

ST. VRain VALLEY SCHOOL DISTRICT FRINGE BENEFIT PLAN

Revised Effective as of May 1, 2017

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## ARTICLE I. Introduction

### 1.1 Establishment of Plan

St. Vrain Valley School District (the Employer) hereby amends and restates the St. Vrain Valley School District Fringe Benefit Plan (the Plan) effective May 1, 2017 (the Effective Date). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay for his or her share of Contributions to participate in various Employer-sponsored health benefit programs on a pre-tax Salary Reduction basis and to contribute on a pre-tax Salary Reduction basis to one or more types of benefit accounts as permitted under Article V of the Plan that may pay or reimburse certain expenses of the Employee and his or her Dependents.

### 1.2 Legal Status

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

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

Any components in this Plan that are intended to establish an ERISA benefit plan and be subject to the provisions of ERISA, if any, are noted in Section 15.5.

## ARTICLE II. Definitions

### 2.1 Definitions

**Account(s)** means the Health FSA Accounts described in Section 7.5 and the DCAP Accounts described in Section 9.5.

**Benefits** means: Premium Payment Benefits, DCAP Benefits and Health FSA Benefits, as offered under the Plan and listed in Section 5.1.

**Benefit Package Option** means a qualified benefit under Code §125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan). Benefits prohibited under Code §125(f) (such as long-term care insurance and certain exchange-participating qualified health plans) are not permitted Benefit Package Options.

**Change in Status** means any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Plan Administrator, in its

sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations as a “change in status” that should be recognized under this Plan:

- (a) *Legal Marital Status*. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;
- (b) *Number of Dependents*. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;
- (c) *Employment Status*. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) any other change in such individual's employment status resulting in the individual becoming (or ceasing to be) eligible under this Plan or another employee benefit plan of the Employer (or of the Spouse's or Dependent's employer), such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa);
- (d) *Dependent Eligibility Requirements*. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and
- (e) *Change in Residence*. A change in the place of residence of the Participant or his or her Spouse or Dependents.

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

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

**Contributions** means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits and Section 7.2 for Health FSA Benefits, as well as Section 9.2 for DCAP Benefits.

**Committee** means the Benefits Committee, if any, appointed by the Plan Administrator to carry out the functions delegated to the Committee as identified in this Plan or as otherwise delegated by the Plan Administrator pursuant to Section 14.2

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

**DCAP** means dependent care assistance program.

**DCAP Account** means the account described in Section 9.5.

**DCAP Benefits** has the meaning described in Section 9.1.

**DCAP Component** means the component of this Plan described in Article IX.

**Dependent** means:

For purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component), (1) a dependent as defined as in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (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); and

For purposes of the DCAP Component, a Qualifying Individual.

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

**Dependent Care Expenses** has the meaning described in Section 9.3.

**Earned Income** shall have the meaning given such term in Code §129(e)(2).

**Effective Date** of this Plan means May 1, 2017.

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

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

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

**Employer** means St. Vrain Valley School District, and any Related Employer that adopts this Plan with the approval of St. Vrain Valley School District. Related Employers that have adopted this Plan, if any, are listed in Appendix A of this Plan. However, for purposes of Articles IX and XIV and Section 15.3, "Employer" means only St. Vrain Valley School District.

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

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

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

**General-Purpose Health FSA Option** has the meaning described in Section 7.3(b).

**Grace Period** means the period that begins immediately following the close of a Plan Year and ends on the fifteenth day of the third month following the close of that Plan Year.

**Health FSA** means health flexible spending arrangement, which consists of the following options: the General-Purpose Health FSA Option; the Limited (Vision/Dental/Preventive Care) Health FSA Option; the Employee-Only Health FSA Option; and the Employee-Plus-Children Health FSA Option, to the extent such options are described in Section 7.3(b).

