# Cerner Corporation
# Flexible Spending Account Plan and Summary Plan Description

**Restated Effective January 01, 2017**

A CONSOLIDATED Plan and Summary Plan Description For The:

Cerner Foundations Premium Spending Account Plan (Plan No. 510);
Cerner Foundations Benefits Program Health Care Spending Account Plan (Plan No. 511); and
Cerner Foundations Benefits Program Dependent Care Expense Assistance Program (Plan No. 512)

Human Resources

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## About the Flexible Spending Account Plan

The Cerner Corporation Foundations Flexible Spending Account Plan (the "Plan") permits eligible Associates to take advantage of certain tax benefits provided under sections 105, 125 and 129 of the Internal Revenue Code (the "Code"). This Plan document serves as the plan document and summary plan description for the following three separate Cerner Corporation welfare plans, each of which shall be administered separately in accordance with the terms of this document.

### *The Cerner Foundations Premium Spending Account Plan*

Associates pay for their portion of any health care insurance premiums under one or more of Cerner's self-insured or fully insured health care plans on a pre-tax rather than after-tax basis. This plan is referred to in this document as the "Premium Spending Plan." This plan is not subject to ERISA.

### *The Cerner Foundations Benefits Program Health Care Spending Account Plan*

This plan serves as Cerner Corporation's health care reimbursement/flexible spending account plan, which is a self-insured medical reimbursement plan within the meaning of section 105 of the Code. Under this Plan, eligible Associates may pay for certain medical expenses, which are not otherwise covered under Cerner's Health Care Plans, on a pre-tax rather than after-tax basis. This plan is referred to in this document as the "HCFSA Plan."

### *The Cerner Foundations Benefits Program Dependent Care Expense Assistance Program*

This plan serves as Cerner Corporation's dependent care assistance plan within the meaning of section 129(d) of the Code, pursuant to which eligible Associates may pay for household and dependent care services on a pre-tax rather than after-tax basis. This Plan is referred to in this document as the "Dependent Care Assistance Plan." This plan is not subject to ERISA.

One of the most important features of each of these three benefit plans is that the benefits under them (e.g., medical care and dependent care) are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under these benefit plans, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Although each of these three plans is a separate plan for certain federal governmental reporting purposes, Cerner has consolidated the documents for these three plans into one plan document for simplification purposes. Collectively, these three plans are sometimes referred to as the "Flexible Spending Account Plan" or the "Plan." Cerner intends that this Flexible Spending Account Plan qualify as a "Cafeteria Plan" within the meaning of section 125(d) of the Code.

## About This Plan Document and Summary Plan Description

This document serves as both the Plan's plan document and the summary plan description.

Cerner reserves the right to amend or terminate the Plan at any time. You will be notified of any changes that affect Your benefits, as required by federal law.

The Plan Administrator has the complete power, in its sole discretion, to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any related documents and underlying policies). Any such determination by the Administrator shall be conclusive and binding upon all persons.

## Eligibility

All Associates are immediately eligible to participate in this Plan **except** the following:

Part-Time Associates
Any Associate who is regularly scheduled to work less than 24 hours a week, and is designated as a part-time Associate on Cerner's personnel records, shall be ineligible to participate in this Plan.

Reclassified Associates
Any individual whom Cerner does not treat as an Associate (including, but not limited to, independent contractors, persons Cerner pays outside of its payroll system and out-sourced workers) for federal income tax withholding purposes under Code section 3401(a), but for whom there is a binding determination the individual is an Associate of Cerner, shall be ineligible to participate in this Plan.

Leased Associates
Any individual who otherwise is not an Associate and who is a leased employee (including, but not limited to those individuals defined as leased employees in Code section 414(n)) shall be ineligible to participate in this Plan.

Interns and Global Assignees
Any Associate that is designated as an "intern" or "Global Assignee" on Cerner's personnel records shall be ineligible to participate in this Plan.

## Enrollment and Plan Entry Date

An Eligible Associate enrolls in this Plan by completing online or paper benefits enrollment forms containing a Benefit election and Salary Reduction Agreement and submitting to the Administrator before their applicable Enrollment Period ends. The amount an Eligible Associate contributes to the Premium Spending Plan will automatically adjust in the event of a change in the cost of the benefits selected under the Cerner Health Care Plan.

The enrollment includes an Eligible Associate's personal choices for each of the Benefits which are being offered under each Flexible Spending Account Plan. By enrolling and authorizing a Salary Reduction Agreement an Eligible Associate is authorizing Cerner to set some of his or her earnings aside on a pre-tax basis in order to pay for the benefits the Eligible Associate has elected.

The "entry date" on which an Eligible Associate will actually enter one or more of such benefit plans depends on which plans he or she elects to participate in.

An Eligible Associate shall become a Participant in the respective Flexible Spending Plans at the times set forth below. To the extent that any Associate was a Participant in one or more of the below plans on the Effective Date, such Associate shall continue to be eligible to participate in such Plan(s).

Premium Spending Plan
Eligible Associates automatically participate in the Premium Spending Plan and begin participating in the Premium Spending Plan on the first date on which the Associate is covered by a Cerner Health Care Plan for which the Associate is responsible for some or all of the premiums. In all other circumstances, an Eligible Associate will begin participating in the Premium Spending Plan on the first day of the payroll period for which a deduction is first taken from the Associate's paycheck pursuant to the Associate's election to participate in a Cerner Health Care Plan.

HCFSA Plan
If an Eligible Associate properly elects to participate in the HCFSA Plan during his or her new hire enrollment period, he or she will begin participating in the HCFSA Plan on the date of hire. In all other circumstances, an Eligible Associate will begin participating in the HCFSA plan on the first day of the payroll period for which a deduction is first taken from the Associate's paycheck pursuant to the Associate's election to participate in the HCFSA Plan.

Dependent Care Assistance Plan
If an Eligible Associate properly elects to participate in the Dependent Care Assistance Plan during his or her new hire enrollment period, he or she will begin participating in the Dependent Care Assistance Plan on the date of hire. In all other circumstances, an Eligible Associate will begin participating in the Dependent Care Assistance Plan on the first day of the payroll period

for which a deduction is first taken from the Associate's paycheck pursuant to the Associate's election to participate in the Dependent Care Assistance Plan.

Thus, all eligible expenses a Participant incurs after this entry date under either the HCFSA or the Dependent Care Assistance Plan will be reimbursable under such applicable plans. Each year during the election period, Participants will be required to re-enroll in the HCFSA Plan and/or Dependent Care Assistance Plan if he or she wants to continue participating in such plan(s). Participants already participating in the Premium Spending Plan will automatically be reenrolled in this Plan and Salary Reduction will continue to be taken, unless during the "Election Period" you elect not to participate in such plan or you are no longer eligible.

## *New Hire Enrollment Period*

A newly hired Eligible Associate's new hire enrollment period begins on the date of hire and continues for 31 days (including the date of hire). For these purposes, a newly hired Eligible Associate does not include an Associate who (1) terminates and is rehired within 30 days after termination or (2) returns to employment following an unpaid leave of less than 30 days.

## *Initial Enrollment Period*

A newly Eligible Associate's initial election period will start on the date he or she became eligible and end 31 days later (including the date he or she became eligible).

## *Annual Enrollment Period*

An Annual Enrollment Period will be held by the Plan whereby each Eligible Associate will be given the opportunity to elect to participate in one or more of the Flexible Spending Plans for the following Plan Year. With the exception of Special Enrollment Periods, this Annual Enrollment Period is the only time when Associates who did not enroll in the Plan at the time they were initially eligible may enroll in the Plan. Generally, Cerner's annual enrollment period is held sometime each year during the months of October and/or November. The exact timing of the annual enrollment period will be communicated to Participants each year.

## *Failure to Enroll*

Any Eligible Associate who fails to complete a new Salary Reduction Agreement by the end of the applicable Enrollment Period shall be treated in the following manner:

- With regard to Benefits available under the HCFSA Plan or the Dependent Care Assistance Plan, such Participant shall be deemed to have elected not to participate in such plan for the upcoming Plan Year. No further Salary Reductions shall therefore be authorized or made for the subsequent Plan Year for any Benefits

provided under these two plans.

- With regard to Benefits available under the Premium Spending Plan, such Participant shall be deemed to have elected Salary Reduction on a pre-tax basis in an amount necessary to pay the Participant's share of any Cerner Health Care Plan premiums.

## Changing Plan Election(s)

Each year Associates must elect among the various benefits offered under the Plan. Outside of this Annual Enrollment and the Special Enrollment Periods outlined above, an Associate may only change his or her Benefit election as described in this section.

An Associate may change a Benefit election after the Plan Year (to which such election relates) has commenced and make a new election with respect to the remainder of such Plan Year if the Associate experiences an event described in the applicable Treasury regulations, the provisions of which are incorporated by reference and are described in this Plan immediately below. Notwithstanding anything herein to the contrary, if the Treasury regulations conflict with this Plan, then the Treasury regulations shall control.

