PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

COMMERCE BANCSHARES, INC.

FLEXIBLE BENEFITS PLAN

Updated January 2012

1/12

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ARTICLE I
INTRODUCTION

1.1 Introduction

This is not just a summary of the Plan, but the actual plan document written so that it can be used by the Employee, the Employer, the Claim Administrator and the Plan Administrator in administering the Plan.

1.2 Establishment of Plan

Commerce Bancshares, Inc. hereby amends and restates its existing Commerce Bancshares, Inc. Flexible Benefits Plan effective January 1, 2003. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay for his or her share of premiums under the Insurance Plans on a pre-tax Salary Reduction basis, and to contribute on a pre-tax Salary Reduction basis to an account for reimbursement of certain Medical Care Expenses and Dependent Care Expenses.

1.3 Legal Status

This Plan is intended to qualify as a "cafeteria plan" under Code § 125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a “self-insured medical reimbursement plan” under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees’ gross income under Code § 105(b). The Dependent Care Assistance Program Component is intended to qualify as a “dependent care assistance plan” under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees’ gross income under Code § 129(a).

Although reprinted within this document, the Health FSA Component and the Dependent Care Assistance Program Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§ 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of ERISA and COBRA.

ARTICLE II
DEFINITIONS

2.1 Definitions

"Account(s)" means the Health FSA Accounts and the Dependent Care Assistance Program Accounts described in Sections 7.5 and 8.5, respectively.

"Benefit" means the Premium Payment Benefits, the Health FSA Benefits and the Dependent Care Assistance Program Benefits offered under the Plan.

"Benefit Package Option" means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option or a PPO option under an accident or health plan).

"Change in Status" has the meaning described in Section 9.3.

"Claim Administrator" the party contracted by the Plan Administrator to review, process, and pay claims.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Compensation" means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan, (b) any salary reduction election under any other cafeteria plan and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k) or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b) or (c) of the prior sentence.

"DCAP" means Dependent Care Assistance Program.

"Dependent Care Assistance Program Account" means the account described in Section 8.5.

"Dependent Care Assistance Program Benefits" has the meaning described in Section 8.1.

"Dependent Care Assistance Program Component" means the Component of this Plan described in Article VIII.

"Dental Insurance Benefits" means the Employee's Dental Insurance Plan coverage for purposes of this Plan.

"Dental Insurance Plan" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing dental benefits through a group insurance policy or policies whether fully or self-insured (including a high option and a basis option). The Employer may substitute, add, subtract or revise at any time the menu of such plans and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

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

"Dependent." Notwithstanding the foregoing, effective January 1, 2011, any adult natural child, stepchild, legally adopted child (or child legally placed for adoption) or eligible foster child, whether married or unmarried, for any calendar year before the calendar year in which the individual reaches age 27, shall for purposes of the Premium Payment Component and the Health FSA Component be considered a "Dependent" even if the child does not otherwise meet the definition of "Dependent" set forth above.

"Dependent Care Expenses" has the meaning described in Section 8.3.

"Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any Dependent Care Assistance Program established under Code § 129; or (b) any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

"Effective Date" of this Plan has the meaning described in Section 1.2.

"Election Form/Salary Reduction Agreement" means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Premium Payment Benefits, Health FSA Benefits and Dependent Care Assistance Program Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 3.1.

"Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employees (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer.

"Employer" means Commerce Bancshares, Inc. and any Related Employer that participates in this Plan with the approval of Commerce Bancshares, Inc. Related Employers that have adopted this Plan, if any, are listed in Appendix A to this Plan. However, for purposes of Article XI and Section 12.3, "Employer" means only Commerce Bancshares, Inc.

"Employment Commencement Date" means the first regularly-scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Health FSA" means health flexible spending arrangement.

"Health FSA Account" means the account described in Section 7.5.

"Health FSA Benefits" has the meaning described in Section 7.1.

"Health FSA Component" means the Component of this Plan described in Article VII.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Insurance Benefits" means the Medical and Dental Insurance Benefits.

"Insurance Plans" means the Medical and Dental Insurance Plans.

"Medical Care Expenses" has the meaning defined in Section 7.3.

"Medical Insurance Benefits" means the Employee's Medical Insurance Plan coverage for purposes of this Plan.

"Medical Insurance Plan" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies whether fully or self-insured (with HMO and PPO options). The Employer may substitute, add, subtract or revise at any time the menu of such plans and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Open Enrollment Period" with respect to a Plan Year means the period of time in the year preceding the Plan Year as prescribed by the Plan Administrator.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Premium Payment Benefits, Health FSA Benefits or Dependent Care Assistance Program Benefits, and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their premiums under the Insurance Plans (if any) with after-tax dollars outside of this Plan and who have not elected any Health FSA Benefits or Dependent Care Assistance Program Benefits.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.2.

"Plan" means the Commerce Bancshares, Inc. Flexible Benefits Plan as set forth herein and as amended from time to time.

