverse determination of the appeal, or a statement that a copy of such rule will be provided free of charge to the Participant upon request;

(4) If the Participant's claim was denied based on a medical necessity or experimental treatment or similar exclusion, the Participant will be provided a statement explaining the decision, which will be provided to the Participant free of charge upon request; and

(5) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

13.6 Claimant Representative. For purposes of this Article, any action required or authorized to be taken by the claimant may be taken by a representative authorized in writing by the claimant to act on his or her behalf.

13.7 Finality of Decision and Legal Action.

(a) Subject to the claimant's rights, if any, for an External Review, the decision on appeal by the Claims Administrator shall be deemed final and shall be conclusive and binding on all parties.

(b) No legal action may be brought against the Plan or relating to the Plan or Benefits unless and until:

(1) The claimant has exhausted the Plan's internal claims and appeals procedures, that is, the claimant (i) has submitted a written claim in accordance with this Article; (ii) has received an Adverse Benefit Determination; (iii) has filed a written

request for review of the claim in accordance with this Article; and (iv) has been notified by the Claims Administrator that it has affirmed the an Adverse Benefit Determination; or

(2) Such internal claims and appeals procedures are deemed to have been exhausted in accordance with Section 13.10.

(c) No action in law or equity shall be brought more than one (1) year after the Claims Administrator's affirmation of a denial of the claim, as set forth in Section 13.1(b), 13.2, 13.3(e) and (f) or 13.5(b) above, as applicable.

(d) Notwithstanding Sections 13.7(a) and (c), no legal action may be brought more than four (4) years after the facts or events giving rise to the claimant's allegation(s) or claim(s) first occurred.

13.8 External Review. A claimant has the right to have a final decision regarding an Adverse Benefit Determination submitted for External Review, but only with respect to the following:

(a) Benefit claims involving medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; or

(b) Rescission of Coverage.

A request for External Review must be made within four (4) months of the date of receipt of a final decision regarding an Adverse Benefit Determination, or, if such date does not exist, by the first day of the fifth month following receipt of such a determination. The Plan must complete a preliminary review of such a request within five (5) business days after its receipt. Notice of the Plan's determination with respect to a claimant's eligibility for External Review shall be provided within one (1) business day after completion of the preliminary review.

External Reviews will be conducted by an Independent Review Organization and applying a de novo standard. Within five (5) business days of an Independent Review Organization being assigned, the Plan will provide to the Independent Review Organization any documents and information considered in the internal review process. Notice of the Independent Review Organization's decision will be furnished to both the Plan and the claimant within forty-five (45) days following receipt of a request for a review. The Plan must provide any benefits (including by making payment on the claim) pursuant to the Independent Review Organization's final external review decision without delay.

13.9 Expedited External Review. A claimant has the right to immediately request an expedited External Review, and need not have obtained a final decision regarding an Adverse Benefit Determination, under the following circumstances:

(a) An Adverse Benefit Determination or a final decision with respect to an Adverse Benefit Determination involving a medical condition that would seriously jeopardize the claimant's life or health, or would jeopardize the claimant's ability to regain maximum function if the claimant followed the standard procedures; or

(b) A final decision with respect to an Adverse Benefit Determination involving admission, availability of care, continued stay, or a health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

13.10 Deemed Exhaustion of Internal Claims or Appeals Procedures. A claimant is permitted to initiate an External Review or pursue any remedies available under section 502(a) of ERISA prior to having obtained a final decisions with respect to an Adverse Benefit Determination if the Plan violates applicable claims and appeals procedures in a manner that is not: (A) de minimis; (B) non-prejudicial; (C) attributable to good cause or matters beyond the Plan's control; (D) in the context of an ongoing good faith exchange of information; and (E) not reflective of a pattern or practice of non-compliance. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

13.11 Timing of Notification for Deemed Exhaustion. If a claimant requests a written explanation of the Plan's violation, the Plan must provide such an explanation within ten (10) days. Such explanation shall include a specific description of the Plan's bases, if any, for asserting that the violation should not cause the internal review processes to be deemed exhausted. If a claimant's request for, as applicable, External Review or legal or equitable action, is denied, the claimant shall have a right to resubmit a claim for internal review in accordance with procedures described in this Article XIII.

ARTICLE XIV

HIPAA PRIVACY COMPLIANCE

14.1 Disclosures of Summary Health Information. The HIPAA Group Health Benefit Programs may disclose Summary Health Information to the Employer if the Employer requests this information in order to obtain premium bids for health insurance coverage under the HIPAA Group Health Benefit Programs, or in order to modify, amend or terminate the HIPAA Group Health Benefit Programs.