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

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

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

**Health Insurance Benefits** means the Employee's Health Insurance Plan coverage for purposes of this Plan.

**Health Insurance Plan** means the plan(s) (other than the Health FSA) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing medical, dental, vision, or other accident and health benefits excludable from Employees' gross income under Code §105 or 106, whether or not provided on an insured or self-funded basis. Dental and vision benefits will be considered separate from any medical benefit if provided through a group insurance policy or policies separate from the respective Medical Insurance Plan, or if Employees can otherwise decline such coverage independently of the Medical Insurance Plan. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

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

**HMO** means the health maintenance organization Benefit Package Option under the Medical Insurance Plan.

**Medical Care Expenses** has the meaning described in Section 7.3.

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



**Medical Insurance Plan** means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing medical type benefits (for example, HMO, PPO, and/or High Deductible Health Plan coverage for annual well exams, laboratory tests, physician office visits, hospitalization, and/or mental health treatment) through one or more group insurance policies or self-funded arrangements, or both. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

**Open Enrollment Period** with respect to a Plan Year means the month of November in the year preceding the Plan Year, or such other period as may be prescribed by the Administrator.

**Participant** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Benefits listed in Section 5.1 and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash (rather than paying for any Contributions under any Health Insurance Plans with pre-tax dollars through this Plan) and who have not elected any of the following under the Plan: DCAP Benefits, Health FSA Benefits.

**Period of Coverage** means the twelve-month period coinciding with the Plan Year, as described in Plan enrollment materials, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of such twelve-month period following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of such twelve-month period prior to the date on which participation terminates, as described in Section 3.2.

**Plan** means the St. Vrain Valley School District Flexible Benefit Plan as set forth herein and as amended from time to time.

**Plan Administrator** means St. Vrain Valley School District. The contact person is the Assistant Superintendent of Human Resources, who has the full authority to act on behalf of the Plan Administrator, except to the extent a Committee or other person has been delegated (pursuant to Section 14.2) the full authority to act on behalf of the Plan Administrator with respect to appeals (as described in Section 13.1) or other matters under the scope of the Plan Administrator's authority.

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

**Premium Payment Benefits** means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

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

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

**Qualifying Dependent Care Services** has the meaning described in Section 9.3.

**Qualifying Individual** means (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, a Qualifying Individual who is a child shall, as provided in Code §21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code §152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

**Related Employer** means any employer affiliated with St. Vrain Valley School District that, under Code §414(b), §414(c), or §414(m), is treated as a single employer with St. Vrain Valley School District for purposes of Code §125(g)(4).

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

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

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

## **ARTICLE III. Eligibility and Participation**

### **3.1 Eligibility to Participate**

An individual is eligible to participate in this Plan if the individual satisfies all of the following:

is an Employee;

Works at least 17 ½ hours per week.

Eligibility for Premium Payment Benefits shall also be subject to the additional requirements, if any, specified in the Health Insurance Plans. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the calendar month coinciding with or following the date such requirements are attained, or for any subsequent Plan Year, in accordance with the procedures described in Article IV.

### **3.2 Termination of Participation**

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

- (a) the termination of this Plan; or
- (b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, limited continuation for certain Benefits is permitted to certain Employees for certain periods on the terms and subject to the restrictions described in Section 6.4 for Health Insurance Benefits, as well as Section 7.8 for Health FSA Benefits, and Section 9.8 for DCAP Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Health Insurance Benefits will terminate as of the date(s) specified in the Health Insurance Plans. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 9.8 for DCAP Benefits.

### **3.3 Participation Following Termination of Employment or Loss of Eligibility**

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

### **3.4 FMLA Leaves of Absence**

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

To the extent an Employer requires Participants on non-FMLA paid leave to continue Health Insurance Benefits and Health FSA Benefits coverage, an Employer may require Participants to continue such coverage while they are on paid FMLA leave. In that circumstance, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Health Insurance Benefits, and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA

leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

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

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

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

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

### **3.5 Non-FMLA Leaves of Absence**

If a Participant goes on an unpaid non-FMLA leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid non-FMLA leave that affects eligibility, then the election change rules in Section 12.3(d) will apply.

## **ARTICLE IV. Method and Timing of Elections**

### **4.1 Elections When First Eligible**

Employees who first become eligible to participate in the Plan midyear may elect to commence participation in one or more Benefits on the first day of the month coinciding with or following the date eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described under Section 12.3. Eligibility for Premium Payment Benefits shall be subject to the additional requirements, if any, specified in the Health Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Health Insurance Plan.

### **4.2 Elections During Open Enrollment Period**

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described under Section 12.3.

