INTUIT INC.

FLEXIBLE BENEFIT PLAN

Amended and Restated:
August 1, 2017

TABLE OF CONTENTS

ESTABLISHMENT AND PURPOSE

Intuit Inc. ("Intuit" or the "Company") has established the Intuit Inc. Flexible Benefits Plan (the "Plan") to provide Eligible Employees the choice between cash compensation or benefits under the Plan pursuant to Section 125 of the Internal Revenue Code of 1986, as amended. Intuit intends that the Plan qualify as a cafeteria plan within the meaning of Section 125 of the Code, including a premium payment account, a health care reimbursement component, a dependent care assistance component, and to permit employer contributions and employee contributions to the individual health savings accounts of HSA Eligible Individuals. The Health Care Flexible Spending Account is a component of the Intuit Inc. Consolidated Welfare Plan but is also described herein to meet the requirements of Code Section 125. The Health Care Flexible Spending Account is intended to qualify as a health care reimbursement plan under Section 105 of the Code and the Health Care Expenses reimbursed thereunder are intended to be eligible for exclusion from Participants' gross income under Code Section 105(b) and shall be interpreted in a manner consistent with the requirements thereof. The Dependent Care Flexible Spending Account is intended to qualify as a dependent care assistance plan under Section 129 of the Code, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from Participants' gross income under Code Section 129(a) and shall be interpreted in a manner consistent with the requirements thereof. The Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Premium Payment Account, and Health Savings Account funding feature are separate programs for purposes of all reporting and nondiscrimination requirements imposed by Code Sections 105, 125 and 129. Only the Health Care Flexible Spending Account is subject to ERISA, HIPAA and COBRA. The Dependent Care Flexible Spending Account, Premium Payment Account and the Health Savings Account funding feature described herein are not subject to ERISA or intended to establish an ERISA plan. The Plan provisions shall apply uniformly to all Eligible Employees. The Plan was originally effective March 1, 1991 and is hereby amended and restated in its entirety, effective August 1, 2017.

ARTICLE I - DEFINITIONS

1. Benefit shall mean the amount of Salary Reduction Contributions allocated to the Participant's Dependent Care Flexible Spending Account, Health Care Flexible Spending Account, Premium Payment Account, and/or Health Savings Account and available to the Participant for Health Care Expenses, Dependent Care Expenses and/or Premiums, as applicable.

2. COBRA shall mean the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 that require continuation of group health coverage as set forth in Code Section 4980B.

3. COBRA Administrator shall mean the entity engaged by the Plan Sponsor, from time to time to administer COBRA.

4. Code shall mean the Internal Revenue Code of 1986, as amended from time to time.

5. Company shall mean Intuit Inc. or any successor entity by merger, consolidation, purchase or otherwise.

6. Compensation shall mean the cash wages or salary paid to an Eligible Employee by the Employer through its United States payroll.

7. Contract Administrator shall mean the organization appointed by the Plan Administrator to perform the day-to-day administration of the Plan.

8. Dependent shall mean:

(a) for purposes of the Health Care Flexible Spending Account (i) any individual who qualifies as a dependent under Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof, (ii) a son, daughter, stepson, stepdaughter, adopted child (including a child placed for adoption) or foster child of an Eligible Employee through the end of the month in which they turn age twenty-six (26), and (iii) any child to whom Code Section 152(e) applies (regarding a child of divorced parents) is treated as a dependent of both parents;

(b) for purposes of underlying health coverage (i) a son, daughter, stepson, stepdaughter, adopted child (including a child placed for adoption) or foster child of an Eligible Employee through the end of the month in which they turn age twenty-six (26), (ii) a son, daughter, stepson, stepdaughter, adopted child (including a child placed for adoption) or foster child of an Eligible Employee who, regardless of age, is permanently and totally disabled (as defined in Code Section 22(e)(3)) at any time during the year, (iii) a grandchild that qualifies as a dependent of an Eligible Employee under Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof, (iv) a Domestic Partner and/or child of a Domestic Partner who qualify as a dependent under Code Section 152; and (v) any child to whom Code Section 152(e) applies (regarding a child of divorced parents) is treated as a dependent of both parents; and

(c) for purposes of the Dependent Care Flexible Spending Account, a dependent means a "Qualifying Dependent" as defined in Section 7.2(c).

9. Dependent Care Flexible Spending Account shall mean the bookkeeping account established for a Participant pursuant to the provisions of Article VII to which part of his or her Salary Reduction Contributions may be allocated and from which allowable Dependent Care Expenses may be reimbursed.

10. Effective Date of this amended and restated Plan is August 1, 2017.

11. Election Period shall mean (i) the period immediately preceding the beginning of each Plan Year established by the Plan Administrator for the election of Benefits and Salary Reduction Contributions, such period to be applied on a uniform and nondiscriminatory basis for all Eligible Employees and Participants; or (ii) with respect to newly Eligible Employees, the Election Period shall be the period established by the Plan Administrator not to exceed the first thirty-one (31) days following becoming an Eligible Employee.

12. Eligible Employee shall mean any Employee of the Employer who the Employer classifies or treats as a U.S. domestic regular employee scheduled to work twenty (20) or more hours per week and who is on the U.S. payroll. An Eligible Employee under this Plan does not include any individuals who the Employer classifies or treats as: (i) leased employees (whether or not within the meaning of Code Section 414(n)), staffing, payroll or temporary agency employees, independent contractors, or consultants, even if such persons are later determined by a court, regulatory body or administrative agency to be or have been common law employees of the Employer; (ii) an employee subject to collective bargaining, except as otherwise provided in applicable collective bargaining agreements; (iii) nonresident aliens with no U.S. source of income; (iv) an individual who is not on the U.S. payroll of the Employer; (v) individuals who are a party to an agreement that provides that he or she shall not be eligible to participate in the Plan, whether or not such agreement is upheld upon governmental or judicial review; (vi) Employees classified by the Employer as part-time, seasonal, flextime employees, and intern/co-op, unless they are specifically designated as benefit eligible. For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. Notwithstanding the foregoing exclusions, Employees who meet eligibility requirements during a measurement period, as described in Affordable Care Act (ACA) regulations, will be deemed, solely with respect to underlying medical benefits, to have met the eligibility requirements for corresponding stability period as determined by the Plan Sponsor.

13. Employee shall mean an individual that is classified as an employee by the Employer and on the Employer's United States payroll, and shall exclude any individual during any period he or she is not classified as an employee by the Employer, regardless of whether such individual is subsequently determined to be (or have been) a common law employee of the Employer, by a court, regulatory body or administrative agency during such period.

14. Employer shall mean the Company and any other corporation or other entity affiliated with the Company within the meaning of the controlled group rules of Code Sections 414(b) or (c) that has adopted this Plan with the approval of the Plan Administrator or any successor to all or a major portion of the assets or business of the Company, that by appropriate action, adopts the Plan.

15. ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

16. FMLA shall mean the Family and Medical Leave Act of 1993, as amended from time to time.

17. Health Care Expense shall mean:

(a) with respect to the General Purpose Health Care Flexible Spending Account any expense by a Participant, his or her spouse or dependent for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213 and the effective rulings and Treasury Regulations thereunder, and not otherwise used by the Participant as a deduction in determining his or her tax liability under the Code.

(b) with respect to the Limited Purpose Health Care Flexible Spending Account any expense incurred by a Participant, his or her spouse or dependent for medical care within the meaning of Section 213(d) that is for dental care or vision care within the meaning of Code Section 223(c).

(c) Health Care Expenses eligible for reimbursement shall include expenses for medicines or drugs only if the medicine or drug is prescribed (even if the medicine or drug is available over-the-counter without a prescription) or is insulin. A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his or her Spouse or Dependent nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through an underlying health plan, other insurance, or any other accident or health plan.

18. Health Care Flexible Spending Account shall mean either the General Purpose Health Care Flexible Spending Account (not available to Participants who establish a Health Savings Account) or the Limited Purpose Health Care Flexible Spending Account, each of which is a bookkeeping account established for a Participant pursuant to the provisions of Article VI to which part of his or her Salary Reduction Contributions may be allocated and from which allowable Health Care Expenses may be reimbursed.

19. Health Savings Account or HSA shall mean a trust or custodial account within the meaning of Code Section 223(d) established and maintained by an HSA Eligible Individual.

20. HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

21. HSA Eligible Individual shall mean an individual who is eligible to contribute to an HSA under Code Section 223 and who has elected Qualified High Deductible Health Plan coverage and who is not covered under any health plan (other than coverage that is disregarded) which is not a high deductible health plan pursuant to Code Section 223.

22. Incurred shall mean an expense is incurred when the Participant is provided with the medical care that gives rise to the Health Care Expenses, or provided with the services that give rise to the Dependent Care Expenses, and not when the Participant is formally billed or charged for, or pays for the Health Care or Dependent Care Expenses.