To change a Benefit election under this section, an Associate must notify the Plan Administrator and submit appropriate enrollment and substantiating information within 31 days of the event (60 days if the event is a special enrollment due to (i) loss of Medicaid or CHIP coverage or (ii) eligibility for a Medicaid or CHIP premium assistance subsidy). Provided that the Associate timely submits such information, the effective date of the new Benefit election will be the later of: the date of the event or the date on which the change is made by the Associate in the Cerner Benefits Enrollment application or enrollment form (except for Benefit elections on account of birth, adoption, or placement for adoption, which subject to the provisions of the underlying group health plan, may be effective retroactively).

(a) A Participant may change his or her election based on a "Change in Status," provided that the election change corresponds to or is consistent with the Change in Status. For example, a change in election is not consistent if the Change in Status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel health insurance coverage for any individual other than the one involved in such event.

In addition, if the Participant, Spouse or Dependent gains eligibility for coverage under a family member plan as a result of a change in marital status or a change in employment status, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

A change in elections is not consistent unless the Change in Status affects eligibility under an employer's plan.

Regardless of the consistency requirement, if the Participant, the Participant's Spouse, or Dependent becomes eligible for continuation coverage under a Cerner Health Care Plan as provided in Code section 4980B (COBRA) or any similar state law, then the Associate may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

For the purposes of this subsection (a), a Change in Status shall only include the following events (or other events subsequently permitted by Treasury regulations):

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

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

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

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent.

(b) Dependent Care Assistance Plan Exception. In addition to the change of election provisions set forth above, for purposes of the Dependent Care Assistance Plan, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code section 21(b) shall also qualify as a change in status.

(c) If an Associate has and exercises a special enrollment right under Code Section 9801(f), the Associate may make an election change that is consistent with the exercise of the special enrollment right. In such cases, if the Associate enrolls one or more individuals in a Cerner

Health Care Plan, the Associate will be deemed to have elected to pay the Associate's share of the premium through the Premium Spending Account.

(d) In the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA section 609) which requires health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child under the individual's plan and such coverage is actually provided.

(e) A Participant may change elections to cancel health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in one or more of Cerner's Health Care Plans and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(f) If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Reduction Agreements of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage or drop coverage prospectively if no similar coverage is offered.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage or drop coverage prospectively if no similar coverage is offered.

If, during the period of coverage, a new benefit package option or other coverage option is added (or an existing benefit package option or other coverage option is eliminated), then the affected Participants may elect the newly-added option, or elect another option if an

option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Associates who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefit plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

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 provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Assistance Plan only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code section 152(a)(1) through (8).

Notwithstanding the above, a Participant shall not be permitted to change an election to the HCFSA Plan as a result of a cost or coverage change under this subsection.

(g) A Participant taking leave under the Family and Medical Leave Act of 1993, as amended, may revoke existing elections as to the Premium Spending Plan and the HCFSA Plan. The Participant may make new elections for the remaining portion of the Plan Year, as more fully described in the section titled "Benefits and Elections During a Leave of Absence."

(h) A Participant who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Premium Spending Plan coverage, provided that the Participant certifies that he or she, and his or her Spouse and/or Dependent(s) whose coverage is being revoked, have enrolled in or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of Premium Spending Plan coverage.

## Contributions to the Plan

In general, before the start of each Plan Year, Eligible Associates will decide whether they want to participate in the HCFSA Plan or the Dependent Care Assistance Plan during the upcoming Plan Year. To become a Participant, an Eligible Associate must enroll. An Eligible Associate will automatically participate in the Premium Spending Plan, where Cerner will withhold from a Participant's paychecks enough of his or her compensation to pay for the coverage provided

under the applicable Health Care Plan(s). However, a Participant may not elect to contribute more than 50% of his or her compensation.

If an Eligible Associate wants to participate in the Dependent Care Assistance Plan or the HCFSA Plan, he or she will also need to elect the amount of money he or she wants to have deducted from his or her salary or wages to later be reimbursed to him or her for Eligible Dependent care expenses and/or eligible medical expenses. To the extent a Participant elects to participate in the Dependent Care or HCFSA Plan, the amounts that are deducted from the Participant's salary or wages will be credited to special funds or accounts which will be set up for the Participant in order to pay for the benefits he or she has chosen. The portion of a Participant's pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows a Participant to use tax-free dollars to pay for certain kinds of benefits and expenses which the Participant otherwise would pay for with out-of-pocket, taxable dollars. However, Participants who receive a reimbursement for an expense under the Plan cannot claim a Federal income tax credit or deduction on his or her tax return.

Any Salary Reduction shall be determined prior to the beginning of a Plan Year (subject to initial eligibility period elections) and prior to the end of the enrollment period and shall be irrevocable for such Plan Year, except as set forth herein. Salary Reduction amounts shall be contributed on a pro-rata basis. All individual Salary Reduction Agreements are deemed to be a part of this Plan and are incorporated by this reference.

Notwithstanding the requirement set forth herein that Salary Reductions be contributed to the Plan by Cerner on behalf of an Associate on a level and pro-rata basis for each payroll period, the Administrator may implement a procedure in which Salary Reductions are contributed throughout the Plan Year on a periodic basis that is not pro-rata for each payroll period. However, with regard to the HCFSA Plan, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event that Salary Reductions are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Reductions.

As soon as reasonably practical after each payroll period, Cerner shall credit the Salary Reduction amounts to the Participant's Premium Spending Account, HCFSA Account and/or Dependent Care Assistance Account, according to the Participant's elections.

## Benefits

Under our Flexible Spending Account Plan, you can choose to receive your entire compensation or use a portion thereof to pay for the following benefits or expenses during the Plan Year.

## HCFSA Plan

## *Establishment Of Plan*

The HCFSA Plan is intended to qualify as a medical reimbursement plan under Code section 105 and shall be interpreted in a manner consistent with such Code section and the Treasury regulations thereunder. Participants who elect to participate in this HCFSA Plan may submit claims for the reimbursement of Medical Expenses incurred by the Participant and his or her Dependents and Spouse. All amounts reimbursed under the HCFSA Plan shall be periodically paid from amounts allocated to the HCFSA Account. Periodic payments reimbursing Participants from the HCFSA Account will generally occur on a weekly basis.

The HCFSA Plan enables Participants to pay for expenses which are partially covered or may not be covered by an insured medical plan and allows the savings of taxes at the same time. The Plan allows Participants to be reimbursed by his or her HCFSA Account (which he or she has contributed to) for out-of-pocket medical, dental and vision expenses incurred by the Participant and his or her Dependents and Spouse. The expenses which qualify are generally those permitted by section 213 of the Internal Revenue Code, with some exceptions noted in the definition of "Medical Expenses" in this document. A list of covered expenses is available from the Plan's third-party administrator, Cerner HealthPlan Services. To request a copy of this list, please call Cerner HealthPlan Services at 1-877-765-1033. Current Participants may also obtain a copy of the list from the Cerner HealthPlan Services web site at www.cernerhps.com.

## *Limitation On Contributions*

Notwithstanding any provision contained in this HCFSA Plan to the contrary, no less than $250.00 and no more than $2,550 may be allocated to the HCFSA Account by a Participant in or on account of any Plan Year.

## *HCFSA Plan Claims*

All Medical Expenses incurred by a Participant or his or her Dependents or Spouse shall be reimbursed even though the submission of such a claim occurs after his or her participation hereunder ceases but provided that the Medical Expenses were incurred during the applicable Extended Plan Year. Medical Expenses are treated as having been incurred when an individual is provided with the medical care that gives rise to the medical expenses, not when the individual is formally billed or charged for, or pays for the medical care. However, if an otherwise covered Medical Expense is an advance payment for orthodontia services, and if the advance payment is made in order to obtain such orthodontia services, that Medical Expense will be treated as incurred when the payment is actually made.

The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for his HCFSA Account for the Plan Year. Reimbursements shall be made available to the Participant

throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the HCFSA Account at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

Claims for the reimbursement of Medical Expenses incurred in any Extended Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim by March 31st of the Plan Year immediately following the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The Administrator shall create administrative procedures for the handling and payment of claims and communicate the terms of such procedures to the Participants. Such administrative procedures shall require that a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense is submitted to the Administrator or the third-party administrator processing Plan claims. Furthermore, such procedures must ensure that each Participant's Medical Expenses for which a reimbursement request is being made have not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the HCFSA Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such claims for medical reimbursement applications submitted under the Plan.

In order to be reimbursed for a health care expense, a Participant must submit to the Administrator either an itemized bill from the service provider or a proper explanation of benefits form documenting the services a Participant received and the cost of such services. Alternatively, to the extent a Participant's medical expense is one that Cerner HealthPlan Services can withdraw from your HCFSA Account, the Participant may elect for such form of direct reimbursement. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursements from a Participant's account will generally be paid at least once a week.

