Employee Benefits Corporation

Flexible Compensation Plan
Plan Document

 101-0625 6/24

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ABOUT THE PLAN DOCUMENT

The Plan Document is the legal outline of your plan and follows your plan setup as specified in the *Plan Adoption Agreement*, incorporated by reference herein. All references to the *Plan Adoption Agreement* shall be interpreted to include any subsequent amendments to the *Plan Adoption Agreement*, which shall be reflected in the *My Company Plan* provided to employees as part of the *Summary Plan Description.*

In the case of any conflict between this *Plan Document*, the *Summary Plan Description*, and/or any other reference materials provided to you or your Participants, this *Plan Document* controls. You should keep your *Plan Document* available at all times and, when necessary, use it as a reference tool. You must make the *Plan Document* available to your flexible compensation plan Participants upon request.

ARTICLE 1 - PURPOSE

This document, together with the *Plan Adoption Agreement* as completed and adopted by the Employer, sets forth the flexible compensation plan, hereinafter referred to as the "Plan." The purpose of the Plan is to furnish Participants an opportunity to receive certain nontaxable benefits provided by the Employer in lieu of taxable compensation.

The Plan is intended to qualify as a cafeteria plan within the meaning of Code § 125 and its implementing regulations, as amended from time to time. Further, the benefits that a Participant elects to receive under the Plan are intended to be excludable from the Participant's income under Code § 125(a).

ARTICLE 2 - DEFINITIONS

Section 2.1: **Administrator** means the Employer or a person or entity appointed by the Employer to function in this capacity.

Section 2.2: **Benefits Card** means a prepaid debit card.

Section 2.3: **Benefit Package Option** means a benefit offered under this Plan, or an option for coverage under an Underlying Medical Plan (such as an indemnity option, an HMO option, or a PPO option under a major medical plan).

Section 2.4: **COBRA** means the group health plan continuation coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time.

Section 2.5: **Code** means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.6: **Dependent** means "dependent" as defined in Code § 152(f), except that:

(a) for purposes of the Dependent Care FSA, Dependent means qualifying individual as defined in Code § 21(b)(1):

(1) a qualifying child, as defined in Code § 152(a)(1), who is under the age of 13;

(2) a dependent who is physically or mentally incapable of caring for himself/herself and has the same principal place of abode as the Participant for more than half of the taxable year; and

(3) the Participant's spouse, if he/she is physically or mentally incapable of caring for himself/herself and has the same principal place of abode as the Participant for more than half of the taxable year

(b) for purposes of health plan coverage (including a Health Care FSA), any child of divorced parents shall be treated as a Dependent of both parents if all of the following conditions are met:

(1) more than one-half of the child's support during the calendar year comes from one or both parents;

(2) the child is in the custody of one or both parents for more than one-half of the calendar year; and

(3) the child qualifies under Code § 152(c) or § 152(d) as a qualifying child or qualifying relative of one of the parents.

Section 2.7: **Dependent Care Expenses** means employment-related expenses under Code § 21(b)(2), namely, services for the care of a Dependent to the extent the expenses are incurred to enable the Participant (and spouse, if any) to be gainfully employed, or for the Participant's spouse to seek gainful employment or attend school full-time. Services shall be Dependent Care Expenses only if incurred for the care of: a qualifying individual as defined in Code § 21(b) (1) who resides at least eight hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides for more than six individuals not residing at the facility), then the center must comply with all applicable state and local laws and regulations.

Nevertheless, Dependent Care Expenses do not include:

(a) expenses incurred when the Employee is not a Participant in Dependent Care FSA under Article 5;

(b) amounts paid to an individual with respect to whom a dependent-exemption deduction is allowable under Code § 151(a) to the Participant or his or her spouse;

(c) amounts paid to the Participant's spouse;

(d) amounts paid to a child of the Participant who is under 19 years of age at the end of the year in which the expenses were incurred; or

(e) amounts paid for overnight camp or care that is primarily educational in nature.

Section 2.8: **Dependent Care FSA** is the account described in the Article titled Dependent Care FSA, providing for pre-tax treatment of Dependent Care Expenses.

Section 2.9: **Earned Income** has the meaning set forth in Code § 129(e)(2).

Section 2.10: **Election Form** means the form that the Administrator provides to an Eligible Employee for him/her to elect participation in the various Accounts of the Plan by electing to pay for the available benefits by means of pretax salary reductions.

Section 2.11: **Eligible Child** means a child as defined in Code § 152(f), if the child has not attained age 27 as of the end of the calendar year.

Section 2.12: **Eligible Employee** means an Employee eligible to participate in this Plan or any component thereof, as provided in the *Eligibility Requirements* section of the *Plan Adoption Agreement*.

Section 2.13: **Employee** means an individual who is on the Employer's Form W-2 payroll. Employee does not include any individual not on the Employer's Form W-2 payroll, even if a governmental agency or a court later determines that he/she is a common-law employee who should have been included on the Employer's Form W-2 payroll. The preceding notwithstanding, to the extent provided for by the Employer, Employee may include an individual who was on the Employer's Form W-2 payroll (i.e., former employees, retirees). Employee does not include sole proprietors, partners in a partnership, members of an LLC taxed as a partnership, more-than-2% shareholders of a Subchapter S Corporation, or any other individual considered "self-employed".

Section 2.14: **Employer** means the entity listed in *Organization Information* section of the *Plan Adoption Agreement*. The Plan is maintained by the Employer for the benefit of its employees and for the benefit of employees of employers which are affiliated with the Employer and which adopt the Plan with the consent of the Employer (as named in an Addendum to the *Plan Adoption Agreement*). Unless indicated otherwise by the context in which it is used, the word "Employer" refers to each such employer, not just the primary employer that executes this document.

Section 2.15: **ERISA** means the Employee Retirement Income Security Act of 1974, as amended from time to time. If the Employer is a governmental entity or church-controlled entity whose employee benefit plans are "governmental plans" or "church plans" and thereby exempt from Title I of ERISA, then the Plan shall likewise be exempt.

Section 2.16: **FMLA** means the Family and Medical Leave Act of 1993 and any other similar state law to the extent applicable, as amended from time to time.

Section 2.17: **FMLA Leave** means a leave of absence governed by FMLA.

Section 2.18: **Group Insurance Premiums** are described in the Article titled *Group Insurance Premiums and Other Pre-tax Benefits*, providing for pre-tax treatment of employee premiums for coverage under an Underlying Plan.

Section 2.19: **Health Care Expense** means an expense incurred by a Participant (or spouse, Dependent or Eligible Child of the Participant) for medical care as defined in Code §§ 105(b), 106(f), and 213(d) (other than excluded expenses, if any, that are specified in a writing attached to this Plan), but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any insurance, governmental program, or accident or health plan (such as an Underlying Medical Plan).

Section 2.20: **Health Care FSA** is the account described in the Article titled *Health Care FSA*, providing for pre-tax treatment of Health Care Expenses.

Section 2.21: **HIPAA** means the Health Insurance Portability and Accountability Act of 1996 and any other similar state law to the extent applicable, as amended from time to time.

Section 2.22: **Open Enrollment Period** with respect to a Plan Year means the period, occurring before the Plan Year begins, that the Administrator prescribes for an Eligible Employee to make an election to participate for the Plan Year.

Section 2.23: **Participant** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of the Article titled *Elections to Participate*.

Section 2.24: **Permitted Election Change Event** means an event described in Treas. Reg. § 1.125-4 and explained in the Article titled *Events Permitting Election Changes*.

Section 2.25: **Plan Year** is defined in the *Plan Adoption Agreement.*

Section 2.26: **Qualified Reservist Distribution** means a taxable distribution from a Health Care FSA to an employee of all or a portion of the balance in the employee's Health Care FSA if:

(a) the employee is a member of a reserve component (as defined in 37 U.S.C. § 101) who is ordered or called to active duty for a period of 180 days or more or for an indefinite period; and

(b) the employee's active duty commences on or after June 18, 2008, or the employee's prior order or call to active duty continues beyond June 18, 2008; and

(c) the request for distribution is made during the period beginning with the order or call to active duty and ending on the last day of the Plan Year (or grace period, if applicable) in which the order or call to active duty occurred.