23. Participant shall mean any Eligible Employee who becomes a Participant pursuant to Article II and has not for any reason become ineligible to participate further in the Plan.

24. Plan shall mean the Intuit Inc. Flexible Benefit Plan, as set forth herein and as it may be amended from time to time.

25. Plan Administrator shall mean the Committee designated by the Company in accordance with Article X of the Plan.

26. Plan Sponsor shall mean the Company or any successor to all or a major portion of the assets or business of the Company that by appropriate action adopts the Plan.

27. Plan Year shall mean the twelve (12) month period commencing on August 1 and ending on July 31.

28. Premiums shall mean the Participant's cost for the Premium Payment Account Benefits described in Section 4.2.

29. Premium Payment Account shall mean the bookkeeping account established for a Participant pursuant to this Plan to which Salary Reduction Contributions may be allocated and from which the Participant's share of underlying accident or health benefits (whether insured or self-insured) may be paid.

30. Qualified High Deductible Health Plan shall mean a health plan within the meaning of Code Section 223(c)(2) that is sponsored by the Employer.

31. Salary Reduction Contributions shall mean the amount of Compensation which the Participant elects to forego pursuant to a Salary Reduction Agreement and which the Employer contributes to the Plan for the purchase of Benefits for the Participant pursuant to Section 5.1.

32. Salary Reduction Agreement shall mean the actual or deemed agreement (which may be in paper, electronic or interactive voice response form) between the Participant and the Employer pursuant to Section 5.1.

33. Spouse shall mean an individual (regardless of gender) to whom the Eligible Employee is legally married pursuant to the applicable law of the jurisdiction in which the marriage ceremony occurred or a legally married common law spouse.

34. USERRA shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

ARTICLE II - ELIGIBILITY AND PARTICIPATION

2.1 Eligibility

An individual who is an Eligible Employee or Participant on the Effective Date of the Plan shall continue to participate in the Plan. An individual who becomes an Eligible Employee after the Effective Date of the Plan is eligible to participate on the date on which he or she first becomes an Eligible Employee.

2.2 Commencement of Participation

An Eligible Employee shall automatically become a Participant in the Premium Payment portion of the Plan upon enrollment (including automatic enrollment) in an underlying accident or health plan and shall become a Participant in the Health Care and/or Dependent Care Flexible Spending Account portions of the Plan upon the timely completion of a Salary Reduction Agreement during the applicable Election Period. To participate in the Health Savings Account portion of the Plan the individual must be an HSA Eligible Individual and establish a Health Savings Account with an HSA provider approved by the Plan Administrator. With respect to a newly Eligible Employee who enrolls during his or her applicable Election Period, the election is

effective as of his or her hire date or eligibility date but Salary Reduction Contributions shall only be deducted from Compensation earned after enrollment.

2.3 Domestic Partner Coverage

(a) An Eligible Employee may elect to cover his or her domestic partner (as defined by the Employer's policy and herein after referred to as Domestic Partner) and/or the children of his or her Domestic Partner under any underlying accident or health plan that provides for such coverage and contribute towards Premiums for such coverage under the Premium Payment Account. However, pursuant to applicable Federal law, payment of the Premiums for such coverage may not be made on a pre-tax basis (unless such Domestic Partner and/or children of same, qualify as Dependents of the Eligible Employee) and the value of coverage is imputed income for Federal income tax purposes to the extent not paid for by after-tax contributions.

(b) Pursuant to Federal law, coverage for Domestic Partners (or their children) is not available under the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account unless the Domestic Partner (and/or their children) qualify as Dependents of the Eligible Employee.

2.4 Cessation of Participation

(a) Cessation of Participation. Participation in the Plan will automatically cease upon the earliest of the following:

(i) the date the Participant terminates employment with the Employer (subject to COBRA continuation coverage as specified in the applicable documents governing underlying health benefits, or with respect to the Health Care Flexible Spending Account as provided for in Section 6.7);

(ii) the date the Participant ceases to be an Eligible Employee;

(iii) if the Participant fails the remit Premiums or Salary Reduction Contributions for the Benefits selected, the end of the last pay period for which required Premiums or Contributions have been paid, except for certain leaves of absences described in Section 2.5;

(iv) on July 31st with respect to the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account unless the Eligible Employee affirmatively enrolls during the applicable Election Period; or

(v) the date of the termination of the Plan or component hereof, (participating shall cease with respect to the component that is terminated).

Cessation of participation will automatically revoke the Participant's elections. Reimbursements from the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account after cessation of participation shall be made pursuant to Article VI and VII, as applicable. Distributions from a Participants' Health Savings Account (whether before or

after cessation of participation) and all other matters relating to the Participant's HSA are outside of this Plan and are governed by the Participant and the HSA custodian in accordance with the agreement between such parties.

(b) Regaining Eligibility. If a former Participant whose participation in the Plan ceased once again becomes an Eligible Employee he or she shall become a Participant in accordance with Sections 2.1 and 2.2 as if he or she were a newly Eligible Employee, provided that if he or she again becomes an Eligible Employee within thirty (30) days of termination or loss of eligibility and in the same Plan Year, he or she may participate by continuing the original elections for the remainder of the Plan Year on a pro rata basis. If the time elapsed between loss of eligibility and termination and being rehired or regaining eligibility is greater than thirty (30) days, the Eligible Employee may elect any coverage offered under the Plan and therefore is not bound by the original elections.

2.5 Coverage During a Leave of Absence

(a) **Generally**. If a Participant goes on an approved leave of absence (e.g. parental or family support) where he or she is receiving his or her regular Compensation directly from the Employer, his or her Salary Reduction Contributions shall continue in the normal course as provided for under the Employer's leave of absence policy (as it may be updated from time to time). If a Participant goes on a leave of absence where he or she is not receiving Compensation directly from the Employer, the Employer will continue the Participant's underlying health plan coverage with respect to FMLA leaves for the time period required under the FMLA or with respect to leaves other than FMLA leaves for such period (if any) as provided in the Employer's leave of absence policy (as it may be updated from time to time), subject to the following payment provisions. The Participant will pay his or her Contributions on an after-tax basis during his or her leave in accordance with the schedule established by the Plan Administrator. With respect to the Health Care Flexible Spending Account, a Participant entitled to continue coverage (e.g. due to an FMLA leave) pursuant to the Employer's leave of absence policy (as it may be updated from time to time) may elect (prior to going on leave) to continue his or her Salary Reduction Contributions provided he or she makes his Contributions on an after-tax basis during his or her leave in accordance with the schedule established by the Plan Administrator. If the Participant fails to pay his or her Contribution or fails to return to employment, the Employer is entitled to recover any Contributions which the Employer has paid on his or her behalf while he or she was on a leave of absence.

While on leave, the Participant shall be afforded the same rights regarding open enrollment and change of status or other mid-year election modifications as those Participants who are not on leave. Pursuant to Treasury Regulations, the Plan will provide reimbursements under the Health Care Flexible Spending Account for the full amount of the elected coverage so long as coverage under the Health Care Flexible Spending Account does not cease during the leave. If coverage does cease, the Plan will reimburse allowable Health Care Expenses Incurred only during the period the coverage was in effect.

(b) **Eligibility While on Military Leave**. If a Participant is covered under an underlying health plan and becomes absent from employment due to military service, the

Participant will continue to be covered under the underlying health plan for the period of approved military leave.

Upon expiration of Employer provided coverage described above during an ongoing military leave, the Participant and his or her dependents will be entitled to elect continuation coverage under those plans in accordance with the COBRA provisions and procedures. This special USERRA COBRA coverage continues until the earlier of the following: (a) twenty-four (24) months from the date the continuation coverage commenced; (b) the premium payment required for continued coverage is not made; (c) the Participant fails to report back to work or apply for reemployment within the time period required under USERRA after completion of military service; (d) the Participant loses USERRA rights for one of the reasons provided in 38 U.S.C. § 4304; or (e) the Employer no longer provides health benefits to any of its employees. The special USERRA COBRA continuation coverage provided pursuant to this Section will be concurrent with the COBRA continuation of coverage provisions of Section 6.7 and/or the continuation of coverage provisions of the underlying health plan.

If the Participant returns as an active employee after his or her military service, the Participant's coverage and his or her Spouse's and/or Dependent's coverage will be immediately reinstated if (1) the Participant and his or her Spouse and/or Dependents were covered under an underlying health plan on the day before the Participant's absence from employment due to military service began, and (2) the Participant's total military service while he or she was absent from employment did not exceed five (5) years.