"Plan Administrator" shall mean the Retirement Committee of Commerce Bancshares, Inc.

"Plan Year" means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"Premium" means the amount contributed to pay for the cost of benefits (including self-funded Benefits as well as those that are self-insured), as calculated under Sections 6.2, 7.2 and 8.2.

"Premium Payment Benefits" means the Premium Payment Benefits described in Section 6.1.

"Premium Payment Component" means the Component of this Plan described in Article VI.

"QMCSO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Qualified Benefit" means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code (other than benefits excluded under Code §§ 106(b), 117, 127, or 132) and any other benefit permitted by regulations under the Code (i.e., any group-term life insurance coverage that is includible in gross income by reason of exceeding the dollar limitation on non-taxable coverage under Code § 79). Long-term care insurance shall not be a Qualified Benefit.

"Qualifying Dependent Care Services" has the meaning described in Section 8.3.

"Qualifying Individual" has the meaning described in Section 8.3.

"Related Employer" means any employer affiliated with Commerce Bancshares, Inc., that, under Code § 414(b), (c), or (m), is treated as a single employer with Commerce Bancshares, Inc., for the purposes of Code § 125(g)(4).

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the Dependent Care Assistance Program Component, the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"Student" means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual is employed by Commerce Bancshares, Inc. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the next calendar month, or for any subsequent Plan Year, in accordance with the procedures described in Article IV. For purposes of pre-taxing COBRA coverage, a former Employee receiving severance pay or other taxable compensation may continue eligibility for the remainder of the Plan Year in which the Employee ceased to be employed by the Employer, as described in Section 3.2.

3.2 Termination of Participation

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

- the termination of this Plan;
- the expiration of the Period of Coverage for which the Employee has elected to participate (unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating);
- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of pre-taxing COBRA coverage, as may be permitted by the Plan Administrator on a uniform and consistent basis (but not beyond the end of the current Plan Year) under Section 6.4 or 7.8; or
- the date the Participant revokes his or her election to participate under a circumstance when such change if permitted under the terms of this Plan.

Termination of participation in this Plan will automatically revoke the Participant's elections and terminate the Premium Payment Benefits as of the applicable dates specified in the Insurance Plans. Reimbursements from the Health FSA and Dependent Care Assistance Program Accounts after termination of participation will be made pursuant to Sections 7.8 and 8.8.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Benefits will be reinstated only to the extent that coverage under the applicable Insurance Plan is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction in hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

a) **Health Benefits.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical and Dental Insurance Benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the premium.

An Employer may elect to continue all Medical and Dental Insurance Benefits and Health FSA Benefits coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the premiums shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis if that was the method used before FMLA leave.)

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Medical and Dental Insurance Benefits and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the premium in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any, including unused sick days and vacation days), or pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the premium, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation upon the Participant's return on a pre-tax or after-tax basis).

If the Employer requires all Participants to continue Medical and Dental Insurance Benefits and Health FSA Benefits during an unpaid FMLA leave, the Participant may elect to discontinue payment of the Participant's required premiums until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the premiums not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant.

If a Participant's Medical and Dental Insurance Benefits and Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), the Participant is entitled to re-enter the Medical and Dental Insurance Benefits and Health FSA Benefits, as applicable, upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. Participants whose Medical and Dental Insurance Benefits and Health FSA Benefits coverage terminated during the leave are entitled to be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. Notwithstanding the preceding sentence, with regard to Health FSA Benefits, a Participant whose coverage ceased will be entitled to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay premiums. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

b) **Non-Health Benefits.** If a Participant goes on a qualifying leave under the FMLA, entitlement to non-health benefits (such as Dependent Care Assistance Program Benefits), is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, the Participant will upon returning from leave be required to repay the premiums not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by

the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the premium due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, the election change rules in Section 9.4 will apply.

ARTICLE IV

METHOD AND TIMING OF ELECTIONS

4.1 Elections When First Eligible

An Employee who is on the payroll as of January 1, 2003, shall be eligible to participate in the Plan as of that date. An employee who is hired after that date shall be eligible to participate on the first day of the month following thirty (30) days of employment provided the Employee properly enrolls within thirty (30) days of the date of employment. An Employee who is not on the payroll as of January 1, 2003, or who does not enroll within thirty (30) days of the date of employment, shall become eligible to participate in the Plan as of the beginning of any subsequent Plan Year, provided the Employee has been employed by the Employer for at least thirty (30) days prior to that date. An Election Form/Salary Reduction Agreement must be submitted to the Plan Administrator in order for participation to commence. An Employee who does not elect to participate when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 9.4. Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit plan or policy. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable Benefit plan or policy.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period. If an Eligible Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect to participate in this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 9.4.