### **4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement**

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a midyear election change, as described under Section 12.3 or 12.4. If an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Health Insurance Benefits and is permitted to make an effective election for such Benefits under the respective Health Insurance Plans, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a midyear election change as described under Section 12.3), a timely Election Form/Salary Reduction

Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

#### **4.4 Irrevocability of Elections**

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

### **ARTICLE V. Benefits Offered and Method of Funding**

#### **5.1 Benefits Offered**

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

Premium Payment Benefits, as described in Article VI

Health FSA Benefits, as described in Article VII. The Health FSA election may be for the following:

- General-Purpose Health FSA Option

DCAP Benefits, as described in Article IX.

No Benefits under the Plan shall be provided in the form of deferred compensation, provided, however:

- Amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year as provided in Article VII.
- Amounts remaining in a Participant's DCAP Account at the end of a Plan Year can be used to reimburse the Participant for Dependent Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year as provided in Article IX.
- A Participant's Salary Reductions during the last month of a Plan Year under the Premium Payment Component may be applied by the Employer to pay the Participant's share of the Contributions for Health Insurance Benefits that are provided to the Participant during the first month of the following Plan Year.

#### **5.2 Employer and Participant Contributions**

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

(b) *Participant Contributions.* Participants who elect any of the Health Insurance Benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after-tax deductions if permitted, by completing an Election Form/Salary Reduction Agreement. Participants who elect DCAP Benefits or Health FSA Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

### 5.3 Using Salary Reductions to Make Contributions

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits and Section 9.2 for DCAP Benefits, as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the Health FSA Component or DCAP Component to the extent permitted under Section 12.3, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 12.3, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

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

(c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

(d) *After-Tax Contributions for Premium Payment Benefits.* For those Participants who elect to pay their share of the Contributions for any of the Health Insurance Benefits with after-tax deductions, if permitted, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

### 5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. The Employer may choose to hold assets in trust as a reserve or otherwise for purposes of ensuring adequate funds for payment of claims and expenses incurred under the Plan. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits, as described in

Section 6.2; and (b) as described under Section 7.4(b) for Health FSA Benefits and Section 9.4(b) for DCAP Benefits.

## **ARTICLE VI. Premium Payment Component**

### **6.1 Benefits**

The Premium Payment Component offers benefits under each Health Insurance Plan. Notwithstanding any other provision in this Plan, the Health Insurance Benefits are subject to the terms and conditions of the Health Insurance Plans, and no changes can be made with respect to such Health Insurance Benefits under this Plan (such as midyear changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Health Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and pay for his or her share of the Contributions, if any, for Health Insurance Benefits with after-tax deductions outside of this Plan, if permitted. Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

### **6.2 Contributions for Cost of Coverage**

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

### **6.3 Benefits Provided Under the Health Insurance Plans**

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

### **6.4 Health Insurance Benefits; COBRA**

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under any Health Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health Insurance Plans the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for COBRA coverage for Health Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because



the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

## **ARTICLE VII. Health FSA Component**

### **7.1 Health FSA Benefits**

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses under one of the Health FSA coverage options described in Section 7.3(b) (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XII), any such election is irrevocable for the duration of the Period of Coverage to which it relates. Notwithstanding any other provision of this Plan, an Eligible Employee shall not be eligible for the Health FSA Component unless he or she is also eligible for the Medical Insurance Plan.

### **7.2 Contributions for Cost of Coverage of Health FSA Benefits**

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 7.4(b).

### **7.3 Eligible Medical Care Expenses for Health FSA**

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

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

(b) *Medical Care Expenses.* The following limits apply to the scope of "Medical Care Expenses" under a Health FSA.

- *General-Purpose Health FSA Option.* For purposes of this Option, Medical Care Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code §213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VII. Notwithstanding the foregoing, the term Medical Care Expenses does not include:

- (1) premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer);

- (2) medicines or drugs, unless the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin (for this purpose, the Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug and whether the requirement of a prescription has been satisfied);
- (3) cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease); or
- (4) any other expense excluded under Appendix B or otherwise under the terms of this Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.