Section 2.27: **Spouse** means a person to whom an individual is legally married under the laws of a state or country and from whom the individual is not legally separated under a decree of divorce or separated maintenance.

Section 2.28: **Underlying Health Plan** means a plan identified in the section of the *Plan Adoption Agreement* titled *Group Insurance Premiums* that provides medical care as defined in Code § 213(d) to an Employee or an Employee's Dependent, whether directly or through insurance, reimbursement, or otherwise.

Section 2.29: **Underlying Plan** means a plan identified in the section of the *Plan Adoption Agreement* titled *Group Insurance Premiums*.

Section 2.30: **Uniformed Services Leave** means a leave of absence governed by USERRA.

Section 2.31: **USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

ARTICLE 3 - ELECTIONS TO PARTICIPATE

Section 3.1: **Election to Participate.** For any Plan Year, an Eligible Employee may elect to participate in one or more Accounts of the Plan as set forth below. Such elections may be changed mid-year only as permitted by the Article titled *Events Permitting Election Changes*.

Section 3.2: **Automatic Election for Group Insurance Premiums.** An Eligible Employee is deemed to have elected to participate in the Plan with respect to Group Insurance Premiums for a Plan Year if:

(a) he/she is covered under an Underlying Plan during the Plan Year;

(b) the Employer requires him/her to pay part or all of the cost of coverage under the Underlying Plan during the Plan Year (or pays him/her to forego such coverage); and

(c) he/she does not elect to make such payments (or receive the coverage) on an after-tax basis (if allowed by the Employer). Such an election must be made before the Plan Year begins (or when he/she becomes an Eligible Employee, if that occurs after the Plan Year begins) and must be in writing acceptable to the Administrator. If an Employee does not participate in the Pre-tax Premium Account for a Plan Year but is eligible for Underlying Plan coverage, then the Employee shall pay his/her share of the premiums for such coverage on an after-tax basis outside of this Plan (and the Employer's share of the premium shall be paid outside of this Plan).

Section 3.3: **Annual Elections Under Other Accounts.** To become a Participant in the Health Care FSA, Dependent Care FSA, or Individual Premium FSA for a Plan Year, an Eligible Employee shall make an election as follows:

(a) Election When First Eligible. An Employee who first becomes an Eligible Employee after a Plan Year begins may, by submitting an acceptable Election Form (or Online Enrollment option) to the Administrator before the first day he/she becomes an Eligible Employee, become a Participant for the remainder of the Plan Year. Except as otherwise permitted by the Article titled *Events Permitting Election Changes*, an Employee who does not elect to participate when first eligible may not enroll until the next Open Enrollment Period. Employees should refer to the *My Plan Eligibility* section of *My Company Plan* for the Plan's eligibility requirements.

(b) Elections During Open Enrollment Period. Before or during the Open Enrollment Period for each Plan Year, the Administrator shall provide each Eligible Employee with an Election Form (or Online Enrollment option) on which he/she may elect to participate for the Plan Year. To participate for the Plan Year, the Employee must return the Election Form to the Administrator on or before the last day of the Open Enrollment Period. Except as otherwise permitted by the Article titled *Events Permitting Election Changes*, an Employee who does not make a timely election during an Open Enrollment Period may not elect to become a Participant until the next Open Enrollment Period.

Section 3.4: **Termination of Participation.** A Participant ceases to be a Participant in this Plan upon the earliest of:

(a) the termination of this Plan;

(b) the date on which the Participant ceases to be an Eligible Employee (or, if later, the date on which COBRA coverage under the Plan terminates); or

(c) the date on which the Participant revokes his/her election as permitted under the Article titled *Events Permitting Election Changes*.

Section 3.5: **Rehire Following Termination of Employment**. If during a Plan Year, a Participant's employment with the Employer is terminated but, within 30 days of termination (but within the same Plan Year), the Participant is rehired by the Employer, then the Participant shall be treated for the purposes of the Plan as if his or her employment had never been terminated, with a reinstatement of all elections that he or she had made for the Plan Year and that had been in effect at the time of termination.

If instead, such a terminated Participant is rehired by the Employer more than 30 days after termination (but within the same Plan Year), then upon rehire he or she shall be treated as a new Employee and, subject to any waiting period set forth in the *Plan Adoption Agreement*, be permitted to make new elections under all parts of the Plan other than the Health Care FSA and Dependent Care FSA. Such a participant who is rehired more than 30 days after termination (but within the same Plan Year) cannot participate in the Health Care FSA and Dependent Care FSA (except to the extent required by COBRA) until the next Plan Year.

Section 3.6: **FMLA Leave.** Notwithstanding any contrary provision in this Plan, if a Participant is on FMLA Leave, then to the extent required by FMLA, the Employer shall continue to maintain the coverage under a Health Care FSA or any Underlying Medical Plan on the same terms and conditions as if the Participant were still an active Employee, including continued payment of the Employer's portion of any premium. Participants electing to continue such coverage while on unpaid FMLA leave may pay their share of the premiums in one of the following ways:

(a) with after-tax dollars, by sending monthly payments to the Employer;

(b) with pre-tax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave (during the current Plan Year only) on a pre-tax salary reduction basis out of pre-leave compensation, by making a special election to that effect prior to the date that such compensation would normally be made available; or

(c) under another arrangement that the Participant and the Employer agree upon (for example, an arrangement whereby the Employer pays for coverage during the leave and withholds "catch-up" amounts upon the Participant's return).

If a Participant's coverage ceases while on FMLA Leave, then, upon return from such leave, the Participant shall be permitted to re-enter the Plan on the same basis on which the Participant had been participating prior to the leave, or as otherwise required by the FMLA.

Section 3.7: **Non-FMLA Leave.** When a Participant goes on a non-FMLA leave of absence, the Employer's usual procedures apply. The leave constitutes a change in employment status which, if it affects benefit eligibility, would be a qualifying Change in Status as described in the Article titled *Events Permitting Election Changes.*

ARTICLE 4 - EVENTS PERMITTING ELECTION CHANGES

Section 4.1: **Irrevocability of Election.** Except as permitted in this Article, a Participant's election under the Plan is irrevocable for the duration of the applicable Plan Year. The irrevocability of elections applies to:

(a) Participation in this Plan;

(b) Salary reduction amounts elected under this Plan; and

(c) Election of any particular Benefit Package Option

Section 4.2: **Exceptions to Irrevocability Rule.** The following Permitted Election Change events are exceptions to the irrevocability rule:

(a) **Change in Status.** A Participant may change or terminate his/her actual or deemed election under the Plan as described in Treas. Reg. § 1.125-4(c) if the Administrator determines (based on prevailing IRS guidelines) that a change in status has occurred and the election change satisfies the consistency rule described in (b). The change in status events are:

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

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

(3) **Employment Status:** Any change in employment status of the Participant, the Participant's Spouse, the Participant's Dependents or the Participant's Eligible Children that affects benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of the Employer or the employer of the Spouse, Dependents or Eligible Children, such as: (1) termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in work site; (5) switching from salaried to hourly-paid or union to non-union or vice versa; (6) incurring a reduction or increase in hours of employment (e.g., going from part-time to full-time); or (7) any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

(4) **Dependent Eligibility Requirements:** An event that causes a Participant's Dependent or Eligible Child to satisfy or cease to satisfy the Dependent or Eligible Child eligibility requirements for a particular benefit, such as attaining a specified age, getting married or ceasing to be a student; and

(5) Change in Residence: A change in the place of residence of the Participant, the Participant's Spouse, the Participant's Dependent or the Participant's Eligible Child, that results in a gain or loss of eligibility under a group insurance plan.

(b) The consistency rule is set forth in Treas. Reg. § 1.125-4(c)(3), which requires the election change to be on account of and correspond with a change in status that affects coverage eligibility for his/her Spouse, Dependent or Eligible Child:

(1) Change in Marital Status, Loss of Dependent Status. If the event is the Participant's divorce, annulment, or legal separation from a Spouse, the death of a Spouse, Dependent or Eligible Child, or a Dependent or Eligible Child's ceasing to satisfy the eligibility requirements for coverage, then the Participant may not elect to cancel Underlying Plan coverage for anyone other than the Spouse, Dependent or Eligible Child that ceased to satisfy the eligibility requirements. However, if the Participant, the Participant's Spouse (but not ex-Spouse), the Participant's Dependent or the Participant's Eligible Child becomes eligible for COBRA (or similar health plan continuation coverage under state law) coverage under an Underlying Health Plan, then the Participant may increase his/her election to pay for such coverage.