4.3 Failure to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect to participate in the Plan: (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Section 9.4.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article IX), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V

BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

a) Premium Payment Benefits, as described in Article VI;

b) Health FSA Benefits, as described in Article VII; and

c) Dependent Care Assistance Program Benefits, as described in Article VIII.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.2 Employer and Participant Contributions

a) **Employer Contributions.** For Participants who elect Insurance Benefits described in Article VI, the Employer will contribute a portion of the premium as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement. There are no Employer contributions for Health FSA Benefits or Dependent Care Assistance Program Benefits.

b) **Participant Contributions.** Participants who elect any of the Insurance Benefits described in Article VI must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an the Election Form/Salary Reduction Agreement (Failure to make this election will result in the loss of your health/dental benefits). Participants who elect Health FSA Benefits or Dependent Care Assistance Program Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

a) **Salary Reductions per Pay Period.** The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) (a) the annual premium for such Benefits (as described in Sections 6.2, 7.2 and 8.2, as applicable), divided by (b) the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld may fluctuate). If a Participant increases his or her election under the Health FSA Component or the Dependent Care Assistance Program Component as permitted under Section 9.4, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 9.4, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change, (2) an amount otherwise agreed upon between the Employer and the Participant, or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld may fluctuate).

b) **Considered Employer Contributions for Certain Purposes.** Salary Reductions are applied by the Employer to pay for the Participant's share of the premiums for the Premiums Payment Benefits, the premiums for the Health FSA Benefits and the Dependent Care Assistance Program Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

c) **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions under the Health FSA account exceed the Participant's required contributions for the coverage, then the Participant may continue to receive reimbursement from the Plan for claims incurred while the FSA coverage was actively in force.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance plan. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which benefits under the Plan are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third party paying agent to make Benefit payments on its behalf. The maximum contributions that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits, as described in Section 6.2; and (b) as described under Sections 7.4(b) and 8.4(b) for Health FSA and Dependent Care Assistance Program Benefits.

ARTICLE VI

PREMIUM PAYMENT COMPONENT

6.1 Benefits

The benefits that can be elected under the Premium Payment Component (Premium Payment Benefits) are as follows:

- Medical Insurance Benefits (with or without PPO and HMO options);
- Dental Insurance Benefits;
- Voluntary Vision;
- Voluntary Cancer Plan;
- Voluntary Accident Plan

Benefits elected will be funded by Employer and Participant contributions as provided in Section 5.2. Only Qualified Benefits may be elected under this Plan. Required premiums must be paid on a pre-tax Salary Reduction basis through the Plan, failure to make this election will result in the loss of your health benefits.

Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 Benefit Premiums (aka Contributions for Cost of Coverage)

The annual premium for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier, if any.

6.3 Insurance Benefits Provided Under the Applicable Insurance Plan

All Insurance Benefits will be provided by the applicable Plan, not this Plan. The types and amounts of such Insurance Benefits, the requirements for participating in the applicable Insurance Plans, and the other terms and conditions of coverage and benefits of the Insurance Plans are set forth in the applicable Insurance Plans. All claims to receive benefits under the Insurance Plans shall be subject to and governed by the terms and conditions of the applicable Insurance Plans and the rules, regulations, policies and procedures from time to time adopted in accordance therewith, as may be amended from time to time.

6.4 Health Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Medical or Dental Insurance Benefits because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Premium Payment Component the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA), with premiums for such coverage to be paid on a pre-tax basis unless determined otherwise by the Plan Administrator on a uniform and consistent basis (but not beyond the current Plan Year).

ARTICLE VII

HEALTH FSA COMPONENT

7.1 Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses (Health FSA Benefits); and (b) to pay the premium for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article IX), such election is irrevocable for the duration of the Period of Coverage to which it relates.

7.2 Benefit Premiums (aka Contributions for Cost of Coverage)

The annual premium for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $2,400 annual benefit amount is elected, then the annual premium amount is also $2,400).

7.3 Eligible Medical Care Expenses

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.

a) **Incurred.** A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed for, is charged for, or pays for the medical care.

b) **Medical Care Expenses.** "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care as defined in Code § 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs), other than expenses that are excluded under Appendix A to this Plan, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through any Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.

Effective January 1, 2011, expenses incurred for a medicine or a drug shall be Medical Care Expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. Over-the-counter (OTC) drugs may be reimbursable expenses with a physician prescription. Over-the-counter items that are not drugs or medicines but that are for medical care may be reimbursable expenses without a physician prescription. An adequate receipt and, if for a drug or medicine expense, a physician's prescription, must be submitted to the Plan to receive reimbursement. The receipt must state the name of the medicine, drug, or other item, the date and the amount paid. The physician prescription, if for a drug or medicine expense, must include the name of the patient and the name of the medicine or drug on the corresponding receipt.

- OTC Items that are not reimbursable under any circumstances (even with a physician prescription) by the Plan include, but are not limited to:
    - Toothpaste or toothbrushes (electric or otherwise), even if a dentist recommends special ones to treat a condition;
    - Chapstick;
    - Face cream, moisteners and suntan lotion;
    - One-a-day vitamins.