#### **7.4 Maximum and Minimum Benefits for Health FSA**

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

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be \$2,600, subject to Sections 7.4(c) and 7.5(c). The Plan Administrator may, from time to time, establish a minimum annual benefit amount that each Participant must elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage as a condition to participate in a Health FSA Account. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document, provided that the maximum dollar limit shall not exceed the maximum amount permitted under Code §125(i). If a Participant enters the Health FSA Component midyear or wishes to increase his or her election midyear as permitted under Section 12.3, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable. Notwithstanding the foregoing, the Plan Administrator may limit the elections of a

Participant who is terminated and rehired during the same Plan Year to the extent necessary to comply with the requirements of Code §125(i).

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII (other than under Section 12.3(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 12.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) *Monthly Limits on Reimbursing OTC Drugs.* Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's Health FSA Account in a single calendar month (even assuming that the drug otherwise meets the requirements of this Article VII, including that it has been prescribed (unless it is insulin) and is for medical care under Code §213(d)); stockpiling is not permitted.

(f) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of Section 7.4(b), an individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year Health FSA Amounts") if he or she is either: (1) a Participant with Health FSA coverage that is in effect on the last day of that Plan Year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

- Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.
- Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 7.7 will be reimbursed first from any available Prior Plan Year Health FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Medical Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year Health FSA Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year Health FSA Amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Health FSA Amounts.
- Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than the March 31<sup>st</sup> following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health FSA Amounts. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for

expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.6(b)

## **7.5 Establishment of Health FSA Account**

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

- (a) *Crediting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.
- (b) *Debiting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period.
- (c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time except as provided in Section 7.4(f). Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

## **7.6 Forfeiture of Health FSA Accounts; Use-or-Lose Rule**

- (a) *Use-or-Lose Rule.* Except as otherwise provided in Section 7.4(f) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.
- (b) *Use of Forfeitures.* All forfeitures under this Plan shall be retained by the Employer as part of its general assets available to offset the cost of Plan administration or for any other purposes determined appropriate by the Employer, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

## **7.7 Reimbursement Claims Procedure for Health FSA**

- (a) *Timing.* Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care

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

(b) *Claims Substantiation.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the March 31 following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 90 days after the date that eligibility ceases, as described in Section 7.8) setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. The Plan Administrator may, from time to time, establish a minimum aggregate amount for each reimbursement claim submitted other than the final reimbursement claim for the applicable Period of Coverage. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

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

(d) *Claims Ordering; No Reprocessing.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

## **7.8 Reimbursements From Health FSA After Termination of Participation; COBRA**

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. Participants will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

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

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

## **7.9 [Reserved]**

## **7.10 Coordination of Benefits**

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

## **7.11 Qualified Reservist Distributions**

Notwithstanding any other provision of the Plan to the contrary, a Participant who meets each of the following requirements may elect to receive a distribution of certain funds from his or her account in the Health FSA for a Plan Year ("Qualified Reservist Distribution"):

- (a) The Participant's contributions to his or her Health FSA Account for the Plan Year as of the date of the request for a Qualified Reservist Distribution exceed the reimbursements he or she has received from his or her Health FSA Account for the Plan Year as of that date.
- (b) The Participant is ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of 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. The Participant has provided the Plan Administrator with a copy of the

order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.

(c) During the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant delivers a written election to the Plan Administrator in such form as the Plan Administrator may prescribe, requesting a Qualified Reservist Distribution.

The Plan Administrator will review all requests for Qualified Reservist Distributions on a uniform and consistent basis. Requests for qualified reservist distributions that are approved by the Plan Administrator shall be paid within a reasonable time, not to exceed 60 days after the date of the Participant's request. The amount of any Qualified Reservist Distribution made under this provision shall be equal to the Participant's contributions to his or her Health FSA Account for the Plan Year as of the date of the request for a Qualified Reservist Distribution, minus the reimbursements he or she has received from his or her Health FSA Account for the Plan Year as of that date. Notwithstanding any other provision of the Plan to the contrary, this portion of the Participant's balance may be distributed without regard to whether Medical Care Expenses have been incurred. Any portion of the distribution that is not a reimbursement for substantiated Medical Care Expenses will be included in the Participant's gross income and wages. A Participant who has requested a Qualified Reservist Distribution shall forfeit the right to receive reimbursements for Medical Care Expenses incurred during the Plan Year and on or after the date of the distribution request. However, such a Participant may claim reimbursement for Medical Care Expenses incurred during the Plan Year (or other Period of Coverage, if applicable) and before the date of the distribution request, even if such claims are submitted after the date of his or her distribution, so long as the total dollar amount of such claims does not exceed the amount of the Participant's election under the Health FSA Component for the Plan Year, less the sum of his or her Qualified Reservist Distribution under this provision and the reimbursements he or she has received from his or her Health FSA Account for the Plan Year.