(2) Gain of Coverage Eligibility under Another Employer's Plan. The Participant may decrease or cancel coverage for him/herself, or his/her Spouse, Dependent, or Eligible Child as applicable under this Plan only if:

a. The individual gains eligibility for coverage under a plan providing qualified benefits under Code § 125 that is sponsored by the employer of the Participant's Spouse, Dependent, or Eligible Child;

b. the eligibility for coverage is gained as a result of a change in marital status or employment status; and

c. the individual enrolls in coverage or increases coverage under the other plan.

(3) Special Rule for Dependent Care FSA. A Participant may change his/her election under the Dependent Care FSA if the change is made on account of and corresponds with a qualifying event that affects

a. eligibility for coverage under the Dependent Care FSA, or

b. expenses described in Code § 129.

(c) HIPAA Special Enrollment Rights. As provided by Treas. Reg. § 1.125-4(b), if a Participant (or his/her Spouse, Dependent or Eligible Child) is entitled to a special enrollment right under an Underlying Health Plan or Health Care FSA as required by Code § 9801(f), then the Participant may revoke a prior election under the such plan and make a new salary reduction election, provided that the new election corresponds with such special enrollment right. Special enrollment rights do not apply to any group health plan that is an excepted benefit under HIPAA's portability provisions; many Health Care FSAs are excepted benefits.

A special enrollment right might arise if coverage of the Participant (or his/her Spouse, Dependent or Eligible Child) under the plan had been declined because of other coverage, but eligibility for such other coverage was later lost due to divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period; if a new Dependent or Eligible Child is acquired as a result of marriage, birth, or adoption; or, if the Participant (and/or Dependent or Eligible Child) loses eligibility under the Children's Health Insurance Program (CHIP) or Medicaid programs, or becomes eligible for premium assistance under CHIP or Medicaid. For purposes of this provision,

(1) an election to add previously eligible Dependents or Eligible Children as a result of the acquisition of a new Spouse, Dependent or Eligible Child shall be considered consistent with the special enrollment right; and

(2) a special enrollment election attributable to the birth or adoption of a new Dependent or Eligible Child may, subject to the provisions of the Plan, be effective retroactively to the date of the event (up to 30 days).

(3) For purposes of special enrollment rights, the Participant must inform the Administrator within 30 days (within 60 days for CHIP or Medicaid-related events) of the event creating the special enrollment right. Failure to do so may cause the Participant to lose the right to change his actual or deemed election.

(d) Certain Judgments, Decrees, and Orders. As provided by Treas. Reg. § 1.125-4(d), if a judgment, decree, or order (collectively, "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requires Underlying Health or Health Care FSA coverage for the Participant's Dependent child (or foster child) or Eligible Child, then a Participant may

(1) change his/her election to provide coverage for the child, or

(2) change his/her election to revoke coverage for the child if the Order requires another individual (such as the Participant's Spouse or former Spouse) to provide coverage under that individual's plan and such coverage is, in fact, provided.

(e) Medicare and Medicaid. As provided by Treas. Reg. § 1.125-4(e), if a Participant (or his/her Spouse, Dependent or Eligible Child) who is enrolled in an Underlying Health Plan or Health Care FSA of the Employer becomes entitled to coverage under Part A or Part B of Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act (other than coverage consisting solely of benefits under the pediatric-vaccine program), then the Participant may prospectively reduce or cancel the Underlying Health Plan or Health Care FSA coverage of the person becoming entitled to Medicare or Medicaid. Further, if a Participant (or his/her spouse, Dependent or Eligible Child) who has been entitled to Medicare or Medicaid coverage loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the coverage of that person under the Underlying Plan or Health Care FSA.

(f) Change in Cost. The following rules for election changes resulting from cost changes apply to Group Insurance Premiums, but do not apply to the Health Care FSA. The following rules apply to the Dependent Care FSA only if the cost increase is imposed by a dependent care provider who is not the Participant's relative as defined in Code § 152(a)(1) through (8), incorporating the rules of § 152(b)(1) and (2).

(1) Automatic cost changes. As provided by Treas. Reg. § 1.125-4(f)(2)(i), if during the Plan Year there is an increase or decrease in the cost of a qualified benefit charged to a Participant under the Plan and, under the terms of the Underlying Plan, covered employees are required to make a corresponding change in their payments, then the Administrator shall, on a reasonable and consistent basis (and in accordance with prevailing IRS guidance), make a corresponding, prospective change to the Participant's salary reduction contributions to the Plan.

(2) Significant cost changes. As provided by Treas. Reg. § 1.125-4(f)(2)(ii), if the cost charged to a Participant for a Benefit Package Option significantly increases or significantly decreases during a Plan Year, then the Participant may make a corresponding change in election under the Plan. Changes that can be made include

a. electing to begin participation in the Plan (in the case of a decrease in the cost of a Benefit Package Option) or

b. revoking a Benefit Package Option election and either: receiving prospective coverage under another Benefit Package Option providing similar coverage, or dropping coverage if no other Benefit Package Option providing similar coverage is available (in the case of an increase in the cost of a Benefit Package Option). The Administrator, in its sole discretion, shall decide (in accordance with prevailing IRS guidance) whether a cost increase or decrease is "significant" and whether a substitute Benefit Package Option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(g) Change in Coverage. The following rules for election changes resulting from coverage changes do not apply to the Health Care FSA.

(1) Significant curtailment without loss of coverage. As provided in Treas. Reg. § 125-4(f)(3)(i), if coverage is significantly curtailed (for example, a significant increase in a deductible, co-pay, or out-of-pocket cost sharing limit under an Underlying Health Plan) then an affected Participant may revoke his/her old election and make a new election on a prospective basis. Coverage may not be entirely dropped. Coverage under a Benefit Package Option is deemed "significantly curtailed" only if there is an overall reduction in coverage so as to constitute reduced coverage to Participants generally. The Administrator (in its sole discretion) shall decide, in accordance with prevailing IRS guidance, whether a curtailment is

"significant" and whether a substitute Benefit Package Option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(2) Loss of coverage. As provided by Treas. Reg. § 1.125-4(f)(3)(ii), if coverage under a Benefit Package Option is lost (e.g., elimination of a Benefit Package Option, cessation of HMO availability in an individual's area, or loss of an individual's coverage as a result of an overall lifetime or annual limitation), then an affected Participant may revoke his/her old election and make a new election on a prospective basis for coverage under another Benefit Package Option providing similar coverage, or the Participant may drop coverage under the Plan.

(3) Addition or improvement of Benefit Package Option. As provided by Treas. Reg. § 1.125-4(f)(3)(iii), if a Benefit Package Option is added to the Plan, or if coverage under an existing Benefit Package Option is significantly improved, then an Eligible Employee (whether or not he/she has previously made an election under the Plan) may revoke his/her election and make a new election on a prospective basis for coverage under the new or improved Benefit Package Option. The Administrator (in its sole discretion) shall decide, in accordance with prevailing IRS guidance, whether a Benefit Package Option is "significantly improved" based upon all the surrounding facts and circumstances.

(4) Change in Coverage under Another Plan. As provided in Treas. Reg. § 1.125-4(f)(4), to avoid "election lock," a Participant may make a prospective election change that is on account of and corresponding to a change made under another employer's plan (including a plan of the same employer or of another employer), so long as

a. that plan permits its participants to make an election change that would be permitted under Treas. Reg. § 1.125-4 or

b. the new election is for a Plan Year that is different from the Plan Year under the other plan. The Administrator (in its sole discretion) shall decide, in accordance with prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under such other plan.

(5) Loss of Coverage under Plan of Governmental or Educational Institution. As provided in Treas. Reg. § 1.125-4(f)(5), an Eligible Employee may make an election on a prospective basis to add coverage under the Plan for the Employee (or his/her Spouse, Dependent or Eligible Child), if the Employee (or Spouse, Dependent or Eligible Child) loses coverage under any group health plan maintained by a governmental or educational institution, including: a children's health insurance program maintained by a state under Title XXI of the Social Security Act; a medical care program of an Indian tribal government, the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a foreign government group health plan.