## *Qualified Reservist Distributions*

If a Participant is a member of a reserve component (defined below), and is ordered or called to active duty for a period of 180 days or more (or for an indefinite period), the Participant is entitled to receive a distribution from his or her HCFSA Account. The amount of the distribution cannot exceed the total amount contributed by the Participant during the Plan Year in which the order or call occurs, minus the amount of reimbursed expenses prior to the date of the distribution. A written request for a distribution must be submitted by the Participant and paid by the Plan during the same time frames that would apply to an HCFSA claim occurring on the

same date as the order or call to duty. A "reserve component" means the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

### *Coordination With Flexible Spending Account Plan*

Participants under the Flexible Spending Account Plan are eligible to receive Benefits under this HCFSA Plan. The enrollment under this HCFSA Plan shall constitute enrollment under the Flexible Spending Account Plan. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Flexible Spending Account Plan.

### *Forfeitures*

The amount in the HCFSA Account as of the end of any Extended Plan Year (and after the processing of all claims for such Extended Plan Year) shall be forfeited and credited to the Benefit Plan Surplus. In such event, the Participant shall have no further claim to such amount for any reason.

## Dependent Care Assistance Plan

### *Establishment Of Plan*

The Dependent Care Assistance Plan is intended to qualify as a program under Code section 129 and shall be interpreted in a manner consistent with such section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed under this Dependent Care Assistance Plan shall be paid from amounts allocated to the Participant's Dependent Care Assistance Account.

The Dependent Care Assistance Plan enables Participants to pay for out-of-pocket, work-related Dependent daycare costs with pre-tax dollars. If a Participant is married, he or she can use the account if he or she and his or her Spouse both work or, in some situations, if his or her Spouse goes to school full-time. Single Participants can also use the account.

The Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to participate in the Dependent Care Assistance Plan and completes the appropriate Salary Reduction Agreement. In accordance with such agreement, contributions to such Dependent Care Assistance Account shall be made each pay period. The Dependent Care Assistance Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant.

In order to have the reimbursements made to a Participant from this account be excludable from the Participant's income, he or she must provide a statement from the service provider including their name, address, and in most cases, their taxpayer identification number on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses the Participant may be paying for even if he or she is not a Participant in this Plan. Participants may save more money if they take advantage of this tax credit rather than using the Dependent Care Assistance Account under the Plan. Participants should consult with his or her tax adviser.

## *Limitation On Contributions*

Notwithstanding any provision contained in this Dependent Care Assistance Plan to the contrary, no less than $250.00 and no more than $5,000 may be allocated to the Dependent Care Assistance Account by a Participant in or on account of any Plan Year.

## *Allowable Dependent Care Reimbursement*

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

Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Eligible Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for an Eligible Dependent, or for an Eligible Dependent who regularly spends at least 8 hours per day in the Participant's household;

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

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

## *Dependent Care Assistance Plan Claims*

The Administrator shall direct the payment of all such Dependent Care Assistance Plan claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement of eligible expenses.

## *Annual Statement of Benefits*

On or before January 31st of each calendar year, the Administrator shall make available to each Associate who was a Participant and received benefits during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year.

## *Limitation on Payments*

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

## *Coordination with Flexible Spending Account Plan*

Participants under the Flexible Spending Account Plan are eligible to receive Benefits under this Dependent Care Assistance Plan. The enrollment under this Dependent Care Assistance Plan shall constitute enrollment under the Flexible Spending Account Plan. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Flexible Spending Account Plan.

## *Forfeitures*

The amount in a Participant's Dependent Care Assistance Account as of the end of any Extended Plan Year (and after the processing of all claims for such Extended Plan Year) shall be forfeited and credited to the Benefit Plan Surplus. In such event, the Participant shall have no further claim to such amount for any reason. If a Participant fails to submit a claim by the March 31st following the end of the Extended Plan Year, those claims shall not be considered for reimbursement by the Administrator.

## Premium Spending Plan

The Premium Spending Plan allows Participants to pay premiums for the Cerner Health Care Plan on a pre-tax basis. Participants who enroll in a Cerner Health Plan are automatically covered under the Premium Spending Plan and use tax-free dollars to pay for certain premium expenses under various insurance programs. These premium expenses include:

- Health care premiums under any of Cerner's self-insured or fully insured Health Plans.
- Dental insurance premiums under Cerner's dental plan.
- Vision insurance premiums under Cerner's vision plan.

Cerner shall establish for each Participant a Premium Spending Account with respect to which Cafeteria Plan Dollars from the Participant's Salary Reduction Agreement shall be debited from time to time during the Plan Year in an amount of the Participant's share of the cost of the coverage selected by the Participant for such Plan Year under Cerner Health Care Plans.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. Also, a Participant's coverage will end when he or she leaves employment, is no longer eligible under the terms of any coverage, or when coverage terminates.

***Notwithstanding any provision contained in this Premium Spending Account to the contrary, no more than the Associate's share of the applicable premium may be allocated to the Premium Spending Account by a Participant in or on account of any Plan Year.***

Under this Premium Spending Plan, Eligible Associates automatically apply the amounts contributed to their Premium Spending Account toward the cost of coverage under one or more of Cerner's Health Care Plans. While the automatic enrollment to use amounts in the Premium Spending Account toward the Associate's cost of such coverage are made under this Plan, the coverage and benefits under such Cerner Health Care Plan(s) will be provided not by this Plan but by the respective Cerner Health Care Plan(s).

### *Adjustment of Compensation Reductions*

If the cost under a Cerner Health Care Plan for which a Participant has elected to pay his or her premiums through this Premium Spending Plan increases or decreases during a Plan Year, including any increase or decrease due to a change in the Participant's salary or wages, a corresponding change shall be made in the Salary Reductions of the Participant in an amount reflecting such increase or decrease, as determined by the Administrator.

### *Coordination with Flexible Spending Account Plan*

Participants under the Flexible Spending Account Plan are eligible to receive Benefits under this Premium Spending Plan. The enrollment under the Flexible Spending Account Plan shall constitute enrollment under this Premium Spending Plan. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Flexible Spending Account Plan.

## Claims for Benefits

### *Submission of Claims*

A Participant who has entered into a Salary Reduction Agreement for Qualified Medical Expenses or Dependent Care Expenses may apply for reimbursement of such expenses by submitting a claim form in writing to the Administrator on or before the March 31 following the end of the Plan Year, in such form as the Plan Administrator may describe, stating that such expense has not been reimbursed and/or is not reimbursable from any other source. The claim form shall be accompanied by a written statement from the service provider or an appropriate, independent third party stating that the expense has been incurred and the amount of such expense. The aggregate amount paid to a Participant for reimbursement of expenses incurred in an Extended Plan Year shall not exceed the Participant's Salary Reduction designation for that Plan Year. Any claim for individual benefits under a Health Care Plan shall be administered in accordance with the provisions of the applicable plan.

### *Payment of Claims*

Upon the submission of a properly executed claim for reimbursement by a Participant, if sufficient funds exist in the applicable account, the Administrator shall reimburse the Participant as soon as administratively feasible upon receipt of the claim and in accordance with the procedures set forth herein. The total amount of Salary Reduction designated by a Participant for a Plan Year for reimbursement of Qualified Medical Expenses shall be made available for payment of claims during the entire Extended Plan Year. However, no reimbursement of Dependent Care Expenses shall be made to a Participant unless the amount of Salary Reduction contributions to the credit of the Participant is sufficient to pay the claim.

## *Unused Funds*

Any money left in a Participant's HCFSA Account and/or Dependent Care Assistance Plan at the end of the Extended Plan Year (March 15, of the following Plan Year), will be forfeited and credited to the Benefit Plan Surplus unless a Participant submits a proper claim for reimbursement (for expenses incurred during the Plan Year or Extended Plan Year) by March 31st of the following Plan Year. Thus, if a Participant incurs qualifying expenses from January 1 of a Plan Year through March 15 of the following Plan Year, a Participant will be paid this money before any amount is forfeited. However, the Participant must submit his or her requests for reimbursement no later than the 31st of March after the end of the Plan Year.

Because it is possible to forfeit amounts in the Plan if a Participant does not fully use the funds, it is important that Participants decide, carefully and conservatively, how much to contribute to his or her HCFSA Account and/or his or her Dependent Care Assistance Account.

## Benefits and Elections during a Leave of Absence

A Participant on FMLA Leave may continue all benefits during the leave.

If a Participant elects to continue participation during ***unpaid FMLA*** Leave, the Participant must pay an amount equal to the amount of money that he or she would have been required to pay had he or she not taken such leave. The Participant may elect to pay such amounts under one of the following methods, determined in accordance with a policy established by the administrator.