14.2 Enrollment and Disenrollment Information. The HIPAA Group Health Benefit Programs may disclose information to the Employer concerning whether or not an Individual is participating in the HIPAA Group Health Benefit Programs, or has enrolled or disenrolled from the HIPAA Group Health Benefit Programs.

14.3 Disclosures Pursuant to an Authorization. The HIPAA Group Health Benefit Programs may disclose Protected Health Information to the Employer if the disclosure is made pursuant to a valid Authorization and the information is used as described in the Authorization. In particular, the HIPAA Group Health Benefit Programs may disclose Protected Health Information to the Employer pursuant to an Authorization to assist Participants, Employees and their beneficiaries in connection with their claims under the HIPAA Group Health Benefit Programs, or to help them understand the terms of the HIPAA Group Health Benefit Programs as they may relate to a particular condition or claim.

14.4 Disclosures for Plan Administration Purposes. i) The Employer may use and disclose Protected Health Information to carry out its Plan administration functions under the HIPAA Group Health Benefit Programs with respect to Payment or Health Care Operations. Notwithstanding the foregoing, the Employer shall not use or disclose Protected Health Information that is genetic information, as defined in 45 C.F.R. Section 160.103, for underwriting purposes, as defined in 45 C.F.R. Section 164.501, in accordance with Title I of the Genetic Information Nondiscrimination Act of 2008 and regulations issued thereunder. The Employer shall not use or further disclose Protected Health Information other than as permitted or required in this Article XIV or as required by law. Disclosures of Protected Health Information to the Employer for HIPAA Group Health Benefit Programs administration purposes may only be made if the conditions described in Sections 14.4(a) and 14.4(b) below are met.

(a) The Employer must certify to and comply with the following requirements before the HIPAA Group Health Benefit Programs may disclose Protected Health Information to the Employer for HIPAA Group Health Benefit Programs administration purposes:

(1) The use or disclosure must be described in the HIPAA Group Health Benefit Programs' Notice of Privacy Practices issued pursuant to the Privacy Rule;

(2) The Employer must certify that the Plan document, with respect to the HIPAA Group Health Benefit Programs, has been amended as required by the Privacy Rule, and that it agrees to adhere to the requirements of this Article;

(3) The Employer may not use or further disclose Protected Health Information provided to it except as permitted by the Plan document with respect to the HIPAA Group Health Benefit Programs (as amended to comply with HIPAA), or as required by law;

(4) The Employer will insure that any agents or subcontractors to whom it provides Protected Health Information received from the HIPAA Group Health Benefit Programs will agree to the same restrictions and conditions on the use and disclosure of this information that apply to Employer;

(5) The Employer will not use or disclose Protected Health Information received from the HIPAA Group Health Benefit Programs for any employment-related actions or decisions, or in connection with any other benefit or benefit plan it maintains;

(6) The Employer will report to the HIPAA Group Health Benefit Programs (i) any use or disclosure of PHI which it has received from the HIPAA Group Health Benefit Programs and which is inconsistent with allowed uses and disclosures, to the extent it becomes aware of such uses and disclosures, and (ii) any acquisition, access, use or disclosure of PHI that may constitute a breach of unsecured Protected Health Information under the HITECH Act;

(7) The Employer will make the Protected Health Information it receives from the HIPAA Group Health Benefit Programs available to Individuals as required by the Privacy Rule (pertaining to inspection and copying, amendment, and accounting), including the requirements under the HITECH Act regarding access to electronic health records and accounting for disclosures made through electronic health records;

(8) The Employer will make its internal practices, books and records relating to the use and disclosure of PHI it receives from the HIPAA Group Health Benefit Programs available to the Secretary of Health and Human Services or his or her designee, to determine the Plan's compliance with the Privacy Rules with respect to the HIPAA Group Health Benefit Programs; and

(9) The Employer will, if feasible, return or destroy all Protected Health Information received from the HIPAA Group Health Benefit Programs in any form, and retain no copies, when the information is no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Employer will limit further uses and disclosures of the Protected Health Information to those purposes which make the return or destruction infeasible.

(b) The Employer must provide for adequate separation between itself and the HIPAA Group Health Benefit Programs. The Employer shall ensure that only the employees or classes of employees that it has designated in writing have access to Protected Health Information. Access to Protected Health Information shall be restricted so that such persons

receive only the minimum Protected Health Information necessary to accomplish the administrative functions which they perform for the HIPAA Group Health Benefit Programs. If any persons or employees of the Employer do not comply with the requirements of the HIPAA Group Health Benefit Programs with respect to the use and disclosure of Protected Health Information, the Employer will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. These sanctions will be imposed in accordance with Employer's normal disciplinary policies, and can include termination of employment.