7.4 Maximum and Minimum Benefits

a) **Maximum Reimbursement Available; Uniform Coverage**. The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied.

b) **Maximum and Minimum Dollar Limits.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $5,000, subject to Section 7.5 (c) below. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $120. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

c) **Changes; No Proration.** For subsequent Plan Years, the maximum and minimum dollar limits may be changed by the Plan Administrator and shall be communicate to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year, or wishes to increase his or her election mid-year as permitted under Section 9.4, there will be no proration rule---i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

d) **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election under Article IX affecting annual contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions made by the Participant (if any) as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage.

7.5 Establishment of Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant who has elected to participate in the Health FSA Component, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

a) **Crediting of Accounts.** A Participant's Health FSA Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

b) **Debiting of Accounts.** A Participant's Health FSA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

c) **Available Amount Not Based on Credited Amount.** As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements during the Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Period of Coverage, but any such

negative amount shall never exceed the maximum dollar amount of annual benefits elected by the Participant under this Plan.

7.6 Forfeiture of Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: (a) first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to any Participant in excess of the premiums paid by such Participant through Salary Reductions; (b) second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and (c) third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Procedure

a) **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

b) **Claims Substantiation.** A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than 90 days following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

- the person or persons on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Plan Administrator may request.

c) **Claims Denied.** For reimbursement claims that are denied, see the appeals procedure in Article X.

7.8 Reimbursements After Termination; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his

or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant (or the Participant's estate) files a claim within 60 days following the date participation in the plan ends.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA), with premiums for such coverage to be paid on an after-tax basis, unless permitted otherwise by the Plan Administrator on a uniform and consistent basis (but not beyond the current Plan Year). Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

7.9 Named Fiduciary; Compliance with ERISA, COBRA, HIPAA, etc.

a) **Named Fiduciary.** Commerce Bancshares, Inc. is the named fiduciary for the Health FSA Component for purposes of ERISA § 402(a).

b) **Laws Applicable to Group Health Plans.** Health FSA Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, etc.

c) **Coordination of Benefits.** Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA shall not be considered a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VIII

DEPENDENT CARE ASSISTANCE PROGRAM COMPONENT

8.1 Benefits

An Eligible Employee can elect to participate in the Dependent Care Assistance Program Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses. Benefits elected will be funded by Employer and Participant contributions as provided in Section 5.2. Unless an exception applies (as described in Article IX), such election is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 Benefit Premiums (aka Contributions for Cost of Coverage)

The annual premium for a Participant's Dependent Care Assistance Program Benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $5,000 annual benefit amount is elected, the annual premium amount is also $5,000).

8.3 Eligible Dependent Care Expenses

Under the Dependent Care Assistance Program Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

a) **Incurred.** A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, and not when the Participant is formally billed for, is changed for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

b) **Dependent Care Expenses.** "Dependent Care Expenses" means expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any), and expenses for incident household services, if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Insurance Plans, other insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's Dependent Care Assistance Program imposes maximum benefit limitations), the Dependent Care Assistance Program can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

c) **Qualifying Individual.** "Qualifying Individual" means:

- a Participant's Dependent who is under the age of thirteen (13);
- a Participant's Dependent who is mentally or physically incapable of self-care; or
- a Participant's Spouse who is mentally or physically incapable of self-care.

d) **Qualifying Dependent Care Services.** "Qualifying Dependent Care Services" means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the Dependent Care Assistance Program Component and during the Period of Coverage; and (2) are performed:

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's Dependent who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services), then the center must comply with all applicable state and local laws and regulations.

e) **Exclusion.** Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;
- a Participant's Spouse; or
- a Participant's child who is under 19 years of age at the end of the year in which the expenses were incurred.

8.4 Maximum and Minimum Benefits

a) **Maximum Reimbursement Available; Statutory Limitations.** The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's Dependent Care Assistance Program Account pursuant to Section 8.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements). Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied. Notwithstanding the foregoing, no reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the applicable statutory limit. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense, and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of $200 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $400 per month); or
- either $5,000 or $2,500 for the calendar year, as applicable:

  (1) $5,000 for the calendar year if one of the following applies:

    (A) the Participant is married and files a joint return;

    (B) the Participant is married, but (1) furnishes more than one-half the cost of maintaining the Dependent for whom the Participant is eligible to receive reimbursements under the Dependent Care Assistance Program; (2) the Participant's Spouse maintains a separate residence for the last six months of the calendar year; and (3) the Participant files a separate tax return; or

    (C) the Participant is single or is the head of the household for tax purposes; or

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

b) **Maximum and Minimum Dollar Limits.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000 (subject to the other limitations described above, and subject to Section 8.4(c)). The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $120.

c) **Changes; No Proration.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicate to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Dependent Care Assistance Program Component mid-year, or wishes to increase his or her election mid-year as permitted under Section 9.4, there will be no proration rule---i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

d) **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election under Article IX affecting annual contributions to the Dependent Care Assistance Program Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change) as further limited by Section 8.4(a). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions made by the Participant (if any) as of the end of the portion Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Dependent Care Assistance Program Account, reduced by (3) all reimbursements during the entire Period of Coverage.