(h) Mid-year Marketplace Elections. If an employee has, under the Plan, elected coverage under an employer's group health plan that is not a Health Care FSA and that provides minimum essential coverage as defined in Internal Revenue Code section 5000A(f)(1), then the employee may prospectively revoke the election of such coverage as follows:

(1) Reduction in Hours of Service. The employee may revoke their elections for group health plan coverage if the employee meets both of the following conditions:

a. The employee has been in an employment status under which the employee was reasonably expected to average at least 30 hours of service per week and the status has changed so that the employee will reasonable be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the group health plan; and

b. The revocation of the election of the coverage under the group health plan corresponds to the intended enrollment of the employee (and any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(2) Employee's Enrollment in a Qualified Health Plan. The employee may revoke their election for group health plan coverage if the employee meets both of the following conditions:

a. The employee is eligible for a special enrollment period to enroll in a Qualified Health Plan through a Marketplace (pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance) or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

b. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee (and any related individuals who cease coverage due to the revocation) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the date immediately following the last day of the original coverage that is revoked.

(3) Spouse or Dependent's Enrollment in a Qualified Health Plan. The employee may revoke their election of family group health plan coverage if all of the following conditions are met:

a. One or more related individuals (e.g., a spouse or dependent) is eligible for a special enrollment period to enroll in a Qualified Health Plan through a Marketplace (pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance) or one or more already covered related individuals seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

b. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the related individual(s) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the date immediately following the last day of the original coverage that is revoked; and

c. If the employee does not enroll in a Qualified Health Plan through a Marketplace as otherwise permitted herein, the employee can only revoke coverage for the individual(s) enrolling in the Marketplace plan.

Section 4.3:

New Elections. A Participant (or an Eligible Employee who was eligible to elect Underlying Plan, Health Care FSA or Dependent Care FSA coverage, but who declined to do so during the initial election period or any Open Enrollment Period) may make a new election upon the occurrence of an event described the Section titled *Exceptions to Irrevocability Rule*, as long as the new election is made within 30 days (or 60 days for a Medicaid/State Children's Health Insurance Plan event) of the event, and the new election is made on account of and is consistent with the event.

(a) Except for an election to add coverage for a newborn or newly adopted Dependent or Eligible Child pursuant to a HIPAA special enrollment event described in the Section titled *Exceptions to Irrevocability Rule*, a new election shall be effective on the latter of the event date or the date the new election is made.

(b) New elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event described in the Section titled *Exceptions to Irrevocability Rule* allows a further election change.

(c) Any new election for a Plan Year cannot reduce a Health Care FSA or Dependent Care FSA to a point where the total amount of reimbursement available for the Plan Year is less than the amount already reimbursed for the Plan Year.

(d) The amount available for reimbursement under the Health Care FSA or Dependent Care FSA for the remainder of the Plan Year after a new election is made shall include the balance (positive or negative) of the Health Care FSA or Dependent Care FSA immediately before the effective date of the new election. Further, the maximum reimbursement for the period after a new election shall

not exceed the total contributions made by the Participant for the period prior to the new election plus the total expected Participant contributions for the balance of the Plan Year.

ARTICLE 5 - GROUP INSURANCE PREMIUMS AND OTHER PRE-TAX BENEFITS

Section 5.1: **Description of Group Insurance Premiums.** The Employer may choose to allow pre-tax payments of Group Insurance Premiums through this Plan if the Employer requires employees to pay part or all of the premiums for coverage under an Underlying Plan. Because the employee has a choice between cash (an unreduced salary) and a nontaxable benefit (the Underlying Plan coverage), the employee would be treated as having "constructively received" the cash and used it to purchase the Underlying Plan coverage on an after-tax basis, if not for Code § 125 and this Plan. The Underlying Plan(s) (other than group term life insurance) constitute non-taxable coverage and benefits for medical care and/or accident or health plans under Code § § 105(b) and 106. Any group term life insurance offered as an Underlying Plan of the Group Insurance Premiums portion of this Plan is intended to qualify as non-taxable coverage under Code § 79.

Section 5.2: **Participant Contributions to Group Insurance Premium Account.** An Eligible Employee who, under the Section titled *Automatic Election for Group Insurance Premiums* is a Participant for this portion of the Plan shall, by salary reduction, make annual (or more frequent) contributions to the Employer under rules established by the Administrator. The amount of the contribution shall equal the premium paid by the Participant for Underlying Plan coverage. Such amounts shall be applied to the cost of the Underlying Plan coverage. If group term life insurance is one of the Underlying Plans, then the pre-tax treatment under the Plan shall apply only to the salary reduction contributions that are used to purchase up to $50,000 of such insurance coverage, or any higher limit provided by Code § 79 as amended from time to time.

Section 5.3: **Underlying Plan Benefits.** A Participant's right to benefits under an Underlying Plan shall be determined under the provisions of the Underlying Plan and not under the provisions of this Plan.

Section 5.4: **COBRA Premiums.** If chosen as an option by the Employer, an Eligible Employee may elect to reduce his or her salary, on a pre-tax basis, in order to pay for premiums for group health plan continuation coverage procured through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar state law.

Section 5.5: **Vacation Days or Paid Time Off.** If chosen as an option by the Employer, a Participant may choose to receive taxable salary in lieu of vacation or paid time off (PTO) benefits to which the Participant is otherwise entitled. Conversely, the Participant may elect to reduce his or her salary, on a pre-tax basis, in order to purchase additional days or weeks of vacation/PTO. The Employer has the discretion to determine how many days or weeks may be purchased. Purchased vacation/PTO

shall be available for use by a participant only after all other vacation/PTO is used, and may not be carried over from one Plan Year to the next. The Employer shall determine and make known to Participants prior to the start of the Plan Year whether unused purchased vacation/PTO is paid out in the form of taxable salary, or forfeited to the Employer.

ARTICLE 6 - HEALTH CARE FSA

Section 6.1: **Description of Health Care FSA.** The Health Care FSA applies under this Plan to enable employees to pay their Health Care Expenses on a pre-tax basis by means of salary reduction. The salary reduction amounts are contributed to a Health Care FSA, and Health Care Expenses are reimbursed from that account as set forth in the Article titled *Reimbursement Rules*.

Because the employee has a choice between cash (an unreduced salary) and a nontaxable benefit (reimbursement of the Health Care Expenses), the employee would be treated as having constructively received the cash and used it to obtain reimbursement on an after-tax basis, if not for Code § 125 and this Plan. The Health Care FSA constitutes a health plan whose coverage is intended to be tax free under Code § 106 and whose benefits are intended to be tax free under Code § 105(b).

Section 6.2: **Health Care FSA.** With respect to each Participant in the Health Care FSA for each Plan Year, the Administrator shall maintain a Health Care FSA. Consistent with the Section titled *Funding the Plan* in the Article titled *General Provisions*, the account shall be a bookkeeping account only. As of the beginning of each Plan Year (or, if later, the beginning of the Participant's participation in the Health Care FSA), his/her Health Care FSA shall be credited with the salary-reduction amounts that he/she elected to contribute for the Plan Year plus the Employer's contribution, if any. A Participant's Health Care FSA shall be debited in accordance with reimbursements made to the Participant for Health Care Expenses incurred during the Plan Year.

Section 6.3: **Participant Contributions.** The maximum amount that a Participant may contribute to his/her Health Care FSA for any Plan Year is the lesser of:

(a) the limit set forth in the section regarding Flexible Spending Account annual limit in the *Plan Adoption Agreement* as amended, or

(b) the statutory limit as established in § 125(i) as amended from time to time.

Section 6.4: **Uniform Coverage; Maximum Available Amount.** The maximum amount of reimbursement under the Health Care FSA for a Participant for a Plan Year shall be available at all times during the year, regardless of any salary reduction of amounts credited to his/her Health Care FSA through any particular date during the year. As a result, a Participant's Health Care FSA will have a negative balance if reimbursements (debits) for a Plan Year through a particular date have exceeded salary reduction amounts (credits) through that date. The maximum reimbursement available at any time during a Plan Year shall be reduced by the amount of reimbursements previously made for the same Plan Year.