## **ARTICLE VIII. [Reserved]**

## **ARTICLE IX. DCAP Component**

### **9.1 DCAP Benefits**

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

### **9.2 Contributions for Cost of Coverage for DCAP Benefits**

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 9.4(b). (For example, if the maximum \$5,000 annual benefit amount is elected, then the annual Contribution amount is also \$5,000.)

### **9.3 Eligible Dependent Care Expenses**

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

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

(b) *Dependent Care Expenses.* "Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code §21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services—provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article IX.

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

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility (including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

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

- an individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or his or her Spouse;
- a Participant's Spouse;
- a Participant's child (as defined in Code §152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or
- a parent of a Participant's under age 13 qualifying child as defined in Code §152(a)(1) (e.g., a former spouse who is the child's noncustodial parent).

#### **9.4 Maximum and Minimum Benefits for DCAP**

(a) *Maximum Reimbursement Available.* The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 9.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account, that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements.) Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article IX have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be \$5,000 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election



is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse will be deemed to have earned income of at least \$250 (\$500 if the Participant has two or more Qualifying Individuals) for each month in which the Spouse is either (1) physically or mentally incapable of self-care (provided that the Spouse must have the same principal place of abode as the Participant for more than one-half of such year), or (2) a Student); or
- either \$5,000 or \$2,500 for the calendar year, as applicable under the following provisions:
  - (1) \$5,000 for the calendar year if one of the following applies:
    - the Participant is married and files a joint federal income tax return;
    - the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or
    - the Participant is single or is the head of the household for federal income tax purposes; or
  - (2) \$2,500 for the calendar year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

The Plan Administrator may, from time to time, establish a minimum annual benefit amount that each Participant must elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage as a condition to participate in a DCAP Account

(c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 12.3, then there will be no proration rule—i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 9.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

(e) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of Section 9.4(a), an individual may be reimbursed for Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her DCAP Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year DCAP Amounts") if he or she is a Participant with DCAP Benefits coverage that is in effect on the last day of that Plan Year.

- Prior Plan Year DCAP Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year DCAP Amounts may not be used to reimburse Medical Care Expenses.
- Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 9.7 will be reimbursed first from any available Prior Plan Year DCAP Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year. An individual's Prior Plan Year DCAP Amounts will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such Prior Plan Year DCAP Amounts.
- Claims for reimbursement of Dependent Care Expenses incurred during a Grace Period must be submitted no later than the March 31<sup>st</sup> following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year DCAP Amounts. Any Prior Plan Year DCAP Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 9.6.

### **9.5 Establishment of DCAP Account**

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 9.6.

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

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

(c) *Available Amount Is Based on Credited Amount.* As described in Section 9.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

### **9.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule**

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then, except as otherwise provided in Section 9.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year DCAP Amounts for expenses incurred during a Grace Period), such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be retained by the Employer as part of its general assets available to offset the cost of Plan administration or for any other purposes determined appropriate by the Employer, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

## 9.7 Reimbursement Claims Procedure for DCAP

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

(b) *Claims Substantiation.* A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the March 31<sup>st</sup> following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 90 days after the date that eligibility ceases, as described in Section 9.8), setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 9.4(b); and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. The Plan Administrator may, from time to time, establish a minimum aggregate amount for each reimbursement claim submitted other than the final reimbursement claim for the applicable Period of Coverage.

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

## 9.8 Reimbursements From DCAP After Termination of Participation

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible (except as otherwise provided in Section

9.4(d) regarding certain individuals who may be reimbursed from Prior Plan Year DCAP Amounts for expenses incurred during a Grace Period).

## **9.9 Report to DCAP Participants**

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

## **ARTICLE X. HIPAA Privacy and Security Provisions**

### **10.1 General**

The following provisions governing protected health information ("PHI") are adopted to the extent required by and pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("HIPAA Privacy & Security"), as amended.