ARTICLE III - CONTRIBUTIONS, FUNDING AND FORFEITURES

3.1 Company Determination of Costs and Contributions

Certain underlying accident or health benefits shall be made available to Eligible Employees as determined annually by the Company. The Company shall determine the Employer share of the cost of such underlying accident or health benefits and the cost to Participants for Premiums which may be payable through Salary Reduction Contributions to the Premium Payment Account. In addition, each year, the Company shall determine the amount of Salary Reduction Contributions that may be allocated to each of the Spending Accounts provided under this Plan. Furthermore, each year each participating Employer shall determine the Employer contribution rate to each HSA Eligible Individual's Health Savings Account and the amount of Salary Reduction Contributions that a HSA Eligible Individual may contribute to his or her Health Savings Account. The Company may make changes prior to the beginning of the new Plan Year at its discretion. Before making their annual Benefit elections, all Eligible Employees and Participants shall be notified as to the currently effective Premiums and the maximum Salary Reduction Contributions Participants may make to each of the Spending Accounts provided under the Plan and to their Health Savings Account.

3.2 No Deferral of Compensation

Except as provided for in Proposed Treasury Regulation Section 1.125-1(o) and (p) the Plan does not offer a benefit that defers compensation.

3.3 Funding

Unless otherwise required by law, Contributions to the Plan need not be placed in trust, but shall instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security interest in, any fund, or asset of the Employer from which any payment under the Plan may be made.

All reimbursements under Articles VI and VII are made out of the Employer's general assets. There is no trust or fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire an outside paying agent to make Benefit payments on its behalf out of the Employer's general assets.

3.4 Forfeitures

Any forfeited amounts under this Plan may be used (i) to pay administrative expenses of the Plan; (ii) used to reduce Salary Reduction Contribution in the immediately following Plan Year; or (iii) returned to Employees on a reasonable and uniform basis, in accordance with Proposed Treasury Regulation Section 1.125-5(o)(2). Notwithstanding the foregoing, any forfeited amounts solely related to the Dependent Care Flexible Spending Accounts may be retained by the Employer.

3.5 Uncashed Checks

No Participant shall be legally entitled to the cash benefit underlying any reimbursement check unless and until such Participant actually cashes the reimbursement check. Any reimbursement which remains uncashed will remain the property of the Employer and will not be deemed unclaimed property unless specifically required, and only to the extent specifically required, under applicable state law (to the extent not preempted by ERISA) and shall be administered per the guidelines of the applicable state law. In the event a benefits check is voided due to being uncashed within the time period (generally 180 days) established by the Plan Administrator (or its delegate) and the Participant subsequently properly requests payment with respect to the voided check within one year of its issuance date, the Plan Administrator shall make such payment, but no interest shall be due or payable on such amount.

ARTICLE IV - BENEFITS

4.1 Benefit Options

Subject to the provisions of Article V, each Eligible Employee may elect to reduce his or her Compensation by making Salary Reduction Contributions to the Health Care Flexible Spending Account, the Dependent Care Flexible Spending Account, or to the Premium Payment Account under this Plan, or to receive his or her normal Compensation. An HSA Eligible Individual may receive Employer contributions to, and elect to make contributions to his or her Health Savings Account. An Eligible Employee that elects Health Savings Accounts benefits may not be covered by a General Purpose Health Care Flexible Spending Account or other disqualifying

coverage as set forth in Code Section 223. Only "qualified benefits" as defined under Code Section 125(f) shall be offered under the Plan.

4.2 Premium Payment Account Benefit

Each Eligible Employee may elect to allocate Salary Reduction Contributions towards the payment of Premiums for coverage for the Eligible Employee, his or her Spouse, and/or Dependents under any Benefit that is a qualified benefit under Code Section 125 and the Treasury Regulations thereunder and which has been specified by the Plan Administrator in Schedule A as a Benefit under the Plan. Each Eligible Employee may elect, in accordance with Section 2.3, to allocate Salary Reduction Contributions towards the payment of Premiums for coverage to the Eligible Employee's Domestic Partner (or children) to the extent permitted by the underlying accident or health plans. This Premium Payment Account benefit is solely a mechanism to allow Eligible Employees to pay for Benefits on a pre-tax basis, as permitted under Code Section 125, and is not subject to ERISA. Any underlying accident or health benefits are described in the Intuit Inc. Consolidated Welfare Plan.

4.3 Health Care Flexible Spending Account Benefit

Each Eligible Employee may elect to allocate Salary Reduction Contributions to his or her Health Care Flexible Spending Account (either a General Purpose or Limited Purpose Health Care Flexible Spending Account) for the payment of Health Care Expenses for the Eligible Employee, his or her Spouse and/or Dependents, subject to the provisions of Article VI.

4.4 Dependent Care Flexible Spending Account Benefit

Each Eligible Employee may elect to allocate Salary Reduction Contributions to his or her Dependent Care Flexible Spending Account for the payment of Dependent Care Expenses for his or her Qualifying Dependents, subject to the provisions of Article VII. The Dependent Care Flexible Spending Account Benefit is not subject to ERISA

4.5 Health Savings Account Benefit

The Employer shall make a contribution to the Health Savings Account of each HSA Eligible Individual who establishes a Health Savings Account with an approved vendor, in an amount determined by the Employer each year and communicated to Eligible Employees. In addition, each HSA Eligible Individual may elect to allocate Salary Reduction Contributions to his or her Health Savings Account which shall be forwarded to the Health Savings Account established by the HSA Eligible Individual. The Health Savings Account Benefit is not subject to ERISA.

4.6 Nondiscrimination Requirements

It is the intent of the Plan Sponsor that this Plan operates in a manner which meets the applicable nondiscrimination requirements of the Code and applicable Treasury Regulations.

ARTICLE V - PARTICIPANT ELECTIONS

5.1 Salary Reduction Agreement

Eligible Employees may elect to make Salary Reduction Contributions pursuant to the terms of this Plan to purchase Benefits. The amount of Salary Reduction Contribution shall be specified in the Salary Reduction Agreement which shall be a legally binding agreement in a form (including paper, electronic or interactive voice response prescribed by the Plan Administrator) under which the Eligible Employee agrees to reduce the Compensation otherwise payable to him or her thereafter by a specified amount. The Salary Reduction Contribution amount for the Premium Payment Account may automatically change within a Plan Year if any provider or underlying health or welfare benefit adjusts the amount it charges for such coverage. The Employer agrees to apply the total amount of Salary Reduction Contributions elected by the Eligible Employee toward the purchase of Benefits elected under Article IV.

Any Salary Reduction Contribution shall be elected prior to the beginning of a Plan Year (subject to initial election pursuant to Section 5.2) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke or change a Benefit election or a Salary Reduction Agreement in accordance with Section 5.5 of the Plan and consistent with applicable Treasury Regulations.

5.2 Initial Elections

Before, or as soon as practicable after becoming an Eligible Employee, an individual shall be given the opportunity to elect Benefits on a Salary Reduction Agreement provided by the Plan Administrator. Each newly Eligible Employee must make his or her election prior to the end of the initial Election Period, which is thirty-one (31) days from the date of hire or date of first becoming an Eligible Employee under the Plan. If a newly Eligible Employee enrolls within this time frame, but after the first day of the Plan Year, coverage shall be effective as of the date of eligibility or hire, however, Salary Reduction Contributions must be from Compensation earned after the Salary Reduction Agreement is completed and processed by the Plan Administrator. Subject to Section 5.5, elections made during the initial Election Period shall apply for the remainder of the Plan Year of initial participation and may not be changed until the next Election Period.

5.3 Subsequent Annual Elections

During the Election Period prior to each Plan Year, each Eligible Employee shall be given the opportunity to elect Benefits on a Salary Reduction Agreement provided by the Plan Administrator. Any such election shall be effective for any Benefit expenses Incurred during the Plan Year which follows the end of the Election Period. Subject to Section 5.5, elections made for the Plan Year following the Election Period may not be changed until the next Election Period.

5.4 Failure to Elect

(a) Initial Election. Any Eligible Employee who fails to complete a Salary Reduction Agreement pursuant to Section 5.1 by the end of the initial Election Period shall be deemed to

have elected to receive his or her normal Compensation in cash. Notwithstanding the foregoing, an Eligible Employee who is enrolled (including automatically enrolled) in an underlying accident or health plan provided under the Premium Payment Account shall be deemed to have elected to make Salary Reduction Contributions in an amount equal to the Premium(s) for such underlying benefit. In addition, an HSA Eligible Individual may automatically receive an Employer contribution to his or her Health Savings Account in the amount determined by the Employer from time to time.

(b) Subsequent Election. For any Eligible Employee or Participant who fails to complete a Salary Reduction Agreement during an annual election period pursuant to Section 5.3 by the end of the applicable annual Election Period, the Eligible Employee or Participant will be deemed to have elected to receive his or her normal Compensation in cash for the upcoming Plan Year. Notwithstanding the foregoing, Premium Payment Account elections and any Employer Contributions to the Health Savings Accounts of HSA Eligible Individuals shall continue automatically provided the Participant is enrolled in the underlying accident or health plans and/or has established an HSA, as applicable.