(a) Pre-pay. Before commencement of leave, pay anticipated amounts through pre-tax or after-tax Salary Reduction Agreement from any taxable compensation, provided all other plan requirements are met.

(b) Pay-as-you-go. Participants may pay their share of premium payments on the same schedule as payments would be made if the Participant were not on leave, or under another schedule permitted under Department of Labor regulations. Cerner shall not be required to continue the health coverage of a Participant who fails to make required premium payments while on leave. However, if Cerner chooses to continue the health coverage of a Participant who fails to make required premium payment while on leave, Cerner is entitled to recoup those payments after the Participant returns from leave.

(c) Catch-up. Under this payment option Cerner shall advance the Participant's share of group health premiums while the Participant is on leave and thereafter shall be entitled to recover such advanced amounts when the Participant returns from leave. Upon return from leave, the Participant may pay the catchup amount in a lump sum payment prior to or on the first payroll date following the Participant's return to work, or in pro rata amounts as additional Cafeteria Plan Dollars withheld from the Participant's Compensation during the remainder of

the Plan Year.

If a Participant elects to continue participation during ***paid FMLA*** Leave, the Participant must pay an amount equal to the amount of money that he or she would have been required to pay had he or she not taken such leave. The Participant must make payments using the pay-as-you-go method.

A Participant on ***unpaid Non-FMLA*** Leave may continue participation in medical, dental, and vision coverage, the HCFSA and the Dependant Care Assistance Plan. If a Participant elects to continue participation during unpaid Non-FMLA Leave, the Participant must pay 100% of the cost (including any portion that was previously paid by Cerner), on an after-tax basis, using either the pre-pay method or pay-as-you-go method.

A Participant on ***paid Non-FMLA*** Leave may continue all benefits during the leave. If a Participant elects to continue participation during paid Non-FMLA Leave, then until the end of the Plan Year in which the leave begins, the Participant must pay an amount equal to the amount of money that he or she would have been required to pay had he or she not taken such leave. In the following Plan Year, the Participant must pay 100% of the cost (including any portion that was previously paid by Cerner). All such payments shall use the pay-as-you-go method.

## Termination of Participation

A Participant's participation in this Plan shall cease upon the occurrence of any of the following events:

- Termination of the Participant's employment or failure to meet the eligibility requirements under the Plan.
- The Participant's death.
- The termination of this Plan.
- The Participant fails to make required contributions under the Plan.

## *Termination of Employment*

If a Participant's employment with Cerner is terminated for any reason other than death, his or her participation shall be governed in accordance with the following.

With regard to the Premium Spending Plan, participation shall cease on the date of termination. No further contributions shall be made to the Participant's Premium Spending Account after the date of termination.

With regard to the Dependent Care Assistance Plan, active participation shall cease on the date of termination. No further contributions shall be made to the Participant's Dependent Care Assistance Account after the date of termination. However, the Participant may continue to submit claims for employment-related Dependent Care Expenses incurred prior to the date of termination. Such expenses will be reimbursed only to the extent of the Cafeteria Plan Dollars that have been allocated to the Participant's Dependent Care Assistance Account.

With regard to the HCFSA Plan, the Participant may choose to continue his participation for the remainder of the Plan Year in which termination occurs by electing COBRA coverage (see section titled "Continue Group Health Plan Coverage" below).

(a) If the Participant chooses to continue participation in the HCFSA Plan for the remainder of the Plan Year in which termination occurs, the Participant shall be required to make contributions to the HCFSA Account based on the elections made prior to the beginning of the Plan Year. The Participant may continue to submit claims for expenses incurred during the Extended Plan Year in which termination occurred.

(b) If the Participant does not choose to continue participation in the HCFSA Plan for the remainder of the Plan Year in which termination occurs, the Participant's participation shall cease as of the last day of the payroll period for which the Participant is compensated. No further contributions shall be made to the Participant's HCFSA Account thereafter. However, the Participant may continue to submit claims for expenses incurred during the portion of the Plan Year preceding his date of termination. Such Participant will have until the March 31 immediately following the end of the Plan Year in which the Participant ceased to be employed to submit a claim for reimbursement. After such date, any amounts in the Participant's HCFSA Account will be forfeited and credited to the Benefit Plan Surplus.

(c) If the Participant's participation in the HCFSA Plan ends during the Plan Year, and if Salary Reductions for the Participant were made other than on a pro rata basis, then upon termination the Participant shall be entitled to a refund pursuant to this paragraph. The Participant shall receive a refund for any Salary Reductions which were made before the date of the Participant's termination but which relate to coverage or benefits after the date of the Participant's termination.

This Section shall be applied and administered consistent with rights to which a Participant and his Dependents may be entitled under Code section 4980B and the Continuation of Coverage Section of this Plan.

## *Death*

If a Participant dies, his or her participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his estate, may submit claims for expenses incurred prior to the Participant's death. Such claims shall be submitted no later than the March 31

immediately following the end of the Plan Year in which the Participant dies and will be reimbursed only to the extent that Cafeteria Plan Benefit Dollars were allocated to each specific benefit prior to the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Administrator may designate the Participant's Spouse, one of his Dependents or a representative of his estate.

## *Amendment or Termination of the Flexible Spending Account Plan*

Cerner expressly reserves the right to amend, discontinue or terminate the Plan at any time for any reason. No Eligible Associate or their Dependent shall have or attain any vested right, contractual or otherwise, to any further contributions to the Plan by Cerner after Cerner has discontinued or terminated the Plan. Eligible Associates cannot and should not rely on the Associate's contributions to the Plan as a form of compensation for past or future services.

## Continue Group Health Plan Coverage

Notwithstanding anything in the Plan to the contrary, in the event any benefit under the HCFSA Plan that is subject to the continuation coverage requirement of Code section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code section 4980B.

***This section ("Continue Group Health Plan Coverage") applies only to the HCFSA Plan.***

## *COBRA Notice*

### Introduction

The following paragraphs generally explain COBRA coverage under the HCFSA Plan, when it may become available to you and your family, and what you need to do to protect the right to receive it. The description of COBRA coverage contained in this section applies only to the HCFSA Plan and not to any other benefits offered under the Plan or by Cerner.

### What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section titled "Who Is Entitled to Elect COBRA?"

*COBRA Coverage May Become Available to "Qualified Beneficiaries."* After a qualifying event occurs and any required notice of that event is properly provided to Cerner, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your Spouse and Dependent children could become qualified beneficiaries and be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns,

newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

### COBRA Coverage Under the HCFSA Plan

*COBRA Coverage Is Offered Only in Limited Circumstances.* COBRA coverage under the HCFSA Plan will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered Associate, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for HCFSA Plan COBRA coverage that will be charged for the remainder of the plan year.

*Health FSA COBRA Coverage Lasts Only Until the End of the Plan Year.* Participants with underspent accounts can continue HCFSA Plan benefits only through the end of the year in which the COBRA qualifying event occurs. Qualified beneficiaries who continue coverage through December 31 may receive reimbursement of medical expenses incurred prior to the close of the Extended Plan Year in which the qualifying event occurred.

*All Qualified Beneficiaries Are Covered Together Under the HCFSA Plan Unless Otherwise Elected.* Unless otherwise elected, all qualified beneficiaries who were covered under the HCFSA Plan will be covered together for HCFSA Plan COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate HCFSA Plan annual limit and a separate premium. If you are interested in this alternative, contact Cerner for more information.

*No HCFSA Plan Open Enrollment.* Qualified beneficiaries may not enroll in the HCFSA Plan at open enrollment.

### Who Is Entitled to Elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

*Qualifying Events for the Covered Associate.* If you are a covered Associate, you will be entitled to elect COBRA if you lose coverage under the HCFSA Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

*Qualifying Events for the Covered Spouse.* If you are the Spouse of a covered Associate, you will be entitled to elect COBRA if you lose coverage under the HCFSA Plan because any of the

following qualifying events happens:

- your Spouse dies;
- your Spouse's hours of employment are reduced;
- your Spouse's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your Spouse. Also, if your spouse (the Associate) reduces or eliminates your coverage under the HCFSA Plan in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are the Dependent child of a covered Associate, you will be entitled to elect COBRA if you lose coverage under the HCFSA Plan because any of the following qualifying events happens:

- your parent-Associate dies;
- your parent-Associate's hours of employment are reduced;
- your parent-Associate's employment ends for any reason other than his or her gross misconduct; or
- you stop being eligible for coverage under the Plan as a Dependent.

*Electing COBRA After Leave Under the Family and Medical Leave Act (FMLA).* Under special rules that apply if an Associate does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the HCFSA Plan during the leave. Contact Cerner for more information about these special rules.

**When Is COBRA Coverage Available?**

When the qualifying event is the end of employment, reduction of hours of employment, or death of the Associate, the Plan will offer COBRA coverage under the HCFSA Plan to qualified beneficiaries. You need not notify Cerner of any of these qualifying events.