8.5 Establishment of Account

The Plan Administrator will establish and maintain a Dependent Care Assistance Program Account with respect to each Participant who has elected to participate in the Dependent Care Assistance Program Component, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping tract of contributions and determining forfeitures under Section 8.6.

a) **Crediting of Accounts.** A Participant's Dependent Care Assistance Program Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

b) **Debiting of Accounts.** A Participant's Dependent Care Assistance Program Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

c) **Available Amount Is Based on Credited Amount.** As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's Dependent Care Assistance Program Account, less any prior reimbursements; i.e., it is based on the amount credited to the Dependent Care Assistance Program Account at a particular point in time. Thus, a Participant's Dependent Care Assistance Program Account may not have a negative balance during a Period of Coverage.

8.6 Forfeiture of Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's Dependent Care Assistance Program Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to reduce the cost of the cost of administering the Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and second, to provide increased benefits or compensation to Participants in subsequent years in any fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Dependent Care Assistance Program Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

8.7 Reimbursement Procedure

a) **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

b) **Claims Substantiation.** A Participant who has elected to receive DECAP Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than 90 days following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

- the person or persons on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if an individual); and
- a statement that such Expenses have not otherwise been reimbursed and are not expected to be paid through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Plan Administrator may request.

c) **Claims Denied.** For reimbursement claims that are denied, see the appeals procedure in Article XIII.

8.8 Reimbursements After Termination

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements, subject to the following: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to termination, including expenses incurred in the month following termination if such month is in the current Plan Year, provided that the Participant (or the Participant's estate) files a claim within 60 days following the date participation in the plan ends.

8.9 Report to Participants

On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the Dependent Care Assistance Program Component, as the Plan Administrator deems appropriate.

ARTICLE IX

IRREVOCABILITY OF ELECTIONS; EXCEPTIONS

9.1 Irrevocability of Elections

Except as described in this Article IX, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan;
- Salary Reduction amounts; or
- election of particular Benefit Package Options.

9.2 Procedure for Making New Election if Exception to Irrevocability Applies

a) **Timing for When New Election Must be Made.** A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days (or within 60 days in case of a special election right under Code Section 9801(f)(3) relating to the Children's Health Insurance Program) of the occurrence of an event described in Section 9.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event.

b) **Effective Date of New Election.** Elections made pursuant to this Section 9.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 9.4(e) for HIPAA special enrollment rights in the event of birth, adoption or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable Benefit Package Option commences later).

c) **Effect of New Election Upon Amount of Benefits.** For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and Dependent Care Assistance Program Components, see Sections 7.4 and 8.4 respectively.

9.3 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 9.4, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

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

b) **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption or placement for adoption;

c) **Employment Status.** Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefit plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the

consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefit plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union or non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

d) **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specific age, student status or any similar circumstance; and

e) **Change in Residence.** A change in the place of residence of the Participant or his or her Spouse or Dependents.

9.4 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

a) **Open Enrollment Period (Applies to Premium Payment, Health FSA and Dependent Care Assistance Program Benefits).** A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.

b) **Termination of Employment (Applies to Premium Payment, Health FSA and Dependent Care Assistance Program Benefits).** A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.

c) **Leave of Absence (Applies to Premium Payment, Health FSA and Dependent Care Assistance Program Benefits).** A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

d) **Change in Status (Applies to Premium Payment, Health FSA as Limited Below, and Dependent Care Assistance Program Benefits as Limited Below).** A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 9.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as a general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage on account of attaining a certain age, etc. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) **Loss of Spouse or Dependent Eligibility; Special COBRA Rules.** For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment or legal separation, (b) the deceased Spouse or Dependent, or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these

circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment or legal separation).

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

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

e) **HIPPA Special Enrollment Rights (Applies to Premium Payment Benefits That are Group Health Plans, but Not to Health FSA or Dependent Care Assistance Program Benefits).** If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

(1) A Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or

(2) A new Dependent is acquired as a result of marriage, birth, adoption or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to birth, adoption or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days);

or

(3) A Participant or his or her Spouse or Dependent declined to enroll in the Employer's group health plan because either (i) he or she was 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 eligibility for coverage is subsequently lost or (ii) he or she becomes eligible for assistance under such Medicaid plan or State child health plan to help pay for coverage under the Employer's group health plan, and he or she requests coverage under the Employer's group health plan not later than 60 days after the date of termination described in (i) or the date of eligibility described in (ii).

f) **Certain Judgments, Decrees and Orders (Applies to Premium Payment Benefits That Provide Accident or Health Coverage and to Health FSA Benefits, but Not to Dependent Care Assistance Program Benefits).** If a judgment, decree or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may (1) change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

g) **Medicare and Medicaid (Applies to Premium Payment Benefits That are Accident or Health Plans, to Health FSA Benefits as Limited Below, but Not to Dependent Care Assistance Program Benefits).** If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Further, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility Medicaid and/or the Participant's Health FSA coverage may commence or increase.

h) **Change in Cost (Applies to Premium Payment, to Dependent Care Assistance Program Benefits as Limited Below, but Not to Health FSA Benefits).** For purposes of this Section 9.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA, (2) the HMO and the PPO are considered to be similar coverage, and (3) coverage by another employer, such as a Spouse's or Dependent's employer, is treated as similar coverage.