Section 6.5: **Use It Or Lose It.** Except as provided in accordance with the *Health Care FSA Rollover* described in the Article titled *Reimbursement Rules,* if any balance remains in the Participant's Health Care FSA for a Plan Year after all reimbursements have been made for the Plan Year, then the Participant shall forfeit all rights with respect to the unused balance. Except as provided in accordance with the *Health Care FSA Rollover* described in the Article titled *Reimbursement Rules,* any remaining unused balance shall not be carried forward for reimbursement of Health Care Expenses incurred during a subsequent Plan Year or for reimbursement of "Dependent Care FSA Expenses. Forfeitures shall be used as described in the Article titled *General Provisions*.

Section 6.6: **Reimbursement Procedure.** If a Participant, his/her Spouse, Dependent or Eligible Child incurs Health Care Expenses during the Plan Year, then he/she may apply to the Administrator for reimbursement and, if the Administrator determines that the application is proper and complete, the Administrator shall cause the Participant to be reimbursed for the amount of the expenses, subject to the rules set forth in the Article titled *Reimbursement Rules*.

Section 6.7: **COBRA.** The Health Care FSA is a "group health plan" as defined in Code § 4980B(g)(2) for purposes of COBRA, which requires a Participant (and his/her Spouse, Dependents and Eligible Children) whose coverage under the Health Care FSA would otherwise terminate due to a "qualifying event" to be offered continuation coverage for a limited period on an after-tax basis. Nevertheless, the Health Care FSA shall be entitled to the special COBRA treatment afforded by Treas. Reg. § 54.4980B-2(b)(Q/A8) if:

(a) the maximum reimbursements available for the Plan Year do not exceed the greater of (1) two times any participant's salary reduction election amount for the year or (2) any salary reduction election amount for the year plus $500, and

(b) Participants have other major medical coverage available for the year under a group health plan maintained by the Employer. Under the special COBRA treatment:

(1) COBRA coverage shall be offered only if, on the date of the qualifying event, the Participant's available balance is greater than or equal to the amount the Participant would owe in COBRA premiums for the Health Care FSA for the remainder of the plan year; and

(2) if COBRA coverage is elected, it will be available only for the Plan Year in which the qualifying event occurs and will cease at the end of that year.

Section 6.8: **The Heroes Earnings And Relief Tax Act of 2008 ("HEART Act").** The Plan may allow certain Participants to elect a distribution of unused amounts from their Health Care FSA. A Participant may elect to receive a Qualified Reservist Distribution only once per Plan Year. Further, a Participant's right to submit claims to the Health Care FSA shall terminate following a Qualified Reservist Distribution. A participant may elect to receive a Qualified Reservist Distribution in an amount equal to the balance in the Health Care FSA calculated by subtracting the reimbursements-to-date from contributions-to-date.

ARTICLE 7 - DEPENDENT CARE FSA

Section 7.1: **Description of Dependent Care FSA.** This Dependent Care FSA applies under this Plan to enable Employees to pay their Dependent Care Expenses on a pre-tax basis by means of salary reduction. The salary reduction amounts are contributed to a Dependent Care FSA and, from that account, Dependent Care Expenses are reimbursed as set forth in the Article titled *Reimbursement Rules*.

Because the employee has a choice between cash (an unreduced salary) and a nontaxable benefit (reimbursement of the Dependent Care Expenses), the Employee would be treated as having constructively received the cash and used it to obtain reimbursement on an after-tax basis, if not for Code § 125 and this Plan. The Dependent Care FSA constitutes a dependent care assistance plan whose benefits are intended to be tax free under Code § 129.

Section 7.2: **Dependent Care FSA.** With respect to each Participant in the Dependent Care FSA for each Plan Year, the Administrator shall maintain a Dependent Care FSA for that Participant. Consistent with the Section titled *Funding the Plan* in the Article titled *General Provisions*, the account shall be a bookkeeping account only. The Dependent Care FSA shall be credited with the Participant's salary reduction amounts at the time that they would otherwise be paid to the Participant. The Dependent Care FSA shall also be credited with the Employer's contribution, if any, at the time determined by the Employer. A Participant's Dependent Care FSA shall be debited with the amounts of reimbursements made to the Participant for Dependent Care Expenses incurred during the Plan Year.

Section 7.3: **Participant Contributions.** The amount that a Participant may contribute to his/her Dependent Care FSA for any taxable year shall not exceed the maximum amount that Code § 129 permits to be excluded from gross income. Currently, such amount is the smallest of:

(a) $5,000 ($2,500 if the Participant is married but files separately);

(b) the Participant's Earned Income; or

(c) if the Participant is married at the end of the taxable year, the spouse's Earned Income.

As set forth in Code § 129(b), if the Participant is married and his/her spouse is a full-time student at an educational institution (or is physically or mentally incapable of caring for himself/herself), then the spouse is deemed to have Earned Income of $250 per month ($500 per month if there are 2 or more Dependents).

If contributions are made in excess of the maximums, the Employer shall report the excess as set forth in the Section of this Article titled *Participant Contributions*.

Section 7.4: **Maximum Available Amount.** The maximum amount of reimbursement available to a Participant under the Dependent Care FSA at any time for a Plan Year shall be limited to the balance in his/her Dependent Care FSA for the year. As a result, a Participant's Dependent Care FSA should never have a negative balance.

Section 7.5: **Use It Or Lose It.** Except as provided in accordance with the Grace Period described in the Article titled *Reimbursement Rules*, if any balance remains in the Participant's Dependent Care FSA for a Plan Year after all reimbursements have been made for the year, then the Participant shall forfeit all rights with respect to the unused balance. Except as provided in accordance with the Grace Period described in the Article titled *Reimbursement Rules*, the unused balance shall not be carried over for reimbursement of Dependent Care Expenses incurred during a subsequent Plan Year or for reimbursement of Health Care Expenses or Individual Premium FSA Expenses. The forfeitures shall be used as described in the Article titled *General Provisions*.

Section 7.6: **Reimbursement Procedure.** If a Participant (or his/her Spouse or Dependent) incurs Dependent Care Expenses during the Plan Year, then he/she may apply to the Administrator for reimbursement and, if the Administrator determines that the application is proper and complete, the Administrator shall cause the Participant to be reimbursed for the amount of the expenses, subject to the rules set forth in the Article titled *Reimbursement Rules*.

Section 7.7: **Form W-2 Reporting (Dependent Care FSA).** The Employer shall report the Dependent Care Expense reimbursements as required by the instructions to IRS Form W-2.

ARTICLE 8 - HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTIONS

Section 8.1: **Employee Election of HSA Contributions.** If chosen as an option by the Employer, in any calendar month beginning on or after an Employee's HSA Effective Date for which an Employee of the Employer is an HSA Eligible Employee as defined in Code § 223(c)(1), the Employee may elect to have the Employer withhold an amount from the Employee's salary and contribute it, as an Employer contribution, to a health savings account ("HSA") as defined in Code § 223(d) with the Employee as "account beneficiary" as defined in Code § 223(d)(3). Because the employee has a choice between cash (an unreduced salary) and a nontaxable benefit (contribution to an HSA), the employee would be treated as having "constructively received" the cash and used it to obtain reimbursements on an after-tax basis, if not for Code § 125 and this Plan.

Section 8.2: **Employer Discretionary Contributions.** The Employer may, at its discretion, contribute additional amounts to the HSA of an eligible Employee, subject to the Code § 125 nondiscrimination rules. As provided in IRS Notice 2004-50, Q/A-60, the Employer may also contribute amounts through the cafeteria plan to an Employee's HSA to cover qualified medical expenses incurred by an Employee in excess of the Employee's current HSA balance, but any such accelerated contribution made by the Employer shall be equally available to all participating Employees through the cafeteria Plan Year and shall be provided to all participating Employees on the same terms and the Employee shall repay the amount of the accelerated contribution by the end of the cafeteria Plan Year.

Section 8.3: **Limit on Contribution Amounts.** The amounts contributed to an HSA for any Employee whether through salary reduction, Employer contributions, or otherwise, shall not exceed the limit set forth in Code § 223(b), as amended from time to time.