*You Must Notify the Plan Administrator of Certain Qualifying Events by This Deadline.* **For the other qualifying events (divorce or legal separation of the Associate and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), a COBRA election will be available to you only if you notify Cerner in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying**

**event.**

*No COBRA Election Will Be Available Unless You Follow the Plan's Notice Procedures and Meet the Notice Deadline.* **In providing this notice, you must contact the HR Service Center to initiate the process, and you must follow the notice procedures specified in the section below titled "Notice Procedures." If these procedures are not followed during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

**Notice Procedures**

***Warning***

**If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA.**

**Notices Must Be Written and Submitted on Plan Forms or through an Approved Online Application**

Any notice that you provide must be submitted on the Plan's required form or through an online application specified by the HR Service Center.

**How and When to Send Notices**

You may provide a notice only by mailing, hand-delivery or through an online application specified by the HR Service Center. Delivery by another method, including by fax or email, is not acceptable. Mailed notices should be sent to:

Cerner Corporation
HR Service Center – W0131
2800 Rockcreek Parkway
Kansas City, MO 64117
(866) 434-1543

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice period is described in the paragraph above entitled "You must notify the plan administrator of certain qualifying events by this deadline.")

**Information Required for All Notices**

Cerner will require the following information from you: (1) the name of the Plan (Cerner Corporation Flexible Spending Account Plan); (2) the name and address of the Associate who is

(or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary/beneficiaries who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, name, address, and telephone number of the person providing the notice. It may request such information on such notice, separately after you provide notice, or use information already available to it.

**Who May Provide Notices**

The covered Associate (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

**Electing COBRA Coverage**

*How to Elect COBRA.* **To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and deliver it to:**

**Cerner HealthPlan Services**
**Attn: COBRA**
**P.O. Box 12524**
**Kansas City, MO 64116-0524**
**1-877-765-1033 (phone)**
**1-816-571-6994 (fax)**
**clientservices@cernerhps.com**

An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may provide the Election Form only by mail, hand-delivery, fax or email.

*Deadline for COBRA Election.* **If mailed, your election must be postmarked (or if hand-delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). Faxed or emailed forms will be considered submitted on the date they are received by Cerner HealthPlan Services. IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

*Independent Election Rights.* Each qualified beneficiary will have an independent right to elect COBRA. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

### Length of COBRA Coverage

**COBRA coverage under the HCFSA Plan is temporary and can last only until the end of the year in which the qualifying event occurred—see the section above entitled "COBRA Coverage Under the HCFSA Plan."**

### Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage under the HCFSA Plan will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time; or
- Cerner ceases to provide any group health plan for its employees.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

### Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

### Payment for COBRA Coverage

*How Premium Payments Must Be Made.* Unless you are able to continue eligibility in the Salary Reduction Plan and pay your COBRA premiums on a pre-tax basis, all COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

*When Premium Payments Are Considered to Be Made.* If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

*First Payment for COBRA Coverage.* If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is

postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact Cerner using the contact information provided below to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

**If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.**

*Monthly Payments for COBRA Coverage.* After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Cerner will not send periodic notices of payments due for these coverage periods (that is, **we will not send a bill to you for your COBRA coverage—it is your responsibility to pay your COBRA premiums on time**).

*Grace Periods for Monthly COBRA Premium Payments.* Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month so long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for reimbursement of a medical expense incurred while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

**If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.**

### More Information About Individuals Who May Be Qualified Beneficiaries

*Children Born to or Placed for Adoption With the Covered Associate During a Period of COBRA Coverage.* A child born to, adopted by, or placed for adoption with a covered Associate during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered Associate is a qualified beneficiary, the covered Associate has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Associate. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

*Alternate Recipients Under QMCSOs.* A child of the covered Associate who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Cerner during the covered Associate's period of employment with Cerner is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Associate.

## Flexible Spending Account Plans and Social Security Benefits

Participants in one or more of the Flexible Spending Account Plans may have their Social Security benefits slightly reduced. When Participants receive tax-free benefits under this Plan, the amount of contributions that he or she makes to the Federal Social Security system as well as Cerner's contribution to Social Security on the Participant's behalf may be reduced.

## Highly Compensated Associates

Under the Internal Revenue Code, highly compensated Associates and key Associates generally are Participants who are officers, shareholders or highly paid. The Administrator will determine each Plan Year whether a Participant is a highly compensated Associate or a key Associate.

If a Participant is within these categories, the amount of contributions and benefits for him or her may be limited so that the Flexible Spending Account Plan as a whole does not unfairly favor those who are highly paid, their Spouses or their Dependents. Federal tax laws state that a plan will be considered to unfairly favor the key Associates if they, as a group, receive more than 25% of all of the nontaxable benefits provided for under the Plan.

Plan experience will dictate whether contribution limitations on highly compensated Associates or key Associates will apply. Participants will be notified of these limitations if they are affected.

## *Nondiscrimination Requirements*

It is the intent of this Plan to provide only those benefits which the Secretary of the Treasury would determine to be nondiscriminatory in accordance with Code sections 105, 125, and 129.

If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Associates or a group of Associates in whose favor discrimination may not occur in violation of Code sections 105, 125 and 129, the Administrator may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an Associate who is highly compensated or a Key Associate, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable benefits reduced until the discrimination tests set forth are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth are satisfied. With respect to any affected Participant who has had Benefits reduced, the reduction shall be made proportionately among HCFSA Plan Benefits and Dependent Care Assistance Plan Benefits, and once all these Benefits are expended, proportionately among Premium Spending Plan Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the Benefit Plan Surplus.

# Additional Plan Information

## *Your Rights Under ERISA*

Participants in the HCFSA Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants in the HCFSA Plan shall be entitled to:

## *Receive Information About Your HCFSA Plan and Benefits*

Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Administrator, copies of documents governing the operation of the HCFSA Plan, including insurance contracts and collective bargaining agreements, and

copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the HCFSA plan's annual financial report. The Administrator is required by law to furnish each Participant with a copy of this summary annual report.

## *Prudent Action by Plan Fiduciaries*

In addition to creating rights for HCFSA Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the HCFSA Plan. The people who operate the HCFSA Plan, called "fiduciaries" of the HCFSA Plan, have a duty to do so prudently and in the interest of the Participants and beneficiaries. No one, including the employer, any union, 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 welfare benefit or exercising his or her rights under ERISA.

## *Enforce Your Rights*

If a Participant's claim for a Benefit is denied or ignored, in whole or in part, Participants have a right to know why this was done, to obtain copies free of charge of documents relating to the decision, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps Participants can take to enforce the above rights. For instance, if a Participant requests a copy of the HCFSA Plan documents or the latest annual report from the HCFSA Plan and does not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the HCFSA Plan administrator to provide the materials and pay the Participant up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, a Participant may file suit in a state or Federal court. In addition, if a Participant disagrees with the HCFSA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that HCFSA Plan fiduciaries misuse the HCFSA Plan's money, or if a Participant is discriminated against for asserting his or her rights, he or she 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 he or she is successful, the court may order the person he or she sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees; for example, if it finds the claim is frivolous.

## *Assistance with Your Questions*

If a Participant has any questions about the HCFSA Plan, the Participant should contact the Administrator. If a Participant has any questions about this statement or about their rights under ERISA, or if a Participant needs assistance in obtaining documents from the Administrator, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the Participant's telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Participant may also obtain certain publications about Participant rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## Claims Appeal Procedures

Any claim for Benefits under any one of the Flexible Spending Account Plans shall be handled by the Administrator in accordance with the following claims procedures. The exhaustion of the claims appeals procedures set forth below is mandatory for resolving every claim and dispute arising under the Plan. As to such claims and disputes: (a) no claimant shall be permitted to commence any legal action to recover Plan benefits or to enforce or clarify rights under the Plan under any provision of law, whether or not statutory, until the claims appeal procedure has been exhausted in its entirety; and (b) in any such legal action all explicit and all implicit determinations by the Plan Administrator (including, but not limited to, determinations as to whether the claim, or a request for a review of a denied claim, was timely filed) shall be afforded the maximum deference permitted by law.

No legal action to recover Plan benefits or to enforce or clarify rights under the Plan under any provision of law, whether or not statutory, may be brought by any claimant on any matter pertaining to the Plan unless the legal action is commenced in the proper forum before the earlier of: (a) 30 months after the claimant knew or reasonably should have known of the principal facts on which the claim is based, or (b) six months after the claimant has exhausted the claims appeal procedure set forth below. Knowledge of all facts that the Participant knew or reasonably should have known shall be imputed to every claimant who is or claims to be a beneficiary of the Participant or otherwise claims to derive an entitlement by reference to the Participant for the purpose of applying the previously specified periods.

The Plan Administrator and all persons determining or reviewing claims have full discretion to determine benefit claims under the Plan. Any interpretation, determination or other action of such persons shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the persons reviewing a claim shall be based only on such evidence presented to or considered by such persons at the time they made the decision that is the subject of review.