5.5 Change of Elections

Any Eligible Employee may change a Benefit election and Salary Reduction Agreement after the Plan Year has commenced and make a new election with respect to the remainder of such Plan Year in accordance with this Section 5.5. Solely for purposes of mid-year election changes to the Premium Payment Account, references to the term Spouse shall include Domestic Partner and references to Dependent shall include children of Domestic Partners. Except as specifically provided, any such election change must be made within thirty-one (31) days of the date of the event permitting the change and shall be implemented as soon as administratively feasible thereafter.

(a) **Special Enrollment Rights.** If the Eligible Employee, the Employee's Spouse, and/or a Dependent are entitled to special enrollment rights under a group health plan, the Eligible Employee may exercise the enrollment rights as provided for in Code Section 9801(f).

(i) **Individuals Losing Other Coverage.** If the Eligible Employee (or Spouse or Dependent) was eligible but is not enrolled in coverage, the Eligible Employee may elect to enroll mid-year if (A) the Eligible Employee (or Spouse or Dependent) was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Eligible Employee (or Spouse or Dependent), (B) the Eligible Employee's (or Spouse's or Dependent's) coverage described in (A) above was (i) under COBRA and the coverage was exhausted or (ii) was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated, and (C) the Eligible Employee requests such enrollment not later than thirty-one (31) days after the exhaustion of coverage described in (B) above.

(ii) **Dependent Special Enrollment.** In the case of the birth or adoption/placement for adoption of a child, if the Participant submits his or her election form within

sixty (60) days of the birth or adoption, he or she may begin Incurring claims from the date of birth or adoption/placement for adoption and future Salary Reduction Contributions may reflect the cost of the coverage from the date of birth or adoption/placement for adoption. In the case of marriage, if the Participant submits his or her election form within thirty-one (31) days of the marriage, he or she may begin Incurring claims from the date of marriage and future Salary Reduction Contributions may reflect the cost of the coverage from the date of the election change request.

(iii) **CHIPRA**. If the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of such Act and coverage of the Eligible Employee or Dependent under such plan is terminated as a result of loss of eligibility for such coverage the Eligible Employee may request coverage under this Plan not later than sixty (60) days after the date of termination of such coverage. If the Eligible Employee or Dependent becomes eligible for assistance with respect to coverage under this Plan, pursuant to a Medicaid plan or a state child health plan (including any waiver or demonstration project conducted under or in relation to this Plan) the Eligible Employee may request coverage under this Plan not later than sixty (60) days after the Eligible Employee or Dependent is determined to be eligible for such assistance.

(b) **Change in Status**. An Eligible Employee may revoke an election during a Plan Year and make a new election for the remainder of the Plan Year if, under the facts and circumstances, a change in status occurs and the election change is on account of and corresponds with a change in status that affects eligibility for coverage (including a change in status that results in an increase or decrease in the number of an Eligible Employee's Spouse or Dependents who may benefit from coverage) under the Plan or, with respect to the Dependent Care Flexible Spending Account, affects the amount of Qualified Dependent Care Expenses the Eligible Employee will incur. A change in status includes:

(i) **Legal Marital Status**. Events that change the Eligible Employee's legal marital status, including the following: marriage, death of the Eligible Employee's Spouse, divorce, legal separation, and annulment.

(ii) **Number of Dependents**. Events that change the number of the Eligible Employee's Dependents including the following: birth, death, adoption, and placement for adoption.

(iii) **Employment Status**. Events that change the Eligible Employee's employment status or the employment status of the Eligible Employee's Spouse or Dependent including: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence and a change in work site. In addition, if the eligibility conditions of the cafeteria plan or other employee benefit plan of the employer of the Employee, Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then the change

constitutes a change in employment (e.g. if a plan only applies to salaried employees and an employee switches from salaried to hourly).

(iv) **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements.** Events that cause the Eligible Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage.

(v) **Residence**. A change in the Eligible Employee's place of residence or that of the Eligible Employee's Spouse or Dependent.

(vi) **Reduction in Hours without Loss of Eligibility**. A Participant may prospectively revoke coverage under an underlying group health plan (but not the Health Care Flexible Spending Account) and make corresponding changes to the Participant's Salary Reduction Contributions if (1) the Participant was reasonably expected to average at least thirty (30) hours of service per week, and there is a change in the Participant's status so the Participant will reasonably be expected to average less than thirty (30) hours of service per week after the change in status, even if the reduction in hours of service does not result in the Participant ceasing to be eligible under an underlying group health plan, and (2) the revocation of the election of coverage under an underlying group health plan, and corresponding Salary Reduction Contributions under this Plan, corresponds to the intended enrollment of the Participant (and any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the coverage under this Plan is revoked.

(c) **Enrollment in an Affordable Care Act Qualified Health Plan through an Exchange**. A Participant may prospectively revoke coverage under an underlying group health plan (but not the Health Care Flexible Spending Account) and make corresponding changes to the Participant's Salary Reduction Contributions if (1) the Participant is eligible to enroll in a qualified health plan through a state or the Federal health care exchange during the annual open enrollment or during a "special enrollment period", and (2) the Participant's revocation of the election of coverage under the underlying group health plan, and corresponding Salary Reduction Contributions under this Plan, corresponds to the Participant's (and any related individuals' who cease coverage due to the revocation) intended enrollment in a qualified health plan through a Federal or state exchange that is effective no later than the day immediately following the last day of revoked coverage under this Plan.

(d) **Judgment, Decree or Order**. If an accident or health plan maintained by the Employer receives a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in custody (an "order") (including a medical child support order qualified under ERISA § 609) that requires an Eligible Employee to provide coverage for the Eligible Employee's child, the Plan Administrator may change the Eligible Employee's election under this Plan to add coverage of the child. In addition, if an order requires the non-employee parent to provide coverage for a child who is currently covered under a group health plan maintained by

the Employer, the Participant may change his or her election under this Plan to cancel coverage for that child if the coverage is, in fact, provided by the non-employee parent. Any such election change must be made within thirty-one (31) days of the Participant's receipt of the order and shall be effective as of the first pay date as soon as administratively practicable after receipt by the Plan Administrator of such election change or, if later, the effective date specified in the order. This does not apply to the Dependent Care Flexible Spending Account.

(e) **Entitlement to or Loss of Medicare/Medicaid.** If the Eligible Employee, the Eligible Employee's Spouse, and/or Dependent who is enrolled in any Employer sponsored accident or health coverage becomes enrolled in Medicare/Medicaid (other than coverage consisting solely of the program for distribution of pediatric vaccines), the Eligible Employee may cancel or reduce coverage of that Eligible Employee, Spouse, or Dependent who becomes enrolled in Medicare/Medicaid. Conversely, if the Eligible Employee, the Eligible Employee's Spouse and/or Dependent who was covered under Medicare or Medicaid loses this coverage, the Eligible Employee is allowed to make a prospective election to commence or increase coverage for the person who loses Medicare or Medicaid coverage under the accident or health plan. If there is a loss in Medicaid coverage, the new election must be submitted to the Plan Administrator within sixty (60) days after the date of termination of such coverage. This does not apply to the Dependent Care Flexible Spending Account.

(f) **Significant/Insignificant Change in Cost.** If the cost of the coverage under an accident or health plan *significantly* increases or decreases, an Eligible Employee is allowed to either increase or decrease prospectively his or her Salary Reduction Contribution amounts or make another election to elect a Plan option providing similar coverage. In cases of an *insignificant* decrease or increase in cost of coverage, the Plan Administrator will automatically adjust the Participant's Salary Reduction Contribution to reflect the difference in cost. The basis of whether a change in cost is significant or insignificant is determined on a group level, not on an individual level. In the case of a decrease in cost, changes that may be made include commencing participation in the Plan with the option of the decrease in cost or making a corresponding change in Salary Reduction Contributions to reflect the decrease in cost. In the case of a significant increase in cost, changes that may be made include making a corresponding change in Salary Reduction Contributions to cover the increased cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package options providing similar coverage is available. Regarding the Dependent Care Flexible Spending Account, the Participant may choose to increase his or her Salary Reduction Contributions in the event that the provider of services increases its fees during the Plan Year, as long as the provider of services is not a relative. Conversely, should the Participant choose to remove his or her Qualifying Dependent from child care or the need for child care decreases, the Participant may decrease their Dependent Care Flexible Spending Account election accordingly. This does not apply to the Health Care Flexible Spending Account.

(g) **Significant Curtailment of Coverage/Addition, Significant Improvement or Drop of Benefit Package Option.** If coverage under an accident or health plan or for Dependent Care Expenses is significantly curtailed, the Participant may revoke his or her election and elect another Plan option with similar coverage. Also if the Plan adds a new benefit, or a new coverage option, or significantly improves a coverage option during the Plan Year, an Eligible

Employee may elect the newly added or newly improved option. Conversely, if the Plan should drop an existing benefit, the Participant is allowed to choose another benefit which provides similar coverage or elect no coverage if no similar coverage is available. This does not apply to the Health Care Flexible Spending Account.