The Employer makes arrangements to obtain enrollment and disenrollment information for purposes of its payroll policies and practices, and such enrollment and disenrollment information is not subject to the terms of this Article X.

### **10.2 Definitions**

All capitalized terms within this Article X not otherwise defined by the provisions of this Article X shall have the meaning given them in the Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA Privacy & Security. As used in this Article X, "Participant" shall mean any individual who enrolls in a Health FSA under the Plan. References to PHI mean PHI associated with the Health FSA.

### **10.3 Uses and Disclosures of PHI**

The Plan may disclose a Participant's PHI to the Employer (or to the Employer's agent) for Plan administration functions under 45 CFR 164.504(a), to the extent not inconsistent with HIPAA Privacy & Security.

### **10.4 Restriction on Plan Disclosure to the Employer**

Neither the Plan nor any of its Business Associates, health insurance issuers, or HMOs, will disclose PHI to the Employer except upon the Plan's receipt of the Employer's certification that the Plan has been amended to incorporate the agreements of the Employer under Section 10.5, except as otherwise permitted or required by law.

### **10.5 Privacy and Security Agreements of the Employer**

As a condition for obtaining PHI from the Plan, its Business Associates, Insurers, and HMOs, the Employer agrees it will:

- a. Not use or further disclose such PHI other than as permitted by Section 10.3 of this Article X, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of HIPAA, or as required by law;
- b. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions and security measures that apply to the Employer with respect to such information;
- 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 the Employer;
- d. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware;
- e. Make the PHI of a particular Participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA Privacy & Security regulations 45 CFR 164.524 and 164.526;
- f. Make the PHI of a particular Participant available for purposes of required accounting of disclosures by the Employer pursuant to the Participant's request for such an accounting in accordance with HIPAA Privacy & Security regulation CFR §164.528;
- g. Make the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA Privacy & Security;
- h. If feasible, return or destroy all PHI received from the Plan that the 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, the Employer agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- i. Ensure that there is adequate separation (and that such separation is supported by reasonable and appropriate security measures) between the Plan and the Employer by implementing terms of subparagraphs 10.5.i(1) through (3), below:
  - (1) Employees With Access to PHI: Only individuals performing the following functions under the control of the Employer who are may access PHI received from the Plan:
    - Superintendent of Human Resources
    - Benefit Specialist
  - (2) Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA Privacy & Security regulations 45 CFR §164.504(a) that are performed by the Employer (including its agents) for the Plan.
  - (3) Mechanism for Resolving Noncompliance: If the Employer's Board of Directors or its designate determines that any person described in (1), above, has violated any of the restrictions of this provision, then such individual shall be disciplined in accordance with the policies of the Employer or its designate, up to and including dismissal from employment. The Employer shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

- j. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of a Participant's electronic PHI that the Employer creates, receives, maintains, or transmits on the Plan's behalf; and
- k. Report to the Plan any attempted or successful unauthorized access, use, disclosure, modification, or destruction of electronic PHI, or interference with the system operations in the Employer's information systems, of which the Employer becomes aware.

#### **10.6 PHI not Subject to this Provision.**

Notwithstanding the foregoing, the terms of this provision shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504(f)(l)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by HIPAA..

### **ARTICLE XI. [Reserved]**

### **ARTICLE XII. Irrevocability of Elections; Exceptions**

#### **12.1 Irrevocability of Elections**

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

- (a) participation in this Plan;
- (b) Salary Reduction amounts; or
- (c) election of any Benefit Package Options.

#### **12.2 Procedure for Making New Election If Exception to Irrevocability Applies**

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 12.3 (or within 60 days of the occurrence of an event described in Section 12.3(e)(3) or (4)), as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event.

(b) *Effective Date of New Election.* Except as provided in Section 12.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, elections made pursuant to this Section 12.2 shall be effective only on a prospective basis for the remainder of the Period of Coverage commencing with the first of the month following the date eligibility and enrollment requirements are met unless a subsequent event allows for a further election change. However, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later or if the election change is not submitted in the manner or form required by the Plan Administrator.

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components, see Sections 7.4 and 9.4 respectively.