## *Claims under the HCFSA Plan*

Notwithstanding the foregoing, any claim for Benefits under the HCFSA Plan shall be handled by the Administrator in accordance with the following claims procedures.

### *Initial Denial of Claim*

The Administrator will provide the claimant with notification of whether the claimant's claim for benefits is accepted or denied within 30 days after the claimant filed his or her initial claim. In the event that, due to matters beyond control of the Plan, the Administrator cannot make a determination as to whether to accept or deny the claimant's claim for benefits, the Administrator shall have an additional 15 days (i.e., 45 days after the initial claim was filed) to provide the claimant with its decision. If the Administrator needs an extension of time, it will notify the claimant within the first 30 days of the necessity and reason(s) for the extension.

### *Insufficient Information*

In the event that the Administrator determines that it has insufficient information to determine whether to accept or deny the claim, it will notify the claimant of such a determination. Following such a notice, the claimant will have 45 days to provide the Administrator with the additional information that it requests. Following the receipt of the additionally requested information, the Administrator shall have 30 days to review the claim.

### *Denial of Claim*

If the Administrator denies the claimant's claim, it will provide the claimant with written or electronic notification of such claim denial. The notice will state:

- The specific reason or reasons for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review.

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

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

## *Appeal*

When the claimant receives the denial, the claimant shall have 180 days following receipt of the notification in which to appeal the decision. The claimant may submit written comments, documents, records, and other information relating to the claim. If the claimant requests, the claimant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing. A document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the claim determination;

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

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

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

## *Review of Appeal*

Once an appeal has been filed, a review of the appeal will be conducted by a fiduciary of the Plan who is neither the individual who made the initial adverse determination nor a subordinate of that individual. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the

claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted de novo. The Administrator will make its decision of the benefit determination on appeal and will notify the claimant of such decision with 60 days after the appeal has been filed.

If the Administrator denies the claimant's appeal, the Administrator shall provide the claimant with a notice, written in a manner calculated to be understood by the claimant, setting forth:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the benefit determination is based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information, and a statement of the claimant's right to bring an action under section 502(a) of the Act.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

## *Retroactive Acceptance of Claim*

For purposes of the HCFSA Plan, as long as a Participant's initial claim was submitted to the Administrator prior to March 31st of the Plan Year following the Plan Year in which the medical expense was incurred, if such claim, although initially denied, is subsequently honored in accordance with these claims procedures, such claim will be processed as if such claim had been processed prior to the original March 31st deadline.

## *Claims under Premium Spending and Dependent Care Assistance Plans*

The following claims procedures shall apply with respect to claims made under the Premium Spending Plan or the Dependent Care Assistance Plan.

### *Initial Denial of Claim*

If the Administrator denies any claim, the Administrator will provide notice to the claimant, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

### *Denial of Claim*

If the Administrator denies the claimant's claim, it will provide the claimant with written or electronic notification of such claim denial. The notice will state:

- The specific reason or reasons for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

## *Appeal*

When the claimant receives the denial, the claimant shall have 60 days following receipt of the notification in which to appeal the decision. The claimant may submit written comments, documents, records, and other information relating to the claim. If the claimant requests, the claimant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing. A document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the claim determination;
- was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents, and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

## *Review of Appeal*

Once an appeal has been filed, a review of the appeal will be conducted by a fiduciary of the Plan who is neither the individual who made the initial adverse determination nor a subordinate of that individual. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will be conducted without affording any deference to the initial denial. The fiduciary designated to decide the appeal will make its decision of the benefit determination on appeal and will notify the claimant of such decision within 60 days after the appeal has been filed, unless the Administrator determines that special circumstances require an extension of time for reviewing the appeal. If the Administrator determines that an extension of time for review is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an

extension of time and the date by which the plan expects to render the determination on review.

If the Administrator denies the claimant's appeal, the Administrator shall provide the claimant with a notice, written in a manner calculated to be understood by the claimant, setting forth:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the benefit determination is based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information, and a statement of the claimant's right to bring an action under section 502(a) of the Act.

## Military Leave

If you are going into, or returning from, military service, you may have special rights to health care coverage under your HCFSA Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, please refer to Cerner's Military Leave of Absence Policy or ask the Cerner Benefits Team for further details.

## Uniform Services Employment and Reemployment Rights Act ("USERRA")

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

## Health Insurance Portability and Accountability Act ("HIPAA")

(a) Hybrid Entity Statement. The Plan includes both Covered Components and Non-covered Components, and therefore is a Hybrid Entity. The Plan hereby elects to provide privacy protections only to the Covered Components. The Plan's only Covered Component is the HCFSA.

(b) Definitions. For purposes of this Article, all terms not specifically defined in this Article shall have the meaning ascribed to them in the Privacy Rule and the Security Rule.

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

(2) "Privacy Rule" and "Security Rule" mean means HIPAA's implementing regulations at 45 CFR Parts 160, 162, and 164.

(3) "Privacy Workers" means employees, volunteers, trainees and other persons whose conduct, in the performance of work for Employer, is under the direct control of Employer, whether or not they are paid by Employer. Privacy Workers include associates of Employer who are part of the following groups: Benefits, Payroll, HR Solutions Management, Enterprise Solutions, Office Services, Legal, HR Service Center, and any other individuals appointed by the Privacy Officer who are permitted, under the Plan and HIPAA to access, use, and disclose the PHI that is within the Plan's control. This list includes every person who is under the control of Employer and who may receive Participants' PHI.

(c) Disclosure to Employer.

(1) For the purpose of conducting Plan Administration Functions on behalf of the Plan, which functions must be consistent with HIPAA and the Privacy Rule, Employer shall be entitled to receive PHI from: the Plan; any business associate of the Plan; any person or entity that contracts with such business associate; any person or entity that contracts with Employer to provide services to or on behalf of the Plan; any health insurer or health insurance issuer or HMO that provides health benefits coverage or services to or on behalf of the Plan; any health care clearinghouse that provides services to or on behalf of the Plan or with respect to Plan Participants; and any other person or entity that maintains, or has the authority to direct the disclosure of, PHI related to any Participant.

(2) None of the foregoing shall disclose PHI to Employer unless the Notice of Privacy Practices distributed to the Participants explains that Employer is entitled to receive PHI.

(3) None of the foregoing shall disclose PHI to Employer for the purpose of employment-related actions or decisions, or in connection with any other employee benefit or employee benefit plan of Employer.

(4) The Plan may disclose Summary Health Information to Employer.

(5) The Plan may disclose to Employer information on whether an individual is participating in the Plan, or is enrolled or has disenrolled from a particular coverage options within the Plan.

(d) Restrictions on Employer's Use and Disclosure of PHI.

(1) Employer will not use or disclose Plan Participants' PHI, except as required by law, or as permitted or required by the Plan Document, as amended.

(2) Employer will ensure that any agent, including any subcontractor, to whom it provides Participants' PHI, agrees to the restrictions and conditions of this section of the Plan with respect to Plan participants' PHI.

(3) Employer will not use or disclose PHI that is Genetic Information about an individual for underwriting purposes. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

(4) Employer will not use or disclose Participants' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer.

(5) Employer will comply with the requirements of the HITECH Act and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if the Employer or one of its business associates discovers a breach of unsecured PHI.

(6) Promptly upon learning of any use or disclosure of Participants' PHI that is inconsistent with the uses and disclosures allowed under this section of the Plan, Employer will report such inconsistent use or disclosure to the Plan.

(7) Employer will make PHI available to the Participant who is the subject of the information, in accordance with 45 CFR § 164.524.

(8) Employer will make Participants' PHI available for amendment, and will amend Participants' PHI, in accordance with 45 CFR § 164.526.

(9) Employer will track its disclosures of Participants' PHI, in order to provide the information necessary for the Plan to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(10) Employer will make its internal practices, books, and records (as they relate to its use and disclosure of Plan Participants' PHI) available to the U.S. Department of Health and Human Services for the purpose of determining compliance with 45 CFR Parts 160-64.

(11) If feasible, Employer will return or destroy all Participants' PHI that Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not

feasible, Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(12) Employer will consider requests by a Plan Participant to restrict uses and disclosures of the Participant's PHI to carry out treatment, payment, or health care operations, or restrict uses and disclosures to Participant's family members, relatives, friends or other persons identified by the individual who are involved in care or payment of care. Except as otherwise provided, Employer is not required to agree to the Plan Participant's request; however, if Employer does agree to the request, the request will be honored until the Plan Participant revokes it, or until Employer notifies the individual that the Employer will no longer honor the request. Employer must comply with the restriction request if: (1) except as otherwise provided by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for the purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

(e) Adequate Separation Between Employer and the Plan.

(1) Only Privacy Workers may be given access to Participants' PHI by Employer.