Section 8.4: **Change of Employee Election.** As provided in IRS Notice 2004-50, Q/A-58, because the eligibility requirements and contribution limits for HSAs are determined on a month-by-month basis, an Employee who elects to make HSA contributions under the cafeteria plan may start or stop the election or increase or decrease the election at any time as long as the change is applied on a prospective basis, after the request for the change is received.

Section 8.5: **Exemption of HSA from ERISA.** To the extent the Employer is otherwise subject to ERISA, the Employer intends that HSAs established by Employees to receive contributions through the cafeteria plan not be an "employee welfare benefit plan" for purposes of Title I of ERISA. Consistent with Department of Labor Field Assistance Bulletin 2004-1; therefore, the establishment of HSAs is completely voluntary on the part of Employees and the Employer shall not:

(a) limit the ability of Employees to move their funds to another HSA beyond restrictions imposed by the Code;

(b) impose conditions on utilization of HSA funds beyond those permitted under the Code;

(c) make or influence the investment decisions with respect to funds contributed to an HSA;

(d) represent that the HSAs are an employee welfare benefit plan established or maintained by the Employer; or

(e) receive any payment or compensation in connection with an HSA.

ARTICLE 9 - REIMBURSEMENT RULES

Section 9.1: **Incurrence of Expenses.** An expense is incurred at the time the goods or services giving rise to the expense are furnished, not when the expense is billed or paid. The preceding notwithstanding, certain orthodontic expenses paid for prior to the start of treatment may be reimbursed based on the date of payment as long as evidence of payment is provided along with required claim documentation. For the purposes of orthodontia expenses, a provider payment plan indicating ongoing treatment can be relied upon to determine the appropriate allocation of service dates.

Section 9.2: **Form of Reimbursement Application.** The application for reimbursement shall be in a form acceptable to the Administrator and shall include:

(a) the name of the person on whose behalf the expenses were incurred;

(b) a description of the expenses incurred;

(c) the date(s) services were incurred;

(d) the amount of the requested reimbursement; and

(e) a statement that the expenses have not otherwise been paid (and are not expected to be paid) from any other source. The application shall be accompanied by bills, invoices, or other statements from an independent third party showing the amounts of the expenses, together with any additional documentation that the Administrator may request.

Section 9.3: **Benefits Card.** An employee may use the Benefits Card to pay for eligible Health Care Expenses if all of the following conditions are met:

(a) the card is used at a dental, vision, or medical provider office, or a retailer or pharmacy that utilizes Inventory Information Approval System (IIAS) technology to enable automatic substantiation at the point of sale;

(b) the card transaction takes place in the same Plan Year that the expenses was incurred; and

(c) the Participant submits documentation meeting the requirements outlined in the Section titled *Form of Reimbursement Application* to the Administrator upon request for all expenses that cannot be automatically substantiated at the point of sale. If adequate documentation is not submitted in a timely manner, the Administrator shall:

(1) Seek repayment or an offsetting expense from the Participant for any expense for which sufficient documentation is not submitted, and

(2) Deactivate the Participant's use of the card until such time as the ineligible expense is repaid or otherwise settled by the Employer in accordance with Treas. Reg. § 1.125-6(d)(7).

Section 9.4: **Timing of Reimbursement Applications.** Applications for reimbursement of expenses incurred during the Plan Year (or during the Grace Period described in the following Section, if applicable) shall be submitted to the Administrator prior to the end of the Runout Period determined by the Administrator in the *Plan Adoption Agreement* for any Plan Year.

Section 9.5: **Grace Period for Dependent Care FSA.** As permitted by Internal Revenue Service Notice 2005-42, the Dependent Care FSA portion of this Plan shall have a Grace Period extending until the 15th day of the third calendar month after the end of the Plan Year. Participants in such FSAs may have an additional 2-1/2 months after the end of each Plan Year in which to incur (and be reimbursed for) eligible expenses.

(a) Payment of Claims During Grace Period. In accordance with this Section, eligible expenses incurred during the Grace Period shall be reimbursed from the balance that remains unused at the end of the immediately preceding Plan Year. Such expenses incurred during the Grace Period shall not be reimbursed from the current Plan Year election amount unless and until the remaining balance from the preceding Plan Year has been exhausted.

(b) Forfeiture at the end of Grace Period. If at the end of the Grace Period, and after all reimbursements have been made for eligible expenses incurred during the preceding Plan Year and the Grace Period, any balance remains in the FSA

for which a Grace Period applies in accordance with this Section, such remaining balance shall be forfeited to the Employer at the end of the Runout Period.

(c) No Effect on Runout Period. The establishment of a Grace Period shall have no effect on the Runout Period under this Plan. Applications for reimbursement of expenses incurred during the Plan Year or the Grace Period must be submitted to the Administrator prior to the end of the Runout Period indicated in the *Plan Adoption Agreement.*

Section 9.6: **Health Care FSA Rollover.** As permitted by Internal Revenue Code Notice 2013-71, unused amounts remaining at the end of a Plan Year in a Participant's Health Care FSA will be carried over to and available for reimbursements of eligible Health Care Expenses incurred in the following Plan Year. Such rollover amounts shall be subject to the limitations specified by the Employer in the Plan Adoption Agreement.

(a) Payment of Claims Using Rollover. If Rollover from a prior plan year is available, eligible expenses shall be reimbursed first from the funds available for the Plan Year in which the expense is incurred. Eligible expenses will be reimbursed from Rollover amounts only when such funds have been exhausted.

(b) Forfeiture of Amounts Not Rolled Over. Any balance remaining in a Participant's Health Care FSA at the end of the Plan Year that does not meet the Employer's requirements, or exceeds the limitations specified by the Employer in the Section regarding Rollover in the Plan Adoption Agreement, shall be forfeited to the Employer at the end of the Runout Period.

(c) No Effect on Runout Period. The availability of a Rollover amount shall have no effect on the Runout Period under this Plan.

Section 9.7: **Post-Termination Expenses.** Expenses incurred during the period of coverage before termination of participation may only be reimbursed post-termination if application for reimbursement of such expenses is made within the Runout Period for Mid-Year Terminations as specified in the *Plan Adoption Agreement*, unless, as provided in the Section titled *COBRA* in the Article titled *Health Care FSA*, the Participant is eligible for and elects COBRA for the Health Care FSA thereby extending the period of coverage for the duration of the COBRA coverage period. No reimbursement shall be made for any expense incurred after participation in the applicable part of the Plan has terminated for any reason, except for qualifying Dependent Care Expenses incurred after the Participant's employment with the Employer is terminated, but before the end of the Plan Year in which the termination occurred.

Section 9.8: **Recoupment of Overpayments or Erroneous Payments.** To the extent that the Plan has made a reimbursement to a Participant that is later determined to be an overpayment, an erroneous payment, payment that is later paid for or reimbursed by another plan or a third party, or a payment that cannot be substantiated, the Administrator shall have the power and discretion to offset such overpayment against future reimbursements. If no further reimbursements are forthcoming, the Administrator may demand repayment from the Participant, or advise the Employer

to include the amount of overpayment as IRS Form W-2 compensation to the Employee.

ARTICLE 10 - DECISIONS ON BENEFIT APPLICATIONS

Section 10.1: **Approval/Denial of Applications.** Within a reasonable period of time after the Administrator receives a reimbursement (or other benefit) application (but in any case within 30 days after receipt), the Administrator shall either approve or deny the application and, if approves, make the reimbursement or, if denies, notify the Participant of the denial. The Administrator may extend the 30-day period, once, for up to 15 days, if the Administrator:

(a) determines that the extension is necessary due to circumstances beyond the control of the Administrator; and

(b) notifies the applicant of those circumstances and the date by which the Administrator expects to render a decision, before the expiration of the initial 30-day period.

Section 10.2: **Manner of Providing Denials.** If a reimbursement (or other benefit) application is denied, the Administrator shall provide the denial to the applicant either electronically or in writing. If the denial is provided electronically, then:

(a) the Administrator shall take appropriate measures to ensure that the system for furnishing the denial results in actual receipt by the applicant;

(b) the Administrator shall notify the applicant, through electronic means or in writing, of the significance of the denial and the applicant's right to request and receive, free of charge, a paper copy of the denial; and

(c) upon request of the applicant, the Administrator shall furnish, free of charge, a paper copy of the denial.