14.5 No Other Disclosures of Protected Health Information. The Plan will not disclose Protected Health Information to the Employer (and will not cause a Health Insurance Issuer to disclose Protected Health Information to the Employer) except as described in this Article.

14.6 HITECH Act. Notwithstanding anything in Article XIV to the contrary, this Article XIV shall be interpreted and administered in accordance with the HITECH Act and its implementing regulations and guidance to the extent required by applicable law.

ARTICLE XV

HIPAA SECURITY COMPLIANCE

15.1 Purpose of Article XV. The purpose of this Article is to (a) cause the HIPAA Group Health Benefit Programs to implement security measures designed to ensure the Confidentiality, Integrity, and Availability of all ePHI created, received, maintained, or transmitted to or by the HIPAA Group Health Benefit Programs, (b) cause the HIPAA Group Health Benefit Programs to require that the Employer will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Employer on behalf of the HIPAA Group Health Benefit Programs, and (c) establish the office of security officer, who will be responsible for the HIPAA Group Health Benefit Programs' Security Standards compliance. This Article is to be construed and interpreted in accordance with such purposes. In addition, certain capitalized terms used in this Section that are not defined herein will have the meaning ascribed to such terms under HIPAA.

15.2 Implementation of Security Standards. The HIPAA Group Health Benefit Programs will do all of the following in accordance with HIPAA:

(a) Ensure the confidentiality, integrity, and availability of all ePHI that it creates, receives, maintains, or transmits;

(b) Protect against any reasonably anticipated threats or hazards to the Security or Integrity of such information;

(c) Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Rules;

(d) Ensure compliance with the Security Standards by its Workforce;

(e) Implement each Security Standard and implementation specification thereunder that is designated as "Required" in HIPAA and/or Appendix A to Subpart C of Part 146 thereof, as provided in the Security Manual;

(f) Take the following steps with regard to each Security Standard and implementation specification thereunder that is designated as "Addressable" in HIPAA, as provided in the Security Manual:

(1) Assess whether each implementation specification in the Security Standard is a reasonable and appropriate safeguard in its environment, when analyzed with reference to the likely contribution to protecting the HIPAA Group Health Benefit Programs' ePHI; and

(2) As applicable to the HIPAA Group Health Benefit Programs, implement the implementation specification if reasonable and appropriate or, if implementing the implementation specification is not reasonable and appropriate:

(A) Document why it would not be reasonable and appropriate to implement the implementation specification; and

(B) Implement an equivalent alternative measure if reasonable and appropriate;

(g) Ensure that its Business Associate contracts comply with the requirements of 45 C.F.R. Section 164.314 of HIPAA and Sections 13401 and 13404 of the HITECH Act, 42 USC Sections 17931, 17934.; and

(h) Periodically review the Security Measures implemented to comply with the Security Standards and modify such measures as needed in order to continue provision of reasonable and appropriate protection of ePHI as described in the Security Manual.

15.3 Provision of Electronic Protected Health Information to the Employer. The Employer may receive and use ePHI only if the Employer agrees to comply with and enforce the following restrictions and requirements regarding the ePHI that is provided by the HIPAA Group Health Benefit Programs to the Employer:

(a) the Employer will implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the HIPAA Group Health Benefit Programs as required by HIPAA as set forth in the Security Manual;

(b) the Employer will ensure that the adequate separation required pursuant to Section 14.4(b) is supported by reasonable and appropriate Security Measures as required by HIPAA as set forth in the Security Manual;

(c) the Employer will ensure that any agent, including a subcontractor, to whom it provides ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Group Health Benefit Programs agrees to implement reasonable and appropriate Security Measures to protect such information; and

(d) the Employer agrees to report to the HIPAA Group Health Benefit Programs any successful Security Incident of which it becomes aware in accordance with HIPAA as set forth in the Security Manual. Except that Employer shall only be required to report, upon the HIPAA Group Health Benefit Programs' request, attempted, but unsuccessful Security Incidents of which Employer becomes aware. Such a report of unsuccessful Security Incidents shall consist only of a summary of such unsuccessful Security Incidents targeting Electronic Protected Health Information. For the purposes hereof, an "unsuccessful" Security Incident is an unsuccessful attempt to breach the security of Employer's systems that Employer determines was targeted at HIPAA Group Health Benefit Programs' Electronic Protected Health Information, and shall not include general "pinging" or "denial of service" attacks that are not determined by Employer to have been directed at HIPAA Group Health Benefit Programs' Electronic Protected Health Information.