(2) The Privacy Workers listed above will have access to Plan Participants' PHI only to perform the Plan Administration Functions that Employer conducts for the Plan.

(3) The Privacy Workers listed above will be subject to appropriate disciplinary action and sanctions, up to and including termination of employment or affiliation with Employer, for any use or disclosure of Plan Participants' PHI in violation of the provisions of this Article. Employer will promptly report such violation to the Plan, as required by other provisions of this Plan, and will cooperate with the Plan in order to: correct the violation; impose appropriate disciplinary action or sanctions on each person causing the violation; and mitigate any negative effect of the violation on any Participant, the privacy of whose PHI may have been compromised by the violation.

(f) Uses and Disclosures of PHI by Employer.

(1) Permitted Uses and Disclosures. Employer is entitled to use and disclose any PHI obtained pursuant to this Plan only for the purposes of Plan Administration Functions.

(2) Required Uses and Disclosures. Employer shall be required to use and/or disclose PHI: (i) to an individual, when requested under and required by 45 CFR § 164.524 in order to provide an individual with access to his or her own PHI; (ii) to an individual, when requested under and required by 45 CFR § 164.528 in order to provide an individual with an accounting of disclosures of that individual's PHI; and (iii) when required by the Secretary of the Department of Health and Human Services or those acting under the authority or at the

direction of the Secretary to investigate or determine the Plan's compliance with the Privacy Rule.

(g) Minimum Necessary. Employer must make reasonable efforts to limit its use or disclosure of PHI to the minimum information necessary to accomplish the intended purpose of the use or disclosure. When requesting PHI from another party, Employer must make reasonable efforts to limit its request to the minimum information necessary to satisfy the purpose of the request.

(h) Employer's Certification of Compliance. Neither the Plan, nor any health insurance issuer or business associate providing services to the Plan, will disclose Participants' PHI to Employer unless Employer certifies that the Plan Documents have been amended to incorporate this Article and agrees to abide by this Article.

(i) Security Provisions. Employer will:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that the adequate separation required by § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(4) Report to the Plan any security incident of which it becomes aware.

(j) Breach Notification of Unsecured PHI.

The Plan will provide proper notification in the event of a Breach of Unsecured PHI, as required by HIPAA. Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in guidance. Upon the event of a Breach of Unsecured PHI, the Plan will take appropriate steps to cure the breach and prevent further unauthorized disclosures.

(k) In the event of noncompliance with any of the provisions set forth in this section:

The HIPAA Privacy Officer or Security Officer, as appropriate, will address any complaint promptly and confidentially. The HIPAA Privacy Officer or Security Officer, as appropriate, first will investigate the complaint and document the investigative efforts and findings.

If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this section of the Plan, the HIPAA Privacy Officer and/or the Security Officer, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

## Definitions

Unless otherwise set forth in this Plan, the following terms have the following meanings:

**Administrator**
Means Cerner Corporation and, in the event Cerner retains the services of a third-party administrator to assist with the administration of one or more of the Flexible Spending Plans, such third party administrator.

**Associate**
A person employed by Cerner and reported as an Associate for Social Security purposes.

**Benefit**
Any of the optional benefit choices or benefit programs available to a Participant as outlined in this Plan.

**Benefit Plan Surplus**
Means the aggregate Plan surplus resulting from Participant failures to incur qualifying expenses or seek reimbursements in a timely manner as required under the Plan.

**Cafeteria Plan Dollars**
Means the amount available to Participants, to be applied to and used under the Flexible Spending Plans. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Dollar.

**Cerner**
Cerner Corporation and any of its subsidiary or affiliated corporations duly adopting the Plan, as set forth in the list of Participating Employers.

**Cerner Health Care Plan or Health Care Plan**
Means any medical, dental, vision or other plan pursuant to which Cerner provides health care benefits to Associates and/or their dependents.

**Code**
The Internal Revenue Code of 1986, as amended or replaced from time to time and including any rulings and Treasury regulations issued thereunder.

**Compensation**
The total cash remuneration received by a Participant from Cerner during a Plan Year prior to any reductions pursuant to a Salary Reduction Agreement authorized under this Plan or any salary deferrals made under the Cerner Corporation Foundations Retirement Plan. Compensation shall include overtime, commissions and bonuses.

**Dependent**
For purposes of the Premium Spending Plan and the HCFSA Plan, (1) a dependent as defined in Code §105(b), (2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year).

For purposes of the Dependent Care Assistance Plan, an Eligible Dependent.

Notwithstanding the foregoing, the HCFSA Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

**Dependent Care Assistance Account**
The account established for Participants to which part of their Cafeteria Plan Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed.

**Dependent Care Assistance Plan**
The Cerner Corporation Foundations Dependent Care Assistance Program (Plan No. 512), such plan document being part of this Flexible Spending Account Plan consolidated Plan Document and pursuant to which participating Associates may be reimbursed for eligible expenses for the care of the Qualifying Dependents.

**Earned Income**
Earned income as defined under Code section 32(c)(2), but excluding such amounts paid or incurred by Cerner for dependent care assistance to the Participant.

**Election Period**
The period of time immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Associates and Participants. However, an Associate's initial effective date of participation with respect to the Premium Spending Plan, HCFSA Plan and/or Dependent Care Assistance Plan, shall be determined pursuant to eligible elections (including a deemed election under the Premium Spending Plan).

**Eligible Associate**
Any Associate who is eligible to participate in this Plan.

**Eligible Dependent**
An individual who is: (a) a tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1); (b) a tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, an Eligible Dependent who is a child shall, as provided in Code §21(e)(5), be treated as an Eligible Dependent of the custodial parent (within the meaning of Code §152(e)) and shall not be treated as an Eligible Dependent with respect to the noncustodial parent.

**Employment-Related Dependent Care Expenses**
The amounts paid for expenses of a Participant for those services which, if paid by the Participant, would be considered employment related expenses under Code section 21(b)(2). Generally, they shall include expenses for household services or for the care of an Eligible Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Eligible Dependents with respect to such Participant.

**ERISA**
The Employee Retirement Income Security Act of 1974, as amended from time to time and including any rulings and Department of Labor regulations and Treasury regulations issued thereunder.

**Extended Plan Year**
Extended Plan Year means the 14.5-month period beginning on January 1 of a given year and ending March 15 of the following year.

**Flexible Spending Plans**
Means, either collectively or individually, the Premium Spending Plan, the HCFSA Plan and/or the Dependent Care Assistance Plan.

**FMLA Leave**
An unpaid leave of absence under the Family Medical Leave Act as governed by Cerner's Associate and Family Medical Leave of Absence Policy, as amended by Cerner from time to time.

**HCFSA Account**
The fund established for Participants pursuant to this Plan to which part of their Cafeteria Plan Dollars may be allocated and from which allowable Medical Expenses may be reimbursed.

**HCFSA Plan**
The Cerner Foundations Benefits Program Health Care Spending Account Plan (Plan No. 511), such plan document being part of this Flexible Spending Account Plan consolidated plan document and pursuant to which eligible Associates may be reimbursed for eligible Medical Expenses in accordance with the terms of such plan.

**Insurance Contract**
Any contract issued by an Insurer underwriting a Benefit.

**Insurer**
Any insurance company that underwrites a Benefit under this Plan or, with respect to any self-insured benefits, Cerner.

**Key Associate**
An employee described in Code section 416(i)(1) and the Treasury regulations thereunder.

**Medical Expenses**
With respect to the HCFSA Plan, any expense for medical care within the meaning of the term "medical care" or "medical expense" as defined in Code section 213, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. However,Medical Expenses with respect to the HCFSA do not include: (i) the cost of other health coverage such as premiums paid under a Cerner Health Care Plan, a plan maintained by the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent, (ii) "qualified long-term care services" as defined in Code section 7702B(c), (iii) the cost of medicines or drugs, unless the medicine or drug (x) requires a prescription, (y) is available without a prescription and the individual obtains a prescription, or (z) is insulin.

**Non-FMLA Leave**
Any unpaid leave of absence under either Cerner's Medical Leave of Absence Policy, as amended from time to time, or any other leave of absence policy adopted by Cerner.

**Participant**
Any Eligible Associate who enrolls in one or more Flexible Spending Plans and has not, for any reason, become ineligible to participate in this Plan.

**Participating Employer**
All entities that (i) are part of Cerner Corporation's controlled group of corporations, (ii) are domestic corporations with their principal place of business in the United States, (iii) are the common law employers of Associates who, if such Associates were employed directly by Cerner Corporation would not be excluded from participating in the Plan as set forth herein, and (iv) are not an excluded entity. Excluded entities include the following: (a) Cerner International, Inc. a Delaware corporation, and all subsidiary entities owned by Cerner International, Inc; and (b) Cerner Canada Limited, a Delaware corporation. Participating Employers accept and agree to be bound by all of the elections made under this Plan as of the date such entity first meets the definition set forth above.