Section 10.3: **Content of Denials.** A denial shall set forth, in a manner calculated to be understood by the applicant (and in a culturally and linguistically appropriate manner):

(a) Information sufficient to identify the claim including date of service, the health care provider, and the claim amount (if applicable);

(b) the specific reason for the denial;

(c) reference to the specific Plan provisions upon which the denial is based;

(d) a description of any additional material or information necessary for the applicant to perfect the application (and an explanation of why such material or information is necessary);

(e) a statement describing the appeal procedures below, any external review rights, and the time limits applicable to such procedures, including a statement of the applicant's right to bring a civil action following an adverse decision on appeal;

(f) a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the denial;

(g) a description of any Plan standard relied upon for the denial; and

(h) contact information for the Department of Labor's Employee Benefits Security Administration and any applicable state consumer assistance program.

Section 10.4: **Appeals.** A denial may be appealed by notifying the Administrator within 180 days following receipt of the denial.

Section 10.5: **Decisions on Appeals.** Within a reasonable period of time after the Administrator receives an appeal (but in any case within 60 days after receipt), the Administrator shall have the appeal decided by a decision maker who shall not afford deference to the initial denial and who is not the individual (or a subordinate of the individual) who made the denial. The appellant shall have the opportunity to submit written comments, documents, records, and other information relating to the appeal. The appellant shall be provided, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the appeal. The decision maker shall take into account all comments, documents, records, and other information relating to the appeal, without regard to whether such information was submitted or considered in the initial denial.

Section 10.6: **Manner of Providing Adverse Decisions on Appeals.** If an appeal is denied, the Administrator shall provide the denial to the applicant either electronically or in writing. If the denial is provided electronically, then:

(a) the Administrator shall take appropriate measures to ensure that the system for furnishing the denial results in actual receipt by the applicant;

(b) the Administrator shall notify the applicant, through electronic means or in writing, of the significance of the denial and the applicant's right to request and receive, free of charge, a paper copy of the denial; and

(c) upon request of the applicant, the Administrator shall furnish, free of charge, a paper copy of the denial.

Section 10.7: **Content of Adverse Decisions on Appeals.** An adverse decision on an appeal shall set forth, in a manner calculated to be understood by the applicant (and in a culturally and linguistically appropriate manner):

(a) Information sufficient to identify the claim including the date of service, the health care provider, and the claim amount (if applicable);

(b) the specific reason for the decision and a discussion of the decision;

(c) reference to the specific Plan provisions upon which the decision is based;

(d) a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the denial;

(e) a description of any available external review process;

(f) a statement of the right to sue in federal court;

(g) a statement that the applicant 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 appeal; and

(h) information for the Department of Labor's Employee Benefits Security Administration and any applicable state consumer assistance program.

Section 10.8: **Second Level Appeals.** If a participant disagrees with an adverse decision on an appeal, the participant may submit a second level appeal to the Administrator by notifying the Administrator within 60 days following receipt of the adverse decision on the appeal. The provisions outlined in the Sections under this Article titled Decisions on Appeals through Content of Adverse Decisions on Appeals shall apply to second level appeals.

Section 10.9: **Compliance With Law.** The claims and appeals process will be applied in a manner that complies with all applicable laws and regulations, including regulations under the Patient Protection and Affordable Care Act (PPACA) of 2010.

Section 10.10: **Limitation on Claims.** To the extent that a Participant is affected by any denial of a benefit under this Plan, including any benefit covered by ERISA, legal action may not be taken by any Participant against the Plan or Administrator until after all administrative procedures outlined in this Plan Document have been exhausted. Once such procedures have been exhausted, no legal claim may be filed after 12 months following the date the final Adverse Decision on Appeal is provided to Participant.

ARTICLE 11 - GENERAL PROVISIONS

Section 11.1: **Powers of the Administrator.** Benefits under the Plan shall be paid only if the Administrator decides in its discretion that the individual is entitled to them. The Administrator shall have such powers as are necessary or appropriate for the Administrator to discharge its duties under the Plan. The Administrator may, at any time, require any Participant to amend the amount of his/her salary reductions for a Plan Year if the Administrator determines that such action is necessary in order to satisfy any of the Code's nondiscrimination or election requirements.

Section 11.2: **Third Party Administrator.** The Employer or Administrator may, by a separate written agreement, engage a third party administrator or service provider, such as Employee Benefits Corporation, to perform certain duties of the Administrator under the Plan, including review and payment of qualified claims under a Health Care FSA or Dependent Care FSA.

Section 11.3: **Funding the Plan.** All benefits payable under the Plan shall be paid from the general assets of the Employer or from policies of insurance purchased under the Plan. No funds are required to be set aside for the payment of benefits. To the extent any funds are set aside, they shall be subject to claims of general creditors of the Employer. Funds held by a third party administrator or service provider, such as

Employee Benefits Corporation, for the payment of benefits under the Plan shall be assets of the Employer, subject to claims of general creditors of the Employer.

Section 11.4: **Forfeitures.** All forfeitures under this Plan shall be used in the following order:

(a) forfeitures shall be used to offset any losses that the Employer may have experienced during the Plan Year as a result of providing reimbursements in excess of the amounts contributed through salary reductions;

(b) excess forfeitures shall be used to reduce the Employer's cost of administering the Plan during the Plan Year; then

(c) excess forfeitures may be used to provide increased benefits or compensation to Participants in subsequent Plan Years in any manner that the Administrator deems appropriate, consistent with Proposed Treas. Reg. § 1.125-5(o).

Section 11.5: **Tax Consequences.** The Plan is intended to qualify as a "cafeteria plan" under Code § 125. Coverage and benefits under the Plan are intended to be excluded from Participants' gross income as described above. Any Plan provision that conflicts with the Code shall be deemed amended to comply with the Code. Nevertheless, the Employer and the Administrator do not guarantee any particular tax consequences.

Section 11.6: **Records.** The Employer shall maintain records of the Covered Expenses that are reimbursed for the current Plan Year and the most recent six Plan Years. The Employer shall make available to each Participant the records of the reimbursements made to him or her for those Plan Years.

Section 11.7: **Nondiscrimination Rules.** If, during a Plan Year, the Plan is discriminating in favor of highly compensated participants in violation of Code § § 105(h), 129(d), or 125, as described below, then the Employer shall report the appropriate amounts of additional income on the Forms W-2 of such Participants or take other appropriate corrective measures. Discriminatory practices include those which disproportionately advantage:

(a) Highly compensated individuals as to eligibility to participate, or

(b) Highly compensated participants as to contributions and benefits.

(1) Amounts paid to a highly compensated individual under a self-insured medical reimbursement plan as defined in Code § 105(h) must be included in income if the Plan discriminates in favor of highly compensated individuals as to eligibility to participate or benefits provided.

(2) Amounts paid to a highly compensated individual under a Dependent Care FSA as defined in Code § 129(d) must be included in income if the Plan discriminates in favor of highly compensated employees as to eligibility to participate or benefits provided. Unless the Employer elects otherwise in writing, for purposes of the Code § 129(d) nondiscrimination tests, an employee shall not be treated as a highly compensated employee for a year unless he or she is in the group consisting of the top 20% of employees when ranked on the basis of compensation paid during the year.

(3) Amounts paid to a highly compensated individual under a cafeteria plan as defined in Code § 125 must be included in income if the Plan discriminates in favor of highly compensated employees or key employees as to eligibility to participate or benefits provided. Unless the Employer elects otherwise in writing, for purposes of the Code § 125 nondiscrimination tests, an employee shall not be treated as a highly compensated employee for a year unless he or she is in the group consisting of the top 20% of employees when ranked on the basis of compensation paid during the year.

Section 11.8: Subrogation and Refund.

(a) The Plan has the right to seek recovery from an individual for any reimbursements or payments that have erroneously been or are later paid for or reimbursed by another plan or other third party, for any reason.

(b) If an individual is reimbursed under this Plan for medical expenses incurred due to illness or injuries caused by the act or omission of a third party, the individual

(1) automatically assigns to the Plan any rights he or she has to recoveries from the third party up to the full amount of the reimbursements and

(2) must repay to the Plan the reimbursements paid on his or her behalf out of any recovery.