(h) **Change in Coverage Under Another Employer Plan**. An Eligible Employee is allowed to make an election change that is on account of and corresponds with a change made under the plan of the Employee's Spouse, former Spouse, or Dependent's employer, provided (a) the employer plan of the Eligible Employee's Spouse, former Spouse, or Dependent's employer permits participants to make an election change that would be permitted under the status change rules contained in this Plan document; or (b) this Plan permits Eligible Employees to make an election for a period of coverage that is different from the period of coverage under the plan of the Eligible Employee's Spouse, former Spouse, or Dependent's employer. This does not apply to the Health Care Flexible Spending Account.

(i) **Loss of Coverage under Other Group Health Coverage**. An Eligible Employee may make a prospective election to add coverage for the Eligible Employee, Spouse or Dependent, if coverage is lost under any group health plan sponsored by a governmental or educational institution. This does not apply to the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account.

(j) **FMLA**. An Eligible Employee taking a FMLA leave (regardless of whether it is paid or unpaid) may, with respect to group health plan coverage, revoke an existing election and make a new election for the remaining portion of the Plan Year, in accordance with the requirements of the FMLA.

5.6 Change in Health Savings Account Election.

Notwithstanding anything in the Plan to the contrary, an HSA Eligible Individual may elect or revoke, increase or decrease his or her Salary Reduction Contributions to his or her Health Savings Account at any time, provided that the change is prospective; the change is to be effective only after a valid election change has been received by the Administrator and implemented no earlier than the beginning of the next payroll period of the following month (before salary becomes currently available).

ARTICLE VI - HEALTH CARE FLEXIBLE SPENDING ACCOUNT

6.1 Health Care Flexible Spending Account

The Health Care Flexible Spending Account, which is a component of the Intuit Inc. Consolidated Welfare Plan, is intended to qualify as a medical reimbursement account under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury Regulations thereunder as well as the general provisions of Code Section 125 and the Plan. Eligible Employees may elect to participate in either a General Purpose Health Care Flexible Spending Account or a Limited Purpose Health Care Flexible Spending Account, as applicable. An HSA Eligible Individual who establishes an HSA may not establish a General Purpose Health Care Flexible Spending Account. Eligible Employees who elect to participate in a Health Care Flexible Spending Account may submit eligible claims for the reimbursement of

Health Care Expenses from their General Purpose or Limited Purpose Health Care Flexible Spending Accounts, as applicable. Periodic payments reimbursing Participants from their Health Care Flexible Spending Accounts shall in no event occur less frequently than monthly.

6.2 Accounts

The Plan Administrator shall establish either a General Purpose or Limited Purpose Health Care Flexible Spending Account which shall be a bookkeeping account for each Participant who elects to apply Salary Reduction Contributions to Health Care Flexible Spending Account Benefits. A Participant's Health Care Flexible Spending Account shall be increased each pay period by the portion of Salary Reduction Contributions that he or she has elected to apply toward his or her Health Care Flexible Spending Account and reduced by the amount of any Health Care Expense reimbursements paid to or on behalf of a Participant pursuant to Section 6.5. The total amount of Salary Reduction Contribution amounts the Participant elected to apply to his or her Health Care Flexible Spending Account shall be available at all times during the Plan Year for Health Care Expenses Incurred by the Participant.

6.3 Forfeitures

(a) **Generally**. Amounts remaining in a Participant's Health Care Flexible Spending Account after the processing of all claims for any Plan Year pursuant to Section 6.5 hereof, shall be forfeited and allocated as provided for in Section 3.4.

(b) **Special Rule for Unused Benefits of Individual Called to Active Duty**. In accordance with Section 114 of the Heroes Earnings Assistance and Relief Tax Act of 2008, a Participant who is a member of a reserve component (as defined in Section 101 of Title 37, United States Code) and is ordered or called to active duty for a period in excess of one hundred seventy-nine (179) days or for an indefinite period, may request a distribution of all or a portion of the balance of his or her Health Care Flexible Spending Account, provided such distribution is made during the period beginning on the date of such order or call and ending no later than ninety (90) days after the end of the Plan Year in which such order or call commenced.

6.4 Limitation of Allocations

Notwithstanding any provision contained in this Article VI to the contrary, no more than the amount specified in Schedule A may be allocated to the Health Care Flexible Spending Account of a Participant in any Plan Year.

6.5 Health Care Flexible Spending Account Claims

(a) **Eligibility for Reimbursement**. To be eligible for reimbursement, Health Care Expenses must be Incurred by a Participant while covered under the Plan (including coverage during a leave, or pursuant to USERRA or under COBRA coverage) and during the Plan Year. Notwithstanding the foregoing, certain advance payment for orthodontia and durable medical equipment are permitted provided the requirements of Proposed Treasury Regulation Section 1.125-5(k)(3) are met.

(b) **Amount of Reimbursement**. The Contract Administrator shall direct the reimbursement to each Participant for all allowable Health Care Expenses which have been Incurred, and have been substantiated, in excess of any payments or other reimbursements under any health care plan which may be sponsored by the Employer, any governmental agency or any other plan covering a Participant and/or his or her Spouse or Dependents, up to a maximum of the amount permitted under the terms of the Plan and as designated by the Participant to be allocated to his or her Health Care Flexible Spending Account for the Plan Year.

(c) **Claims**. Participant claims for reimbursement must be made to the Contract Administrator on a form acceptable to the Contract Administrator within a reasonable time but in no event later than the October 31st immediately following the end of the Plan Year. Subject to subsections (d) and (e) below, the claims application shall include a written statement from the provider or provider organization stating that the Health Care Expense has been Incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Health Care Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Flexible Spending Account, such amount will not be claimed as a tax deduction. The Contract Administrator shall retain a file of all such applications. If a Participant fails to submit a claim by October 31st immediately following the end of the Plan Year the claim shall not be considered for reimbursement.

(d) **Substantiation Generally**. Claims for the reimbursement of Health Care Expenses Incurred in any Plan Year shall be paid as soon as administratively practicable after a claim has been filed, reviewed and substantiated in accordance with the applicable requirements of Proposed Treasury Regulation Section 1.125-6; provided however, that if a Participant fails to substantiate a claim or to submit a claim within the time periods specified in subsection (c) above, those Health Care Expense claims shall not be considered for reimbursement by the Contract Administrator.

(e) **Debit Cards**. In accordance with procedures established by the Plan Administrator that shall meet the applicable requirements of Proposed Treasury Regulation Section 1.125-6, a Participant who is an active employee may use a debit card to pay for Health Care Expenses. The Contract Administrator shall follow all of the correction procedures set forth in Proposed Treasury Regulation Section 1.125-6(d)(7) for any improper payments under a debit card.

6.6 Section 105(h) Requirements

The Health Care Flexible Spending Account is intended to meet the Code Section 105 requirements applicable to an employer-funded reimbursement plan, including the non-discrimination in eligibility and benefits requirements of Code Section 105(h) and Treasury Regulation Section 1.105-11.

6.7 Continuation of Coverage under COBRA

Notwithstanding any provision of the Plan to the contrary, Benefit coverage under the Health Care Flexible Spending Account may be continued in accordance with the provisions of this Section.

(a) **Definitions**. For purposes of this Section, the following terms have the following meanings:

(i) Election Period shall mean a period beginning on the date coverage terminates as a result of a Qualifying Event and ending sixty (60) days after the later of: (A) the date coverage terminates under the Health Care Flexible Spending Account; or (B) in the case of a Qualified Beneficiary who is to receive notice from the COBRA Administrator, the date of such notice (as described in Section 6.7(c) below);

(ii) Qualified Beneficiary shall mean any individual who, on the day before the Qualifying Event, is covered under the Health Care Flexible Spending Account as (A) a Participant, (B) a Spouse, or (C) the dependent child of a Participant. A Qualified Beneficiary shall also include any child born to or adopted by the Participant during the period of COBRA continuation coverage; and

(iii) Qualifying Event shall mean, any of the following events which, but for the continuation coverage required under this Section, would result in the loss of the Qualified Beneficiary's coverage under the Health Care Flexible Spending Account: (A) the termination (for reasons other than the Participant's gross misconduct) of the Participant's employment with the Employer, (B) reduction of the Participant's hours of employment with the Employer (C) death of the Participant, (D) divorce or legal separation of the Participant from the Participant's Spouse, (E) the Participant becoming entitled to Medicare, or (F) the dependent child ceasing to be a Dependent.

(b) **Right to Elect Continuation Coverage**.

(i) Each Qualified Beneficiary who would lose coverage under the Health Care Flexible Spending Account as a result of a Qualifying Event shall be entitled to elect, within the Election Period, to continue such coverage under the Health Care Flexible Spending Account for the balance of the Plan Year in which such coverage would otherwise be lost.

(ii) Continuation coverage shall be subject to payment of one hundred two percent (102%) of the Salary Reduction Contribution in effect at the time of the Qualifying Event for the duration of the Plan Year and shall cease upon the failure to make timely payment of the premium (subject to the *de minimus* exception set forth in the applicable Treasury Regulation).