15.4 Security Officer. The Employer shall appoint a security officer for the HIPAA Group Health Benefit Programs. The Employer may remove the HIPAA Group Health

Benefit Programs' then existing security officer at any time upon written notice provided that the Employer has appointed a successor security officer to serve. The HIPAA Group Health Benefit Programs' security officer's duties and responsibilities focus upon the operation and administration of the HIPAA Group Health Benefit Programs in connection with the Security Standards, and HIPAA (including activities conducted via the services of insurers, Business Associates, and employees and agents of the Employer) and activities of the Employer regarding the HIPAA Group Health Benefit Programs. The security officer shall work cooperatively with the Employer's Information Technology Department, other applicable Employer offices/personnel and Business Associates in overseeing the HIPAA Group Health Benefit Programs' compliance with the Security Standards.

15.5 Implementation Authority. The Employer shall have the authority to enter into and enforce on behalf of the HIPAA Group Health Benefit Programs such contracts and agreements (including, specifically, Business Associate agreements), as may be appropriate or necessary to cause the HIPAA Group Health Benefit Programs to satisfy its obligations under HIPAA.

15.6 HITECH Act. Notwithstanding anything in Article XV to the contrary, this Article XV shall be interpreted and administered in accordance with the HITECH Act and its implementing regulations and guidance to the extent required by applicable law.

ARTICLE XVI

NO FUNDING AND COORDINATION OF BENEFITS

16.1 No Funding. The premium costs for the Premium Benefits offered under the Plan are paid in part by Participant Contributions and in part by Employer contributions. The Employer, in its sole discretion, shall determine the amount of contributions and premiums to be paid by the Participant and the amount of contributions and premiums to be paid by the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator (or anyone else) to maintain any fund or to segregate any amount for the benefit of any Participant (or anyone else), and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under the Plan for premiums or Benefits may be made. The Employer shall not pay interest on any Participant Contributions.

16.2 No Obligation to Insure or Fund Benefits. The Employer shall have no obligation, except as mandated by law, but shall have the right, to insure any Benefits under this Plan or to establish any fund or trust for the payment of Benefits under this Plan.

16.3 Insured Benefits. In the case of any Benefit which is insured with an insurance company, any Benefits accruing shall be paid solely by such insurance company, and the Employer shall have no responsibility for the payment of such Benefits.

16.4 Non-Insured Benefits. Payments of all non-insured Benefits under this Plan shall be made solely out of the general assets of the Employer, unless specifically provided otherwise.

16.5 Coordination of Benefit Rules. If Benefits payable under the Plan are also payable under another health care arrangement, the Coordination of Benefits provisions of the two arrangements determine which of the plans pay Benefits. The Coordination of Benefits provisions applicable to any specific Benefit apply; but, if there are none, the provisions of this Section apply.

(a) The Plan will not pay any amount which, when added to the benefits payable by the other plan or plans, will equal more than 100% of allowable expenses. If the other plan does not have a Coordination of Benefits provision, then the other plan will pay its benefits first. If both Plans have Coordination of Benefits provisions the following rules apply:

(1) Employees. The plan that covers the person as an employee will pay its benefits first.

(2) Dependent Children of Parents not Separated or Divorced. The plan covering the parent whose birthday falls earlier in the year will first pay benefits for Dependent children of parents not separated or divorced. If both parents have the same birthday, the plan covering a parent for the longer period of time pays first. The other plan will determine the order if it does not include this rule.

(3) Dependent Children of Parents that are Separated or Divorced. When a claim is made for a Dependent child of divorced or separated parents, the plan covering the parent with custody of the child who has not remarried pays first. The plan covering the parent with custody of the child who has remarried pays second. The plan covering the Spouse of the parent with custody pays third. The plan covering the parent without custody pays fourth. However, if a qualified medical child support order ("QMCSO") or court decree assigns financial responsibility for medical care as defined in Code Section 213(d) (other than expenses excluded in the applicable Treasury regulations) or long-term care insurance of the child regardless of which parent has custody, that parent's plan always pays first.

(4) Active and Retired Employees. A plan covering an active employee and the active employee's Eligible Dependents pays first, before a plan covering a laid off or retired employee and that employee's Eligible Dependents, unless the other plan does not include this rule.

(5) Default. If none of the above rules establish an order of benefit determination, then the plan that has covered the insured for the longer period of time will pay first.

(6) Medicare. If required by law, Medicare benefits are secondary payments for any Medicare eligible individuals covered by this Plan who are disabled or over the age of sixty-five (65).