(c) This subrogation right allows the Plan to pursue any claim that the individual has against any third party, whether or not the individual chooses to pursue that claim. The Plan may make a claim directly against the third party, but in any event, the Plan has an equitable lien on any amount of the individual's recovery, whether or not designated as payment for medical expenses. By accepting reimbursements under this Plan, the individual agrees to hold recoveries in a constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full. If the individual dies as a result of his/her injuries and a wrongful death or survivor claim is asserted against a third party, the Plan's subrogation and refund rights shall apply.

(d) This Plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the Plan from receiving a recovery unless a covered individual has been made whole with regard to illness or injury that is the responsibility of a third party. This Plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan to pay a portion of the attorney fees and costs expended in obtaining a recovery. These doctrines have no application to this Plan, because the Plan's refund rights apply to the first dollars payable by a third party.

(e) To carry out the terms of this section, all individuals covered by the Plan are required to cooperate with the Administrator, and, in particular, are required to:

(1) Cooperate with the Plan, or any representatives of the Plan, in protecting the Plan's rights, including discovery, attending depositions, and/or providing testimony at trial;

(2) Provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information;

(3) Take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(4) Do nothing to prejudice the Plan's rights of subrogation and refund;

(5) Promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received; and

(6) Not settle or release, without the prior consent of the Plan, any claim to the extent that the individual may have recovery rights against any third party.

(f) If the covered individual and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid from any recovery, the individual will be responsible for any and all expenses (including attorney fees and costs) associated with the Plan's attempt to recover such money from the individual or a third party. If a covered individual refuses to cooperate with the Plan's subrogation and refund rights, or refuses to execute and deliver such papers as the Plan may require in furtherance of its subrogation and refund rights, the Plan has no obligation to pay benefits to him/her. If the covered individual is a minor, the Plan has no obligation to pay any medical benefits incurred on account of injury or illness caused by a third party until after the individual or his/her authorized legal representative obtains valid court recognition and approval of the Plan's 100% first-dollar subrogation and refund rights on all recoveries. If an individual (and/or his/her attorney) fails to comply with this section, the Plan may withhold benefits otherwise payable to the individual until he/she satisfies his/her obligation under this section.

Section 11.9:

ERISA Consequences. The Health Care FSA is a welfare plan as defined in ERISA § 3(1). Therefore, unless the Plan is a governmental plan or church plan exempt from Title I of ERISA (as set forth in Section 2.14), the Administrator is required to comply with Title I of ERISA. To the extent the Plan is exempt from ERISA, any portion of this Plan Document relating to ERISA obligations shall not apply to the Plan.

Section 11.10:

HIPAA.

(a) Privacy and Security: Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

(1) General. Unless otherwise permitted by law, and subject to the conditions of disclosure described below, the Plan or a business associate on behalf of

the Plan may disclose PHI and Electronic PHI to Employer, provided that Employer is permitted to use or disclose PHI and Electronic PHI only for Plan Administration purposes. Plan Administration means administration functions performed by Employer on behalf of the Plan, such as quality assurance, appeal adjudication, auditing, monitoring, and Plan management. Plan administration functions do not include functions performed by Employer in connection with any other benefit or benefit plan of Employer or any employment-related actions or decisions. Notwithstanding any provisions of this Plan to the contrary, in no event shall Employer be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

(2) Conditions of Disclosure. Employer agrees that with respect to any PHI (other than PHI disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) disclosed to it by the Plan or a business associate on behalf of the Plan, Employer shall:

a. not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

b. ensure that any agent to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to Employer with respect to PHI;

c. not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Employer; report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

d. make available all PHI necessary for the Plan to comply with an individual's right to access PHI in accordance with 45 CFR §164.524, including the right to access electronic copies of PHI, if applicable;

e. make available PHI required for the Plan to comply with an individual's right to amend PHI, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

f. make available PHI required for the Plan to comply with an individual's right to request an accounting of disclosures in accordance with 45 CFR §164.528;

g. make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

h. if feasible, return or destroy all PHI received from the Plan that Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

i. ensure that adequate separation between Plan and Employer (i.e., a firewall) is established.

(3) Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than Electronic PHI disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) on behalf of the Plan, it will:

a. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b. ensure that the adequate separation between the Plan and Employer (i.e., the firewall) is supported by reasonable and appropriate security measures;

c. ensure that any agent to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

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

(4) Inapplicability to Enrollment, Disenrollment, and Summary Health Information. This provision does not apply to enrollment and disenrollment information created by Employer, or to summary health information as that term is defined under 45 CFR 164.504.

(5) Adequate Separation Between Plan and Employer. Employer shall allow employees with oversight responsibility for the Plan access to the PHI. No other persons shall have access to PHI. This class of employees shall have access to and use of PHI only to the extent necessary to perform the plan administration functions that Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this Amendment, the employee shall be subject to disciplinary action by Employer for noncompliance pursuant to Employer's employee discipline and termination procedures. Employer shall ensure that the provisions of this Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated herein create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

(6) Certification of Employer. The Plan shall disclose PHI to Employer only upon the receipt of a certification by Employer that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Employer agrees to the conditions of disclosure set forth above.

(b) Portability: Unless the Health Care FSA is an excepted benefit, the Health Care FSA shall comply with the HIPAA group market portability rules. The Health Care FSA is an excepted benefit if:

(1) the maximum reimbursements available for the Plan Year do not exceed the greater of:

a. two times any participant's salary reduction election amount for the Plan Year; or

b. any participant's salary reduction election amount for the Plan Year plus $500; and

(2) the Participant has other major medical coverage available for the Plan Year under a group health plan maintained by the Employer, and

(3) the other coverage is not limited to benefits that are excepted benefits as defined by HIPAA.

Section 11.11: **Annual Report (Form 5500).** The Employer shall file an annual report (Form 5500) for the Plan only if required by Title I of ERISA and applicable Department of Labor regulations, which generally require annual reports for ERISA Plans with 100 or more Participants at the beginning of the Plan Year.

Section 11.12: **No Contract of Employment.** Nothing in this Plan shall be construed to create a contract to employ anyone.

Section 11.13: **Assignability of Rights.** No Participant may assign to any third party (and no creditor of any Participant may take) the Participant 's right to receive any benefit under the Plan.

Section 11.14: **Amendment and Termination.** The Employer may amend or terminate this Plan at any time. Unless otherwise provided, any such amendment or termination shall automatically extend to the Plan as adopted by any employer affiliated with the primary Employer.

Section 11.15: **Employer Reorganization.** In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate unless the Plan is continued by the successor to the Employer in accordance with a resolution of its board of directors or other managing body.

CERTIFICATE OF RESOLUTION

The undersigned as an authorized representative of (Legal Name of Organization Sponsoring the Plan)**:**

_____ **(the**

"Employer") hereby certifies that on (Date of Adoption):_____**, the**

Employer adopted the following resolution (Check only one option below):

_____ **This is an entirely new Section 125 Cafeteria Plan:**

WHEREAS, the Employer desires to offer to its employees an Internal Revenue Code section 125 "cafeteria plan."

NOW, THEREFORE, BE IT RESOLVED, that the Employer hereby establishes the cafeteria plan set forth in the attached plan document prepared by Employee Benefits Corporation and presented to the Employer.

BE IT FURTHER RESOLVED, that the individuals who manage the Employer hereby are authorized and directed to execute the plan document and related documents (such as a service agreement with Employee Benefits Corporation) on behalf of the Employer and take such other actions as are necessary or appropriate to carry out the above resolution.

_____ **This is a restatement of a previously established Section 125 Cafeteria Plan:**

WHEREAS, the Employer previously established (and currently maintains) for the benefits of its employees and their beneficiaries a Section 125 cafeteria plan (the Plan) with the name of:

_____
Legal Plan Name

NOW, THEREFORE, BE IT RESOLVED, that the Employer hereby amends and restates the Plan as set forth in the attached plan document prepared by Employee Benefits Corporation and presented to the Employer.

BE IT FURTHER RESOLVED, that the individuals who manage the Employer hereby are authorized to execute the amended and restated plan document and related documents (such as a service agreement with Employee Benefits Corporation) on behalf of the Employer and take such other actions as are necessary or appropriate to carry out the above resolution.

Please Sign and Date the Document

_____ _____
Signature Date

_____ _____
Print Name Title