   (1) **Increase of Decrease for Insignificant Cost Changes.** Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant bases upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

   (2) **Significant Cost Increases.** If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO) significantly increases during a Period of Coverage, the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option offered by the Employer that provides similar coverage (such as the HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) **Significant Cost Decreases.** If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO) significantly decreases during a Period of Coverage, the Plan Administrator may permit the following election changes: (a) Participant's who are enrolled in a Benefit Package Option (such as the HMO, but not the Health FSA) other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO); and (b) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) **Limitation on Change in Cost Provisions for Dependent Care Assistance Program Benefits.** The above "Change in Cost" provisions (Sections 9.4(h)(1)-(3)) apply to Dependent Care Assistance Program Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(a)(1) through (8), incorporating the rules of Code §§ 152(b)(1) and (2).

i) **Change in Coverage (Applies to Premium Payment and Dependent Care Assistance Program Benefits, but Not to Health FSA Benefits).** The definition of "similar coverage" under Section 9.4(h) applies also to this Section 9.4(i).

(1) **Significant Curtailment.** If coverage is "significantly curtailed" (as defined in subsection (i) below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth in subsection (ii) below, if the coverage curtailment results in a "Loss of Coverage" (as defined in subsection (iii) below), Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion and on a uniform and consistent basis, will decide in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(i) **Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(ii) **Significant Curtailment With a Loss of Coverage.** If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA), or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(iii) **Definition of Loss of Coverage.** For purposes of this Section 9.4(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, the HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO or the HMO);
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(2) **Addition or Significant Improvement of a Benefit Package Option.** If during a Period of Coverage, the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (1) Participants who are enrolled in a Benefit Package Option other than the newly-added or significantly improved Benefit Package Option may change their election on a prospective basis to elect the newly-added or significantly improved Benefit Package Option; and (2) Employees who are otherwise eligible under Section 3.1 may elect the newly-added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

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

(4) **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change make under the other employer plan, in accordance with prevailing IRS guidance.

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

A Participant entitled to change an election as described in this Section 9.4 must do so in accordance with the procedures described in Section 9.2.

9.5 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that

contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE X

APPEALS PROCEDURE

10.1 Insurance Plan Coverage Claims

Claims for a benefit under any Insurance Plan will be administered in accordance with the claims procedures for the applicable Insurance Benefit, as set forth in the Insurance plan documents and/or summary plan descriptions for the applicable Insurance Plans.

10.2 Procedures if Benefits are Denied Under This Plan

If (a) a claim for reimbursement under the Health FSA or Dependent Care Assistance Program Components of the Plan is wholly or partially denied, or (b) a Participant is denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to the coverage under the Plan (for example, a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under the Flexible Benefits Plan), then the claims procedures described below will apply.

If a Participant's claim is denied in whole or in part, the Participant will be notified in writing by the Plan Administrator within 30 days of the date the Plan Administrator received the claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow a Participant 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for the Participant to validate the claim and an explanation of why such material or information is necessary; and
- appropriate information of the steps to be taken if the Participant wishes to appeal the Plan Administrator's decision, including the Participant's right to submit written comments and have them considered, the Participant's right to review (upon request and at no charge) relevant documents and other information, and the Participant's right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of the claim.

10.3 Appeals by Participant

If a Participant's claim is denied in whole or part, the Participant (or his or her authorized representative) may request review upon written application to the Plan Administrator. The Participant's appeal must be made in writing within 180 days of the receipt of the notice that the claim was denied. If the Participant does not appeal on time, he or she will lose the right to appeal the denial and the right to file suit in court. The Participant's written appeal should state the reasons that he or she feels the claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his or her claim. The Participant will have the opportunity to ask additional questions and make written comments, and the Participant may review (upon request and at no charge) documents and other information relevant to the appeal.

10.4 Decision on Review

The Participant's appeal will be reviewed and decided by the Plan Administrator or other entity designated in the Plan in a reasonable time not later than 60 days after the Plan Administrator receives the request for review. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of the Participant's right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied on and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the Participant upon request; and
- a statement of the Participant's right to bring suit under ERISA § 502(a) (where applicable).