**Plan**
This Cerner Corporation Foundations Flexible Spending Account Plan document, including all amendments thereto.

**Plan Year**
The 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

**Premium Spending Account**
The account established under this Plan to which part of the Participant's Cafeteria Plan Dollars may be allocated and from which any premiums owed by the Participant for coverage under one or more Cerner Health Care Plans shall be paid or reimbursed to the Participant.

**Premium Spending Plan**
The Cerner Foundations Premium Spending Account Plan (Plan No. 510), such plan document being part of this Flexible Spending Account Plan consolidated Plan Document and pursuant to which participating Associates may pay for their portion of any health care insurance premiums under one or more of Cerner's Health Care Plans on a pre-tax rather than after-tax basis.

**Salary Reduction**
The contributions made by Cerner on behalf of Participants. These contributions shall be converted to Cafeteria Plan Dollars and allocated to the accounts established under the Plan pursuant to the Participants' elections.

**Salary Reduction Agreement**
An agreement between the Participant and Cerner under which the Participant agrees to reduce his or her Compensation and have such amounts contributed by Cerner to the Plan on the Participant's behalf. The Salary Reduction Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the

agreement (after taking this Plan and Code section 125 into account) and, subsequently does not become currently available to the Participant.

**Spouse**
For purposes of this Plan, a Spouse means an individual who is treated as a spouse for federal tax purposes. Notwithstanding the above, for purposes of the Dependent Care Assistance Plan, 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 is married to the Participant and files a separate federal income tax return, where (i) the Participant maintains a household that constitutes an Eligible Dependent's principal place of abode for more than one-half of the taxable year, (ii) the Participant furnishes more than half of the cost of maintaining such household, and (iii) during the last 6 months of such taxable year, the individual is not a member of such household.

## Application Of Benefit Plan Surplus

Any forfeited amounts credited to the Benefit Plan Surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Extended Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts forfeited be used to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the Benefit Plan Surplus shall first be used to defray any administrative costs and experience losses and thereafter be retained by Cerner and used for any purpose permitted under the applicable Treasury Regulations.

## Named Fiduciary

The Administrator shall be the named fiduciary pursuant to ERISA section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

## General Fiduciary Responsibilities

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries; and (a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan; (b)with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and (c) in accordance with the documents and instruments governing the Plan insofar as

such documents and instruments are consistent with ERISA.

## Nonassignability of Rights

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

## Plan Administration

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Associates entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

- To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
- To provide Associates with a reasonable notification of their benefits available by operation of the Plan;
- To approve reimbursement requests and to authorize the payment of benefits; and
- To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and

shall be consistent with the intent that the Plan shall continue to comply with the terms of Code section 125 and the Treasury regulations thereunder.

## Examination of Records

The Administrator shall make available to each Participant, Eligible Associate and any other Associate of Cerner such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

## Payment of Expenses

Any reasonable administrative expenses shall be paid by Cerner unless Cerner determines that administrative costs shall be borne by the Participants under the Plan or by any trust which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated Associates.

## Insurance Control Clause

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured (if any), the benefits Participants are entitled to and the circumstances under which insurance terminates.

## Indemnification of Administrator

Cerner agrees to indemnify and to defend to the fullest extent permitted by law any Associate serving as the Administrator or as a member of a committee designated as Administrator (including any Associate or former Associate who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by Cerner) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

## Amendment

Cerner, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Associate or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

## Termination

Cerner is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, Cerner reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Contract shall be paid in accordance with the terms of the Contract.

No further additions shall be made to the HCFSA Plan or Dependent Care Assistance Account, but all payments from such fund shall continue to be made according to the elections in effect until the end of the Plan Year, or Extended Plan Year, as the case may be, in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims). Any amounts remaining in any such fund or account as of the end of the Plan Year, or Extended Plan Year, as the case may be, in which Plan termination occurs shall be forfeited and deposited in the Benefit Plan Surplus after the expiration of the filing period.

## Plan Interpretation

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner.

## Gender and Number

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

## Written Document

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code section 125 and any Treasury regulations thereunder relating to cafeteria plans.

## Exclusive Benefit

This Plan shall be maintained for the exclusive benefit of the Associates who participate in the Plan.

## Participant's Rights

This Plan shall not be deemed to constitute an employment contract between Cerner and any Participant or to be a consideration or an inducement for the employment of any Participant or Associate. Nothing contained in this Plan shall be deemed to give any Participant or Associate the right to be retained in the service of Cerner or to interfere with the right of Cerner to discharge any Participant or Associate at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

## Action by Cerner

Whenever Cerner, under the terms of the Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

## No Guarantee of Tax Consequences

Cerner does not make any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify Cerner if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

## Indemnification of Cerner By Participants

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse Cerner for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

## Funding

Unless otherwise required by law, Cerner shall have complete discretion as to whether or not it will place any of the contributions from Participant's Salary Reductions to the Premium Spending Account, the HCFSA Account or the Dependent Care Assistance Account in trust. Nothing herein shall be construed to require Cerner or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of Cerner from which any payment under the Plan may be made.

## Governing Law

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall Cerner guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Missouri.

## Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

## Captions

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

## Plan Administration

The Administrator will make available to Participants a statement of his or her accounts under the Flexible Spending Account Plans periodically during the Plan Year that shows his or her account balance under one or more of such plans. These statements may be on an individual plan basis, or they may be combined for both the HCFSA Plan and the Dependent Care Assistance Plan. Remember, Participants want to spend all the money they have designated for a particular benefit by the end of the Extended Plan Year.

Plan Administrator and Agent of Legal Service
Cerner Corporation
2800 Rockcreek Pkwy
North Kansas City, MO 64117
Phone 816-982-7547

Registered Agent - Delaware
The Corporation Trust Company
1209 Orange Street
Wilmington, DE 19801

Registered Agent - Missouri
CT Corporation System
120 South Central Avenue
Clayton, MO 63105

**Employer Address:** 2800 Rockcreek Pkwy
North Kansas City, MO 64117

**Employer ID Number:** 43-1196944

As of January 1, 2017, the Participating Employers are as follows:

- Cerner Corporation
- Cerner Campus Redevelopment Corporation
- Cerner Capital, Inc.
- Cerner Chouteau Data Center, Inc.
- Cerner Galt, Inc.
- Cerner Health Connections, Inc. d/b/a Healthe Clinic
- Cerner Health Services, Inc.
- Cerner Healthcare Solutions, Inc.
- Cerner Innovation, Inc.
- Cerner Lingologix, Inc.
- Cerner Math, Inc.
- Cerner Multum, Inc.
- Cerner Properties, Inc.
- Cerner Property Development, Inc.
- Cerner RevWorks, LLC

- Rockcreek Aviation, Inc.
- The Health Exchange, Inc. d/b/a Cerner HealthPlan Services

**This Plan Document/SPD includes the following three components:**

- The Cerner Foundations Premium Spending Account Plan. Cerner has assigned Plan Number 510 to this Plan. This Plan is not subject to ERISA.
- The Cerner Foundations Benefits Program Health Care Spending Account Plan. Cerner has assigned Plan Number 511 to this Plan.
- The Cerner Foundations Benefits Program Dependent Care Expense Assistance Program. Cerner has assigned Plan Number 512 to this Plan. This Plan is not subject to ERISA.

The Flexible Spending Account Plan was originally effective on January 1, 1989. Its most recent restatement is January 1, 2017.

Your Plan's records are maintained for a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

With respect to the HCFSA Plan and the Dependent Care Assistance Plan, Cerner has partnered with Cerner HealthPlan Services as Cerner's third-party administrator to assist Cerner with some of the day-to-day administrative responsibilities of maintaining these two plans.

To contact Cerner HealthPlan Services about any question you may have about either the HCFSA Plan or the Dependent Care Assistance Plan, please call Cerner HealthPlan Services at 1-877-765-1033 or write to:

**Administrator**

Cerner HealthPlan Services
PO Box 12338
Kansas City, MO 64116

### Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

General Counsel
Cerner Corporation
2800 Rockcreek Parkway
North Kansas City, Missouri 64117-2551

Service of Process may also be made upon the Administrator.

### Type of Administration

The type of Administration is Employer Administration. Cerner may retain the services of a third-party administrator for some or all of the day-to-day administration of one or more of the Flexible Spending Account Plans.

### Type of Plan

This Plan is commonly known as a "Section 125 Cafeteria Plan." **This document, along with the Cerner Corporation Wraparound Benefits Plan & SPD, intends to serve as both the Plan document and the Summary Plan Description (SPD).**

**This Plan Document and SPD has been amended and restated effective January 1, 2017.**

IN WITNESS WHEREOF, this amended and restated Plan document is hereby executed this 19th day of December, 2016.

CERNER CORPORATION

By: _____

Name: Marc G. Naughton

Title: Chief Financial Officer and Exec. V.P.