(iii) Notwithstanding the foregoing, a Qualified Beneficiary shall not be entitled to continuation coverage for the duration of the Plan Year, unless, as of the date of the Qualifying Event, the Qualified Beneficiary can become entitled to receive, during the remainder of the Plan Year, Health

Care Expense reimbursements that exceed the cost for such continuation coverage.

(c) **Notice and Election Requirements.**

(i) **Initial Notice.** The COBRA Administrator shall provide written notice of the rights provided by this Section to each Participant and Participant's Spouse on the date an individual commences coverage under the Health Care Flexible Spending Account.

(ii) **Notice Upon Qualifying Event.** Within thirty (30) days of a Qualifying Event (or notice from the Qualified Beneficiary of those Qualified Events specified in Section 6.7(c)(iii) below), the Employer shall notify the COBRA Administrator of such Qualifying Event and the COBRA Administrator shall provide written notice of the continuation coverage right within fourteen (14) days after receipt of such notice.

(iii) **Qualified Beneficiary's Notice Obligations.** The Participant or Qualified Beneficiary must notify the Employer in writing of a divorce, legal separation, or a child losing dependent status within sixty (60) days of the later of the date of the event or the date coverage would be lost as a result of the event.

(iv) **Election Requirements.** The Qualified Beneficiary may elect COBRA continuation coverage during the Election Period. If no election is made within the Election Period, continuation coverage shall not be available and coverage under this Plan will cease as of the day of the Qualifying Event.

(v) **Notice of Early Termination of Coverage.** In the event that a Qualified Beneficiary who elects COBRA continuation coverage shall have his or her continuation coverage cease prior to the end of the normal COBRA period, the COBRA Administrator shall provide notice in accordance with applicable Treasury Regulation.

(d) **COBRA Savings Clause.** The provisions of this Section are intended to reflect the requirements of COBRA as they may apply to any of the specific Benefits provided under the Plan, and shall be so interpreted and construed.

6.8 HIPAA Privacy Provisions

(a) **Generally.** This Section is intended to reflect the applicable privacy provisions of HIPAA and its implementing regulations, which restrict group health plans (among other covered entities) from using and disclosing protected health information ("PHI"), as such term is defined in 45 CFR Section 164.501. The following provisions regarding the use and disclosure of PHI are intended to meet the applicable provisions of HIPAA.

The Plan is a "hybrid entity" as defined in 45 CFR Section 164.504(a). In accordance with 45 CFR Section 164.504(c)(3)(iii), the Plan designates the Health Care Flexible Spending Account as the health care component of the Plan (hereinafter referred to as "Group Health Plan") that is subject to the security and privacy provisions of Part 164 of HIPAA. The Group Health Plan is part of an "organized health care arrangement" as defined under 45 CFR Sections 160.103. Capitalized terms not otherwise defined shall have the same meaning as those terms in 45 CFR Sections 160.103 and 164.50.

(b) **Use and Disclosure of PHI**. The Group Health Plan will use and disclose PHI to the full extent permitted or required by HIPAA, including (without limitation): (i) for treatment, payment and health care operations; (ii) as required by law; (iii) to the individual; (iv) to the Secretary of Health and Human Services; (v) for legal and public policy purposes; (vi) to Business Associates; (vii) pursuant to a valid authorization; and (viii) to the Plan Sponsor as described below. The Group Health Plan's use and disclosure of PHI shall be in accordance with, and comply with, HIPAA and the Plan's Privacy Policy (as amended from time to time).

(c) **Disclosure to Plan Sponsor**. Pursuant to 45 CFR Section 164.504(f), the Group Health Plan is permitted to disclose PHI to the Plan Sponsor to carry out its plan administrative functions. In accordance with 45 CFR Section 164.504(f), the Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan has been amended to incorporate the provisions set forth in 45 CFR Section 164.504(f)(2). The Plan Sponsor hereby certifies that it agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents or subcontractors to whom it provides PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information and agree to comply with applicable HIPAA requirements;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;
- Report to the Group Health Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available based on HIPAA's access requirements in accordance with 45 CFR Section 164.524;
- Make PHI available for amendment and incorporate any amendments to PHI based on HIPAA's amendment requirements in accordance with 45 CFR Section 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Group Health Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with certain provisions of HIPAA;

- If feasible, return or destroy all PHI received from the Group Health Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that adequate separation between the Group Health Plan and the Plan Sponsor is established as required by 45 CFR Section 164.504(f)(2)(iii).

(d) **Adequate Separation between the Group Health Plan and the Plan Sponsor**. In accordance with HIPAA, only the following employees or classes of employees of the Plan Sponsor shall be given access to the PHI disclosed by the Group Health Plan: the Privacy and Security Officer; designated Company Human Resources personnel, including Benefits Department personnel; IT Department personnel and Legal Department personnel. Access shall be restricted to use by such employees described above for purposes of the Group Health Plan administrative functions that Plan Sponsor performs for the Group Health Plan. If the persons described above do not comply with these provisions, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

6.9 HIPAA Security Provisions

This Section is intended to reflect the applicable security provisions of HIPAA and its implementing regulations (the "Security Rule") which requires group health plans to have appropriate administrative, technical and physical safeguards to protect electronic PHI (as such term is defined in 45 CFR Section 160.103 and herein referred to as "ePHI"). Terms used but not otherwise defined, shall have the same meaning as those terms in 45 CFR Sections 160.103, 164.304 and 164.501.

In accordance with 45 CFR 164.314(b), the Plan Sponsor agrees to reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Group Health Plan. Specifically, the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains or transmits on behalf of the Group Health Plan;
- Ensure that adequate separation (as described in Section 6.8(d) above) between the Group Health Plan and the Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides ePHI which it received from the Group Health Plan agrees to implement reasonable and appropriate security measures to protect the information and shall comply with HIPAA's breach notification requirements; and
- Report to the Group Health Plan any security incident (as that term is defined in 45 CFR Section 164.304) of which the Plan Sponsor becomes aware.

ARTICLE VII - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 Dependent Care Flexible Spending Account

This Dependent Care Flexible Spending Account is intended to qualify as a dependent care assistance program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section, as well as general provisions of Code Section 125 and this Plan. Eligible Employees who elect to participate in this Dependent Care Flexible Spending Account may submit claims for the reimbursement of Dependent Care Expenses. All amounts reimbursed under this Dependent Care Flexible Spending Account shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 Definitions

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

(a) Earned Income means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care reimbursement to the Participant. The provisions of Code Section 21(d)(2) shall apply in determining the earned income of a Spouse who is a student or incapable of caring for himself.

(b) Dependent Care Expenses mean the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment-related expenses under Code Section 21(b)(2). Generally, they shall include expenses for the care of a Qualifying Dependent or incidental household services to the extent that such expenses are Incurred for any period for which there are one or more Qualifying Dependents with respect to such Participant (i) to enable the Participant and the Participant's Spouse, to be gainfully employed, (ii) to enable the Spouse to be a full-time student for at least five (5) months during the year or (iii) if the Spouse is physically or mentally unable to care for himself or herself. The determination of whether an amount qualifies as a Dependent Care Expense shall be made subject to the following rules:

(i) If such amounts are paid for expenses Incurred outside the Participant's household, they shall constitute Dependent Care Expenses only if Incurred for a Qualifying Dependent as defined in Section 7.2(c)(i) (or deemed to be, pursuant to Section 7.2(c)(iv)), or for a Qualifying Dependent as defined in Section 7.2(c)(ii) (or deemed to be, pursuant to Section 7.2(c)(iv)) who regularly spends at least eight (8) hours per day in the Participant's household;

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

(iii) Dependent Care Expenses of a Participant shall not include amounts paid or Incurred to a child of such Participant who is under the age of nineteen

(19) at the close of the Employee's tax year pursuant to Code Section 129(c)(2) or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(c) Qualifying Dependent means, for Dependent Care Flexible Spending Account purposes:

(i) A Dependent (as defined in Code Section 152(a)(1)) of a Participant who is under the age of thirteen (13);

(ii) A Dependent (as defined in Code Section 152, but determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof), who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year;

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

(iv) A child that is deemed to be a Qualifying Dependent described in paragraph (i) or (ii) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

7.3 Accounts

The Plan Administrator shall establish a Dependent Care Flexible Spending Account which shall be a bookkeeping account for each Eligible Employee who elects to apply Salary Reduction Contributions to Dependent Care Flexible Spending Account benefits. A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Salary Reduction Contributions that the Participant has elected to apply toward his or her Dependent Care Flexible Spending Account and shall be reduced by the amount of any Dependent Care Expense reimbursements paid to or on behalf of a Participant pursuant to Section 7.7.