(b) Payment of Benefits. The plan that pays first will pay its benefits without regard to any other coverage. The next plan will then pay its regular benefits up to the amount of the remaining allowable expenses.

(c) Payments to Other Payors. If another plan pays benefits that this Plan should have paid, this Plan may reimburse the other organization or plan for the payments or the reasonable cash value of the services provided. The amount reimbursed is treated as a Benefit provided under this Plan. This Plan will not have to pay that amount again.

(d) Recovery of Overpayments. If any Benefits provided by the Plan exceed the Benefits that should have been provided, the Plan may recover the excess from the recipient or the other plan providing benefits.

16.6 Subrogation of Claims and Reimbursement Provisions. The Subrogation of Claims provisions applicable to any specific Benefit apply; but, if there are none or if any such other provision is rendered invalid or unenforceable, then the subrogation provisions in this Section apply.

If Benefits are paid or payable to a Participant or his or her Covered Dependent, Spouse or Domestic Partner (a "Covered Individual") from a self-insured or partially self-insured component Benefit, and there is a third party, plan, insurer or guarantor, or any other alternate source that is or may be legally responsible (whether in tort, contract or otherwise) to pay the Covered Individual on account of the illness, disease, injury, other mental or physical malady, or condition that resulted in the payment of Benefits (a "Responsible Person"), then, as a condition

of the Covered Individual's participating in the Plan and accepting Benefits thereunder, each Covered Individual agrees to the following, both for the Covered Individual and for any person claiming through the Covered Individual or on account of the Covered Individual's rights under the Plan:

(a) The Plan shall automatically have a first priority lien upon the proceeds of any recovery that the Covered Individual may receive, may be entitled to receive, or may have paid on his or her account, from a Responsible Person, directly or indirectly, whether by litigation, settlement, or otherwise (a "Recovery"). The lien shall be in the amount of Benefits provided through or paid by the Plan for the treatment of any illness, disease, injury, other mental or physical malady, or condition with respect to which the Responsible Person may be liable to the Covered Individual. The Covered Individual consents to this lien and agrees to cooperate with the Plan or its agents or assignees to enforce any rights that the Plan may have with respect to any Recovery. The Covered Individual's failure to acknowledge the Plan's lien shall be grounds for termination of the Covered Individual's future participation in a benefit option or the entire Plan, as well as discontinuance of payment of some or all of the Covered Individual's future benefits under a benefit option or the Plan.

(b) The Plan shall have an automatic specific and first priority right of reimbursement, up to the amount of the Plan's lien, out of the proceeds of any Recovery that a Covered Individual may receive, or may be entitled to receive. The Covered Individual agrees to reimburse the Plan, in full and as a first priority, for Benefits provided or to be provided by the component Benefit, immediately upon collecting any Recovery from a Responsible Person or receiving the benefit of such Recovery. If the Covered Individual is a minor, then any amount recovered by the minor or the minor's representative shall also be subject to the subrogation and reimbursement provisions in this Section, regardless of state law and regardless of whether the minor's representative has access or control of any covered funds. The Covered Individual agrees to segregate any Recovery (up to the amount of the Plan's lien) in a separate account, and shall preserve such Recovery so that the Plan can enforce its lien and so that any disputes as to entitlement can be resolved. Any Recovery or Overpayment (as defined below) must be segregated as described in this Section until the Plan has confirmed in writing that no dispute exists. If the Covered Individual dissipates or transfers the recovery or Overpayment when the Plan has a lien upon or claim to such funds, that will constitute inequitable conduct and a breach of the Plan by the Covered Individual. The Covered Individual agrees that the Plan may, without limitation, trace the transferred or dissipated recovery or Overpayment and recover the disputed amount from the Covered Individual's other assets or assets paid over to a third person (including, without limitation, the Covered Individual's counsel or other representative), all of which for this purpose shall be subject to an equitable lien by agreement in the amount of the Plan's claim.

(c) The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

(d) A Covered Individual shall not, without the Plan's prior written consent, assign any right, claim or cause of action against a Responsible Person to recover for any illness,

disease, injury, other mental or physical malady, or condition on account of which Benefits were paid by the Plan.

(e) If a claim is asserted against any Responsible Person by or on behalf of a Covered Individual, the Covered Individual must advise the Plan in writing of that fact within thirty (30) days of the date when the Covered Individual (or his or her authorized representative) first acts to assert a claim against the Responsible Person (for example, by sending notice of the claim or by submitting or filing a claim). The Plan shall be entitled to intervene and participate in such action, and the Plan's lien shall apply to any judgment recovered.