ARTICLE XI

RECORDKEEPING AND ADMINISTRATION

11.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

11.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator will respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such a manner as the Plan Administrator determines to be appropriate;

d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

j) to maintain the books or accounts, records and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

11.3 Reliance on Participant, Tables, etc.

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

11.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

11.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

11.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

11.7 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

11.8 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purpose of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

11.9 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

11.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XII

GENERAL PROVISIONS

12.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Sections 7.6 and 8.6, and then by the Employer.

12.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specified period of time. All Employees are considered to be employed at the will of the Employer.

12.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer hereby reserves the right, at any time, by action of its Board of Directors or the Human Resources and Compensation Committee of the Board of Directors, to modify, amend or terminate, in whole or in part, any or all of the provisions of the Plan, including specifically the right to make any such amendment effective retroactively. The Plan Administrator shall also be empowered to amend the Plan for purposes of legislative or regulatory compliance, administration of the Plan or that does not increase Employer contributions to the Plan. Any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

12.4 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of Missouri, to the extent not superseded by the Code, ERISA or any other federal law.

12.5 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. (ERISA applies to the Insurance Plans and the Health FSA Component but not to the Dependent Care Assistance Program Component.) This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

12.6 No Guarantee of Tax Consequences

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

12.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a pre-tax Salary Reduction basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnity and reimburse the Employer for any liability it may incur for failure to

withhold federal income taxes, Social Security taxes or other taxes from such payments or reimbursements.

12.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

12.9 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

12.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

12.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

ARTICLE XIII

ERISA RIGHTS

13.1 CERTAIN EMPLOYEE RIGHTS UNDER ERISA

The Flexible Benefits Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act (ERISA). However, the Health FSA Component and the Insurance Plans are governed by ERISA. As a Participant in an ERISA-covered benefit plan, a Participant is entitled to certain rights and protections under (ERISA).

a) **Participant Rights.** As a Participant in this Plan an individual is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

b) **COBRA and HIPAA Rights.** A Participant has a right to continue coverage under the Insurance Plans that are group health plans (and, in some cases, a Participant's Health FSA coverage) for himself or herself if there is a loss of coverage under the Plan as a result of a qualifying event. The Participant may have to pay for such coverage. Review this plan document and summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

A Participant has rights regarding reduction or elimination of exclusionary periods of coverage for pre-existing conditions under his or her group health plan, if the Participant has creditable coverage from another plan. The Participant should be provided a certificate of creditable coverage, free of charge, from his or her group health plan or health insurance issuer when the Participant loses coverage under the plan, when the Participant becomes entitled to elect COBRA continuation coverage, when the Participant's COBRA continuation coverage ceases, if the Participant requests it before losing coverage, or if the Participant requests it up to 24 months after losing coverage. Without evidence of creditable coverage, a Participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after his or her enrollment date in his or her coverage.

c) **Prudent Actions by Plan Fiduciaries.** In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participant and other Plan Participants and beneficiaries. No one, including the Participant's Employer, or any other person, may fire a Participant or otherwise discriminate against him or her in any way to prevent him or her from obtaining a plan benefit or exercising his or her rights under ERISA.

d) **Enforce a Participant's Rights.** If a Participant's claim for a benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that a Participant can take to enforce the above rights. For instance, if a Participant requests a copy of plan documents or the latest annual report (if any) from the Plan and does not receive them within 30 days, he or she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Participant has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or Federal court.

   If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U. S. Department of Labor, or he or she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person he or she has sued to pay these costs and fees. If the Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the Participant's claim is frivolous.

e) **Assistance With Participant Questions.** If a Participant has any questions about his or her Plan, the Participant should contact the Plan Administrator. If a Participant has any questions about this statement or about his or her rights under ERISA or HIPAA, or if he or she needs assistance in obtaining documents from the Plan Administrator, the Participant should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in his or her telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. A Participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

ARTICLE XIV

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

14.1 Privacy Rights

a) Use and Disclosure of Protected Health Information

Notwithstanding any provision in this Plan to the contrary, the Plan will use and disclose Protected Health Information only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations (45 C.F.R. Parts 160-164). Specifically, the Plan will use and disclose Protected Health Information for purposes related to health care treatment, payment for health care and health care operations.

b) Special Definitions

Individually Identifiable Health Information means health information that is created or received by the Plan or the Employer which relates to the past, present or future physical or mental health or condition of an individual or the past, present or future provision of health care to an individual, and which identifies (or provides a reasonable basis for identifying) such individual.