7.4 Allowable Dependent Care Reimbursement

(a) **Generally.** Subject to limitations contained in Section 7.6 of this Plan, and subject to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Dependent Care Expenses shall be entitled to receive reimbursement for the amount of such Dependent Care Expenses Incurred. No reimbursement shall exceed the amount of the Participant's Dependent Care Flexible Spending Account at the time of the reimbursement. The amount of any Dependent Care Expenses not reimbursed shall be carried over to subsequent months during the same Plan Year and reimbursed when the balance in the Dependent Care Flexible Spending Account permits reimbursement.

(b) **Upon Cessation of Participation.** If a Participant ceases to be an Eligible Employee or terminates employment for any reason, his or her participation in the Dependent Care Flexible Spending Account shall cease immediately, provided, however, the Participant

may receive reimbursement for any allowable Dependent Care Expenses Incurred through the end of Plan Year in which the Participant ceased to participate in the Plan, not to exceed the actual amount of Salary Reduction Contributions the Participant had contributed to his or her Dependent Care Flexible Spending Account as of the date the Participant ceased to participate in the Plan.

7.5 Forfeitures

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.7 hereof) shall be forfeited and may remain the property of the Employer or otherwise allocated as set forth in Section 3.4.

7.6 Limitation on Payments

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

7.7 Dependent Care Flexible Spending Account Claims

(a) **Eligibility for Reimbursement**. To be eligible for reimbursement, Dependent Care Expenses must be Incurred by a Participant while covered under the Plan and during the Plan Year.

(b) **Claims**. The Contract Administrator shall direct the payment of all claims for Dependent Care Expenses to the Participant. The claim for reimbursement shall be made to the Contract Administrator on a form acceptable to the Contract Administrator within a reasonable time but in no event later than the October 31st immediately following the end of the Plan Year. Subject to subsection (c) below, the application shall include a statement from an independent third party as proof that the expense has been Incurred and the amount of such expense, and the Participant must certify in writing that the Dependent Care Expenses have not been reimbursed under any other Dependent Care Flexible Spending Account. If a Participant fails to submit a claim by the October 31st immediately following the end of the Plan Year the claim shall not be considered for reimbursement.

(c) **Substantiation Generally**. Claims for the reimbursement of Dependent Care Expenses Incurred in any Plan Year shall be paid as soon as administratively practicable after a claim has been filed, reviewed and substantiated in accordance with the applicable requirements of Proposed Treasury Regulation Section 1.125-6; provided however, that if a Participant fails to substantiate a claim or to submit a claim within the time periods specified in subsection (b) above, those Dependent Care Expense claims shall not be considered for reimbursement by the Contract Administrator.

7.8 Nondiscrimination Rules

The Dependent Care Flexible Spending Account is intended to company with the applicable nondiscrimination rules of Code Section 129, including the eligibility test set forth in Code Section 129(d)(3), the contributions and benefits test set forth in Code Section 129(d)(2), the concentration test set forth in Code Section 129(d)(4), and the average benefits test set forth in Code Section 129(d)(8).

ARTICLE VIII - HEALTH SAVINGS ACCOUNT

8.1 Health Savings Account

An HSA Eligible Individual may have Employer contributions made to, and may elect to make Salary Reduction Contributions to, a Health Savings Account established on his or her behalf and maintained outside the Plan by a trustee or custodian designated by the Plan Administrator. As described in Section 5.6, an HSA Eligible Individual's election to make Salary Reduction Contributions to his or her HSA may be increased, decreased or revoked prospectively at any time during the Plan Year.

An HSA Eligible Individual who elects a Health Savings Account may only elect the Limited Purpose Health Care Flexible Spending Account.

8.2 Maximum Contributions

The maximum annual contributions to a Participant's Health Savings Account shall be the applicable maximum set forth under Code Section 223(b), as adjusted for cost-of-living increases pursuant to Code Section 223(g), and subject to the special rules for married individuals. The maximum amount of Salary Reduction Contributions that an HSA Eligible Individual may elect to contribute to a Health Savings Account arrangement shall be the applicable maximum statutory amount set forth in Code Section 223(b), as adjusted for cost-of-living increases pursuant to Code Section 223(g) reduced by any Employer contributions (other than Salary Reduction Contributions) to the Participant's Health Savings Account.

8.3 Individual Trust or Custodial Account

The Health Savings Account benefits under this Plan consist solely of the ability for an HSA Eligible Individual to receive Employer contributions to, or make Salary Reduction Contributions to, his or her HSA. The Health Savings Account benefits component is not an employer-sponsored employee benefit plan and is not an ERISA plan. A Health Savings Account is an individual savings account that is established and maintained by a designated HSA trustee or custodian outside the Plan to be used primarily for reimbursement of "qualified eligible medical expenses" pursuant to Code Section 223. The Plan Administrator will maintain records to keep track of Employer and Salary Reduction Contributions to an HSA but it will not create a separate fund or otherwise segregate assets for this purpose. Neither the Employer nor the Plan Administrator have any authority or control over the funds deposited in a HSA. Terms and conditions of coverage and benefits will be provided by the custodian or trustee and are set forth in the HSA trust or custodial agreement, which is not a part of this Plan.

8.4 Tax Treatment

The tax treatment of the Health Savings Account, including, but not limited to the tax treatment of contributions and distributions, is governed by Code Section 223.

ARTICLE IX - CLAIMS PROCEDURES

9.1 Claim for Benefits

Any claim for benefits under any of the underlying accident or health plans, shall be submitted under the claims procedure or policy under that plan in accordance with the plan document or summary plan description of the applicable plan. Claims for benefits under a Health Savings Account are governed by the applicable trust or custodian agreement or other separate document(s) governing the Health Savings Account. Any claim regarding eligibility shall be made to the Plan Administrator and the Plan Administrator shall follow the procedures and timeframes described herein for adjudicating such claims. Any claim for Benefits under the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account shall be made to the Contract Administrator. The following claims procedures are intended to comply with ERISA and are therefore applicable to claims made with respect to the Health Care Flexible Spending Account. The Dependent Care Flexible Spending Account is not subject to ERISA and therefore is not subject to the claims procedures set forth below. However, the Contract Administrator may follow claims procedures that are similar to the claims procedures applicable to the Health Care Flexible Spending Account. Notwithstanding the foregoing, no party may rely on, or assert a violation based on the Contract Administrator's failure to follow the claims procedures set forth below with respect to the Dependent Care Flexible Spending Account.

In the event that the claim is denied in whole or in part, the Contract Administrator will notify the Participant or individual authorized to file a claim (referred to hereafter as the "Claimant"), within thirty (30) days of receipt of such claim. Should the Contract Administrator face delays not of its own creation, the Contract Administrator may extend the determination period an additional fifteen (15) days only if it notifies the Claimant of the circumstances requiring the extension prior to the exhaustion of the initial thirty (30)-day period. Should the delay occur as a result of deficient information submitted by the Claimant, the extension notice must describe the required information necessary for determination. The Claimant shall have a minimum of forty-five (45) days to submit the requested information to the Contract Administrator. The notice of a denial of a claim shall be written in a manner calculated to be understood by the Claimant and shall set forth: (i) the specific reason for the denial; (ii) specific references to the pertinent Plan provisions on which the denial is based; (iii) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation as to why such information is necessary; (iv) an explanation of the Plan's claims procedure; and (v) when an internal rule, guideline, protocol or other similar criteria was relied on, a statement that such was relied on as well as the right to receive a copy, upon request, and free of charge, of any such internal rule, guideline or protocol or similar criterion.

9.2 Appeal Procedure

(a) Any Claimant whose claim has been denied will have the right to request a review of the decision made on his or her claim. To initiate an appeal, a claimant must file a written request for an appeal with the Plan Administrator within one hundred eighty (180) days after receipt of the written decision denying the claim. Such appeal should set forth all of the grounds upon which the request for review is based and any facts in support thereof and set forth any issues or comments which the Claimant deems pertinent to the claim and appeal.

(b) A decision on the appeal shall be made by an appropriate party (who is neither the individual who made the initial determination or a subordinate of such person) without deference to the initial adverse determination and shall be made not later than thirty (30) days after receipt of a request for review. The decision shall take into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the original benefit determination. The decision of the Plan Administrator, directly or through the Contract Administrator, shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the Claimant, with specific references to the pertinent Plan provisions on which the decision is based. The decision shall include a statement that the claimant is entitled to receive, upon request and free of charge, (i) reasonable access to, and copies of all documents, records, and other information relevant to the claim for benefits and (ii) a copy of any rule, guideline, protocol, or other similar criteria, if such was relied upon in making the adverse determination.

(c) A Claimant must exhaust these claims procedures prior to filing a suit in court. Except as otherwise required by applicable law, no legal action to recover Plan benefits or to enforce or clarify rights under the Plan may be brought by any claimant on any matter pertaining to this Plan unless the legal action is commenced in the proper legal forum before the earlier of: (i) three (3) years after the claimant knew or reasonably should have known of the principal facts on which the claim is based; or (ii) one (1) year after the Claimant has exhausted the claim and review procedure.