(f) If a Covered Individual (or the estate of a Covered Individual) fails, refuses or is unable to institute legal action against a Responsible Person, then the Plan shall have the right, in its sole discretion and at its option and at any time, to become subrogated to, and thereby assume and prosecute, the Covered Individual's claim (or the claim of the Covered Individual's estate) against any Responsible Person in order to secure the Plan's right of recovery of its payments and expenses regarding services provided under a component Benefit. The Plan shall be entitled to prosecute such a claim in the name of the Covered Individual (or the Covered Individual's estate), with or without specific consent. The Plan may commence a subrogation action by sending a written notice to the Covered Individual and/or the Covered Individual's counsel or other representative. The Plan shall be entitled to retain from any judgment or settlement with a Responsible Person the amount of Benefits paid or to be paid to the Covered Individual (or the Covered Individual's estate), together with all court costs and attorneys' fees.

(g) The Covered Individual shall furnish such information and assistance, execute and deliver such instruments and papers, and take such other actions as the Plan or its agents or assignees may require to secure the rights of the Plan under this Section and/or facilitate the enforcement of the Plan's rights or interests. The instruments and papers that the Covered Person shall execute may include a separate subrogation agreement that does not conflict with the provisions of this Section, if the Plan's fiduciaries or its counsel deem such an agreement to be necessary or appropriate. The Covered Individual shall not, without the prior written consent of the Plan or its agents or assignees (as may be applicable), take any action that may prejudice the Plan's rights or interests respecting subrogation or reimbursement, including without limitation disbursing, transferring, or dissipating all or any part of a Recovery in which the Plan may have an interest; assigning all or part of any claim against a responsible person in which the Plan may have an interest; or settling, releasing or compromising any claim against a Responsible Person in which the Plan may have an interest. Failing to advise the Plan of the assertion of a claim against a Responsible Person, failing to cooperate with the Plan or its agents or assignees, disbursing, transferring or dissipating any Recovery to which the Plan has a claim or upon which the Plan has a lien, or taking any action that prejudices the Plan's rights or interests relating to subrogation or reimbursement, would be a material breach of the Covered Individual's responsibilities under the Plan, shall entitle the Plan to the imposition of a constructive trust, and may result in the Covered Individual's being equitably responsible for reimbursing the Plan.

(h) Each Covered Individual shall fully cooperate with and abide by the terms of the component Benefit and this Plan, including the provisions of this Section. The Plan shall

have the right to withhold and/or set off payment of claims and/or Benefits pending the resolution of disputes relating to subrogation or reimbursement.

(i) The Plan's lien and its rights of subrogation and reimbursement shall have first priority and shall not, without the Plan's prior written consent, be reduced for any reason. The Plan's lien and its rights of subrogation and reimbursement shall not be subject to the make-whole doctrine; principles of comparative or contributory fault; the common fund doctrine; the defense that another party is liable only in part; the defense that the Recovery is less than the actual loss suffered by the Covered Individual; the defense that the other party's resources or insurance may be limited; or to the argument that the Plan should share in a pro rata allocation of a Covered Individual's fees and costs (including attorneys' fees) incurred in pursuit of a claim; or any similar theory whether based on federal common law, state law or some other source. To the extent that such a theory would otherwise have provided equitable defenses against the Plan's lien, each Covered Person disclaims all such defenses and recognizes that the Plan is permitting the Covered Person to receive benefits in reliance upon that disclaimer. The Plan shall not be responsible for paying any part of a Covered Individual's legal fees or costs in connection with obtaining a Recovery from a Responsible Person. The Plan is entitled to recover from the Covered Individual the value of services provided and paid for by, through, or on behalf of, the Plan when the Covered Individual is reimbursed or paid for the cost of care by a Responsible Person. The Plan shall not be required to apportion recoveries and shall remain entitled to one hundred percent (100%) reimbursement, from any Recovery, for all Benefits provided to the Covered Individual, regardless of whether the Covered Individual obtains a full or partial recovery (*i.e.*, is "made whole"), regardless of whether the Recovery is a settlement, judgment or award, and regardless of the attorneys' fees and costs incurred by the Covered Individual in seeking the Recovery from the Responsible Person. Any Recovery received by or on behalf of a Covered Individual may first be used to reimburse the expenses paid by the Plan (including attorneys' fees and court costs, in the event the Plan brings suit in the name of the Covered Individual).