Plan Administration Functions means administration of functions performed by the Employer on behalf of the Plan (including functions related to payment, treatment or health care operations as defined in the HIPAA regulations) but excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

Protected Health Information means Individually Identifiable Health Information except as specifically excluded from this definition, that is (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media at 45 C.F.R. § 162.103 (i.e., which includes the Internet, Extranet (using Internet technology to link a business with information only accessible to collaboration parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disc, or compact disc media); or (iii) transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in (a) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (b) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (c) employment records held by a covered entity in its role as employer.

c) Certification by the Employer

Neither the Plan nor any health insurance issuer or business associate servicing the Plan shall disclose a participants Protected Health Information to the Employer unless the Employer certifies that the Plan has been amended to incorporate HIPAA's privacy provisions and agrees to abide by such privacy provisions.

d) Employer Covenants

The Employer agrees to:

- not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom the Employer provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such Protected Health Information;
- not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an individual;

- not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual with respect to whom the Protected Health Information relates;
- report to the Plan any use or disclosure of Protected Health Information of which it becomes aware that is not permitted under the Plan's privacy policies and procedures or the HIPAA privacy regulations;
- make Protected Health Information available to an individual in accordance with HIPAA's access requirements;
- make Protected Health Information available for amendment by the individual who is the subject of that information and incorporate any amendments to Protected Health Information in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

e) Adequate Separation Between the Plan and the Employer Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees of the Employer may be given access to Protected Health Information:

- The Privacy Officer; and
- Staff designated by the Privacy Officer.

f) Limitations of Protected Health Information Access and Disclosure

The persons described in paragraph E may only have access to and use and disclose Protected Health Information for the Plan Administration Functions that the Employer performs for the Plan.

g) Noncompliance Mechanism

The employees or classes of employees identified in paragraph E of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Protected Health Information and breach or violation of or noncompliance with the provisions of this section. The Employer will promptly report such breach, violation or noncompliance to the Plan as required in paragraph D, above, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any person, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

h) Electronic Protected Health Information

If the Plan discloses electronic Protected Health Information to Commerce (other than summary health information or enrollment/disenrollment information disclosed pursuant to 45 C.F.R. § 164.504(f)(1)(ii) or (iii) or information permitted to be disclosed pursuant to an individual authorization under 45 C.F.R. § 164.508), Commerce will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that Commerce creates, receives, maintains or transmits on behalf of the Plan;

- Ensure that adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

- Ensure that any agent, including subcontractor, to whom Commerce provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and

- Report to the Plan any security incident of which Commerce becomes aware.

"Electronic Protected Health Information" means individually identifiable health information that is transmitted by Electronic Media; maintained in electronic media; or transmitted or maintained in any other form or medium. Notwithstanding the foregoing Electronic Protected Health shall exclude individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g; and employment records held by an employer in its role as such.

"Electronic Media" means (1) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (2) transmission media used to exchange information already in an electronic storage media. Transmission media includes, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper via facsimile and of voice via telephone, are not considered to be transmissions via electronic media because the information being exchanged did not exist in electronic form before the transmission.

ARTICLE XV

OTHER INFORMATION

15.1 Qualified Medical Child Support Order

The components of this Plan that are group health plans extend benefits to a Participant's non-custodial child, as required by an qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

15.2 Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

15.3 Insurance Plan Documents

This plan document and summary plan description does not describe the Insurance Plans. Consult the Insurance plan documents and summary plan descriptions for each Insurance Plan.

APPENDIX A

EXCLUSIONS–MEDICAL EXPENSES THAT ARE NOT REIMBURSABLE

The Commerce Bancshares, Inc. Flexible Benefits Plan Document and Summary Plan Description contains the general rules governing what expenses are reimbursable. This Appendix A, as referenced in this document, specifies certain expenses that are not reimbursable, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under regulations governing Health FSAs.

Exclusions:

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under regulations governing Health FSAs:

- Over-the-counter drugs unless prescribed by a physician for medical care.
- Health insurance premiums that you or your Spouse pay for coverage under another health plan.
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a person injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Cost for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, unless prescribed by a physician for medical care.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code § 213.
- Any item that is not reimbursable under Code § 213 due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(B)(4) or other applicable regulations.

ERISA INFORMATION

PLAN NAME:	Commerce Bancshares, Inc. Flexible Benefits Plan
PLAN ID. NO.:	43-0889454
PLAN SPONSOR:	Commerce Bancshares, Inc. 8000 Forsyth Blvd. Suite 910 St. Louis, MO 63105 (314) 746-3757
PLAN NUMBER:	509
TYPE OF PLAN:	Flexible Benefits Plan (Cafeteria Plan, adopted pursuant to Section 125 of the Internal Revenue Code)
TYPE OF ADMINISTRATION:	Employer administration
PLAN ADMINISTRATOR:	Commerce Bancshares, Inc. 8000 Forsyth Blvd. Suite 910 St. Louis, MO 63105 (314) 746-3757
AGENT FOR SERVICE OF LEGAL PROCESS:	Commerce Bancshares, Inc. Attn: General Counsel's Office 8000 Forsyth Blvd. St. Louis, MO 63105-1797

For disputes arising under the Plan, service of legal process may be made on the Plan Administrator or on the Agent for Service of Legal Process.

PLAN YEAR:	January 1st through December 31st