ARTICLE X - ADMINISTRATION

10.1 Plan Administrator

The Compensation and Organizational Development Committee of the Board of Directors ("CODC") of the Company is the Plan Administrator and named fiduciary pursuant to ERISA Section 402 (with respect to the Health Care Flexible Spending Account, the only component of the Plan subject to ERISA). The CODC has established and delegated certain responsibilities to the Employee Benefits Administrative Committee (the "Committee") as set forth in the Charter of the Employee Benefits Administrative Committee, as it may be amended from time to time. The Committee shall have the authority to manage and control the operation and administration of all of the components of the Plan, except as otherwise set forth herein. The Plan Administrator may, from time to time, delegate any of its rights, powers, and duties (including fiduciary responsibility) with respect to the operation and administration of the Plan to one or more committees, individuals or entities.

The Committee shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated shall receive substantially the same treatment.

10.2 Composition of the Committee

The Committee shall consist of three (3) members appointed by, and who serve at the discretion of, the other members of the Committee. The members shall include the Company's officer in charge of Human Resources, the Company's officer responsible for the Company's Total Rewards program and at least one member from the Company's Finance organization. If a member of the Committee employment terminates, then he or she shall be deemed to be removed from the Committee as of the same date as his or her termination of employment. Notwithstanding the foregoing, the CODC reserves the right to remove any or all member(s) of the Committee at any time, to reconstitute membership of the Committee at any time, and to disband the Committee at any time.

10.3 Duties of the Committee

It shall be the principal duty of the Committee to see that the Plan is carried out, in accordance with its terms. The Committee is responsible for all matters in connection with the operation and administration of the Plan. For this purpose, the Committee's powers will include, but will not be limited to, the following:

- To adopt amendments to the Plan;
- To interpret the Plan in its sole discretion, its interpretation to be final and conclusive on participating Employers, Eligible Employees, Participants, and all persons claiming Benefits under the Plan;
- To administer and oversee the operations and management of the Plan;
- To establish and maintain policies, rules and procedures for the administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law, including Section 503 of ERISA;
- To periodically evaluate the internal procedures for managing and administering the Plans and legal and compliance matters associated with the Plans;
- To be responsible for the compilation and maintenance of all records necessary in connection with the Plan;
- To decide, in its sole discretion, all questions concerning the Plan and the eligibility of any person to participate in the Plan and the amount of Benefits under the Plan;
- To make reasonable assumptions and procedures regarding administrative matters;
- To appoint such agents, counsel, accountants, consultants, specialists and other persons as may be required to assist in administering the Plan; and
- To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan.

10.4 Decisions and Rules

The decisions of the Plan Administrator made in good faith upon any matter within the scope of its authority will be final.

10.5 Liability; Indemnification

The Plan Administrator including the Committee or any delegee who is an Employee, will not be liable for any act, omission, determination, or construction made by itself, except as otherwise provided in this Section. The Employer will indemnify and hold harmless the Plan Administrator, Committee or any Employee to whom any fiduciary duty is delegated from and against any and all liabilities, claims, demands, costs and expenses (including attorneys' fees) incurred by such person as a result of any act, or failure to act, in connection with the performance of his or her duties, responsibilities and obligations under the Plan and under ERISA, the Code or other applicable law, other than such liabilities, claims, demands, costs and expenses as may result from the gross negligence or willful misconduct of such person or to the extent such indemnification is prohibited by ERISA (to the extent ERISA applies). The Employer will have the right, but not the obligation, to conduct the defense of such person in any proceeding to which this Section applies. The Employer may satisfy this indemnification obligation through the purchase of insurance.

10.6 Contract Administrator

The Contract Administrator shall have authority, with respect to those portions of the Plan that the Contract Administrator administers, to review claims, determine entitlement to Benefits and pay claims, subject to the provisions of the Plan and in accordance with ERISA (to the extent ERISA applies), the Code and other applicable law.

10.7 COBRA Administrator

The COBRA Administrator shall have responsibility and authority to administer the Plan's obligations under COBRA, including, providing notices, collecting premiums and compiling and maintaining all necessary records.

10.8 Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including, but not limited to, administrative fees and expenses owing to any administrative service provider, consultant, accountant, specialist, or other person or organization that may be employed in connection with the Plan administration, shall be paid by the Plan, and to the extent not paid by the Plan, by the Employer.

10.9 Insurance Control Clause

In the event of a conflict between the terms of this Plan and the terms of any insurance contract or self-insured plan document providing accident or health benefits in conjunction with this Plan, the terms of the insurance contract or self-insured plan document shall control as to those Participants receiving coverage under such insurance contract or plan document.

ARTICLE XI - AMENDMENT OR TERMINATION OF PLAN

11.1 Amendment

The Company or the Committee as set forth in Article X, may, at any time, amend the Plan. No amendment shall have the effect of modifying any Salary Reduction Agreement or any Participant in effect at the time of such amendment, unless such amendment is made to comply with applicable law.

11.2 Termination

Although the Plan Sponsor has established the Plan with the intention of maintaining it for an indefinite period of time, the Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further Employer or Salary Reduction Contributions shall be made to the Plan and Benefits shall be paid in accordance with the provisions of the Plan. Benefits under any underlying accident or health plan shall be paid in accordance with the terms of the applicable plan. The Plan may be terminated by a written instrument of the Company, or its duly authorized delegate.

11.3 Business Decision

The Company's decision to amend or terminate the Plan, in whole or in part is not a fiduciary decision that must be made solely in the interest of Participants and beneficiaries, but is a business decision that can be made solely in the Company's interest.

ARTICLE XII - MISCELLANEOUS

12.1 Nonassignability of Rights

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be expressly required by law.

12.2 Gender and Number

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

12.3 Written Document

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Regulations thereunder relating to cafeteria plans. Article VI is intended to satisfy the written plan document requirement contained in Code Section 105 for medical reimbursement plans, and Article VII is

intended to satisfy the written plan document requirement contained in Code Section 129 for dependent care assistance plans.

12.4 Information to be Furnished

Participants shall provide the Employer, the Plan Administrator, the Contract Administrator and/or the COBRA Administrator with such information, evidence, and shall sign such documents, as may be reasonably requested from time to time for the purpose of administration of the Plan. When making a determination or calculation, the Plan Administrator and anyone acting on its behalf may request, and rely upon, such documentation as it may determine to be necessary.

12.5 Limitation of Rights; No Contract of Employment

Neither the establishment of the Plan or any amendment thereof, nor the payment of any benefit will be construed as giving to any Participant or other person a legal or equitable right against the Employer or the Plan Administrator except as provided in the Plan. Under no circumstances shall the terms of employment of any Participant be modified or in any way affected by the provisions of the Plan. Nothing contained in the Plan, nor any action taken hereunder, shall be construed as a contract of employment, or as giving any individual any right to be retained as an Employee of the Employer; employment with the Employer is at will and may be terminated at any time.

12.6 USERRA Compliance

The Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time, including, but not limited to, health care continuation provisions.

12.7 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any contributions or amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether contributions, benefits or payments under the Plan are excludable from the Participant's gross income for Federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

12.8 Indemnification of Employer by Participants

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or state income tax or employment tax from such payments or reimbursements.

12.9 Severability

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

12.10 Governing Law

This Plan will be interpreted and administered in a manner consistent with the requirements of ERISA (to the extent applicable) or other pertinent Federal laws, and to the extent applicable, the laws of the State of California.

12.11 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

IN WITNESS WHEREOF, the Plan Sponsor hereby adopts the restated and amended Plan, effective as of August 1, 2017.

INTUIT INC.

By: Stephanie Carroll

Stephanie Carroll

Member of the Employee Benefits Administrative Committee

Date: 11/27, 2017

INTUIT INC.

By: Emily Del Toro

Emily Del Toro

Member of the Employee Benefits Administrative Committee

Date: 11 27, 2017

INTUIT
FLEXIBLE BENEFIT PLAN

SCHEDULE A
BENEFITS

The Benefits outlined below shall be included in the Plan:

A. Premium Payment Account:

Medical
Dental
Vision

B. Health Care Flexible Spending Account (General Purpose or Limited Purpose)

$2,600 Plan Year Maximum (subject to cost-of-living adjustments)

C. Dependent Care Flexible Spending Account

$5,000 Plan Year Maximum

D. Health Savings Account

The Employer may make contributions to the HSA Accounts of HSA Eligible Individuals at such times and in such amounts as determined in the Employer's discretion. The Employer shall communicate the amount and timing of such contributions via enrollment materials or other communications. HSA Eligible Individuals may make Salary Reduction Contributions to their HSA Accounts. Contributions to HSAs are subject to the maximum allowable contributions established pursuant to Internal Revenue Code Section 223. HSA Eligible Individuals are responsible for ensuring that contributions to their HSAs stay within the applicable limits, requesting any distributions if the limits are exceeded and addressing any tax consequences related to contributions that exceed the maximum limits.