(j) A Covered Individual might receive payments through the Plan that exceed the payments to which the Covered Individual is legally entitled under the Plan. Such payments, to the extent they exceed the amount to which the Covered Individual is legally entitled under the Plan, are hereinafter referred to as "Overpayments". In the event that a Covered Individual receives an Overpayment, (i) the Overpayment shall belong to the Plan; (ii) the Covered Individual shall not have any right to retain the Overpayment; (iii) the Covered Individual shall segregate and shall not disburse or dissipate the Overpayment, so that the Overpayment can be returned to the Plan and any dispute over entitlement to the Overpayment can be resolved; (iv) the Covered Individual shall be required to return the Overpayment to the Plan; (v) the Covered Individual shall cooperate fully with efforts to recover the Overpayment; (vi) the Plan shall automatically have a lien, in the amount of the Overpayment, upon any monies paid to the Covered Individual by the Plan; and (vii) the Plan shall be entitled, at its option and in its sole and absolute discretion, to recoupment by withholding and retaining any Benefits or other monies payable to the Covered Individual, up to the amount of the Overpayment.

(k) To the extent that any portion of this Section is inconsistent with applicable law in whole or in part, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of this Section shall

remain in full force and effect. Thus, for example, if an applicable law were to limit the amount of the lien provided for in subparagraph (a) above, then the lien shall be enforceable in the greatest amount allowable consistent with such law.

(l) The Covered Individual acknowledges and agrees that this Section is intended to restore and preserve the *status quo ante* and to avoid duplicative or undeserved recovery by the Covered Individual. The Covered Individual acknowledges his responsibility to give full force and effect to the Plan's subrogation and reimbursement rights under this Section.

(m) For purposes of this Section, any action, right, or entitlement of the Plan may be taken, asserted, or enforced by the Plan's fiduciary. Any ambiguity in this Section, and any dispute arising out of or in connection with this Section, shall be resolved by the Plan fiduciaries pursuant to the Plan's dispute resolution procedures, and the interpretation and application of this Section shall be committed to the Plan fiduciaries' discretion.

ARTICLE XVII

AMENDMENT AND TERMINATION

17.1 Amendment. The Company shall have the full power and authority to amend all or any part of this Plan for any reason, including but not limited to any Benefit provided under the Plan, prospectively or retroactively, to the extent permitted by law. The Company may delegate such power, in whole or in part, to one or more officers or managerial personnel of the Company, or to the Plan Administrator with regard to fiduciary-related issues.

17.2 Termination. Regardless of any other provision of this Plan, the Company reserves the right to terminate this Plan at any time for any reason without prior notice. Upon termination of the Plan, each Participant shall have a period of at least ninety (90) days following such termination to submit claims for reimbursement of Health Care Expenses and/or Dependent Care Expenses incurred prior to the effective date of such termination. Upon the expiration of such ninety (90)-day period, all amounts remaining in Participant's Health Care Reimbursement Program Account and/or Dependent Care Reimbursement Program Account against which no claims have been submitted or with respect to which all claims and appeals have been fully and finally denied pursuant to the procedure set forth in Article XIII shall remain the property of the Company for such use as the Plan Administrator, in its sole discretion, may prescribe.

ARTICLE XVIII

MISCELLANEOUS

18.1 Notice of Address. Each person entitled to benefits under the Plan must submit to the Plan Administrator, in writing, his or her mailing address and each change of mailing address. Any communication, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of the Plan, and there shall be no obligation on the part of the Employer, the Plan Administrator, or any trustee, insurer, or third party provider to search for or to ascertain the location of such person.

18.2 No Enlargement of Employee Rights. Neither the establishment of the Plan, nor any modification thereof, nor anything contained in the Plan shall be deemed to give an Employee or any other person any legal or equitable right to be retained in the service of the Employer or to interfere with the right of the Employer to terminate the employment of any Employee at any time for any reason.

18.3 No Assignment. A Participant's rights, interests or Benefits 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, prior to being received by the persons entitled thereto under the terms of the Benefit or this Plan, and any such attempt shall be void, except as mandated by law.

18.4 Choice of Law. This Plan shall be construed, administered and governed under applicable federal law, and, to the extent not preempted by federal law, the laws of the State of California (notwithstanding California choice of law principles).

18.5 Facility of Payment. If the Plan Administrator receives evidence satisfactory to it that a person entitled to receive any payment under the Plan is physically or mentally incompetent to receive such payment and to give a valid release thereof, and that another person or an institution is then maintaining or has custody of such person, and no guardian, administrator or other representative of the estate of such person has been duly appointed by a court of competent jurisdiction, the Plan Administrator may direct that such payments be made to such other person or institution, and the release of such other person or institution shall be a valid and complete discharge for payment.

18.6 Reliance. The Plan Administrator may rely upon the direction, information and/or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, reports, and the like that are furnished to it or its authorized representative by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

18.7 Headings. The headings of the Plan are inserted for convenience of reference only and shall have no effect upon the meaning of the provision thereof.

18.8 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

18.9 Gender, Singular and Plural References. References in this Plan to one gender shall include both genders, singular references shall include the plural, and plural references shall include the singular, unless the context clearly requires otherwise.

18.10 Indemnity. The Employer may, consistent with its bylaws and applicable law, indemnify some of or all of the members of the Board of Directors, some or all the Employer's officers and any fiduciary of the Plan from any liability or loss, including the costs of defense in legal proceedings, with respect to any act or omission relating to this Plan and including, but not limited to, any liability under ERISA. The Employer may purchase insurance for its fiduciaries or for itself to cover potential liability or losses occurring by reason of the act or omission of a fiduciary or the Plan Administrator. Nothing in this Plan shall be construed as requiring the purchase of any insurance.

[Signature Page Follows]

IN WITNESS WHEREOF, this Plan is hereby restated in its entirety, effective as of July 1, 2012, and executed on this _____ day of June, 2013.

bebe stores, inc.

By: _____
Charles M. Smith

Its: Vice President, Human Resources

APPENDIX A

bebe stores, inc. SECTION 125 PLAN AND WELFARE BENEFITS PLAN

As of July 1, 2012

Program/ Provider	Contract Number/ Document	Type of Benefit	Claims Administrator	Geographic Limitations
Blue Shield of CA	3607117	Medical and Pharmacy Benefits	Blue Shield of California Claims P.O. Box 272540 Chico, CA 95927-25240 1-888-235-1760 www.blueshieldca.com	N/A
Triple-S Salud Blue Cross Blue Shield of Puerto Rico		Medical Benefits	Triple-S Salud P.O. Box 363628 San Juan, Puerto Rico 00936-3628 1-787-277-6622 www.ssspr.com	Limited to Puerto Rico only
CVS/Caremark	WN122170	Pharmacy Benefits (for EPO (90/0))	CVS Caremark Claims Department P.O. Box 52116 Phoenix, AZ 85072-2116 www.caremark.com 1-800-966-5772	N/A
WellNet/Caremark	WN12	Pharmacy Benefits		N/A
Metropolitan Life Insurance Company	113363	PPO Dental Benefits	MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 1-800-942-0854 www.metlife.com/mybenefits	N/A

Program/ Provider	Contract Number/ Document	Type of Benefit	Claims Administrator	Geographic Limitations
Liberty Mutual Insurance Company	SA3-860-065509-018	Life, AD&D, Supplemental Life, STD, LTD	Liberty Mutual Disability and Life Claims 175 Berkeley Street Boston, MA 02117 Disability: 1-800-713-7384 Life: 1-800-210-0268 ext. 38559 www.mylibertyclaim.com (Claimant Svcs. ID: bebestores)	N/A
MHN Employee Assistance Program	001881-006	Employee Assistance Program	Liberty Mutual 1-877-695-2789 MHN EAP 1-800-693-2488 members.mhn.com (Password: smleap)	N/A
Vision Service Plan	368105	Vision Benefits	Vision Service Plan, Inc. 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195 www.vsp.com	N/A
Hawaii Medical Service Association, Blue Cross Blue Shield of Hawaii	72390 1-5	Medical, Dental and Vision Benefits, AD&D and Life	HMSA Attn: Appeals Coordinator P.O. Box 1958 Honolulu, HI 96805-1958 1-808-948-5090	Limited to Hawaii only
HealthEquity		Health and Dependent Care Reimbursement Programs	HealthEquity 1-877-857-6810 www.healthequity.com	N/A

Program/ Provider	Contract Number/ Document	Type of Benefit	Claims Administrator	Geographic Limitations
HealthEquity	N/A	Health Incentive Arrangement	HealthEquity 1-877-857-6810 www.healthequity.com	N/A
HealthEquity	N/A	Health Care Expense Arrangement	HealthEquity 1-877-857-6810 www.healthequity.com	Limited to residents of San Francisco
Quit For Life Program	N/A	Wellness/ Tobacco Cessation	American Cancer Society and Alere Wellbeing 1-866-QUIT-4-LIFE (1-866-784-8454)	N/A

IN WITNESS WHEREOF, this Plan is hereby restated in its entirety, effective as of July 1, 2012, and executed on this 28 day of June, 2013.

bebe stores, inc.

By: _____
Charles M. Smith

Its: Vice President, Human Resources