### **12.3 Events Permitting Exception to Irrevocability Rule for All Benefits**

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

(a) *Open Enrollment Period (Applies to: Premium Payment Benefit, Health FSA Benefit, DCAP Benefit).* A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.

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

(c) *Leaves of Absence (Applies to: Premium Payment Benefit, Health FSA Benefit, DCAP Benefit).* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

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

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Ability to Increase Plan Contributions for Continuation Coverage.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a

Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage.

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

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

(e) *HIPAA Special Enrollment Rights (Applies to Medical Insurance Benefits, but Not to: dental or vision benefits separate from Medical Insurance Benefit, or Health FSA Benefit, or DCAP Benefit).* The events described below may create a right to enroll in the plan under a special enrollment period. The "enrollment date" for anyone who enrolls under special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period under Sections 3.1 or 4.1.

(1)  **Losing other coverage may create a special enrollment right.** An Employee, Spouse or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

- (a) The Employee, Spouse or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for the declining enrollment.
- (c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will be effective the day following loss of other coverage.
- (d) The Employee, Spouse or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will be effective the day following loss of other coverage.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

- (a) The Employee, Spouse or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).



- (b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, reduction in the number of hours of employment or contributions toward the coverage were terminated.
  - (c) The Employee, Spouse or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual).
  - (d) The Employee, Spouse or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual) and no other benefit package is available to the individual.
- (3) **Acquiring a newly eligible Spouse or Dependent may create a special enrollment right.**

If:

- (a) The Employee is a participant under this Plan (or did not enroll after satisfying any eligibility requirements and is still eligible for coverage), and
- (b) A person becomes a Spouse or Dependent of the Employee through marriage, birth adoption or placement for adoption,

then the Spouse or Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this special enrollment period in order for his eligible Spouse or Dependent to enroll. IN the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled if the Spouse is otherwise eligible for coverage.

The special enrollment period for a newly eligible Spouse or Dependent is a period of 31 days after the date of the marriage, birth, adoption or placement for adoption. To be eligible for this special enrollment, the Spouse , Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Spouse, Dependent and/or Employee enrolled in the special enrollment period will be effective:

- (1) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (2) in the case of a Dependent's birth, as of the date of birth; or
- (3) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

- (4) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a special enrollment right.** An Employee, Spouse or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

- (a) The Employee, Spouse or Dependent is covered under a Medicaid plan under Tiutle XIX of the Social Security Act or a state Child Health Insurance Program (CHIP) under Title XXI of such Act, and coverage of the Employee, Spouse or Dependent is terminated due to loss of eligibility for such coverage, and the Employee, Spouse or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
- (b) The Employee, Spouse or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or SHIP plan (including any

waiver or demonstration project conducted with respect to such plan) and the Employee, Spouse or Dependent requests enrollment in this Plan within 60 days after the date the Employee, Spouse or Dependent is determined to be eligible for such assistance.

If a Spouse or Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective the day following loss of other coverage.

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

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

(h) *Change in Cost (Applies to: Premium Payment Benefit, DCAP Benefit as Limited Below, but Not to Health FSA Benefit)*. For purposes of this Section 12.3(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

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

The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

- (2) **Significant Cost Increases.** If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as a PPO that might be offered under a medical plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.
- (3) **Significant Cost Decreases.** If the Plan Administrator determines that the cost of any Benefit Package Option (such as a coverage option under the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as a PPO that might be offered under a medical plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.
- (4) **Limitation on Change in Cost Provisions for DCAP Benefit.** The above "Change in Cost" provisions (Sections 12.3(h)(1) through 12.3(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§152(d)(2)(A) through (G), incorporating the rules of Code §§152(f)(1) and 152(f)(4).
  - (i) *Change in Coverage (Applies to: Premium Payment Benefit, DCAP Benefit, but Not to Health FSA Benefit).*

The definition of "similar coverage" under Section 12.3(h) applies also to this Section 12.3(i).

- (1) **Significant Curtailment.** If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.
  - (i) **Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under

another Benefit Package Option that provides similar coverage (for example, switching from a PPO with increased deductibles to an HMO, but not to a Health FSA). Coverage under a plan is deemed to be “significantly curtailed” only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

- (ii) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.
  - (iii) Definition of Loss of Coverage. For purposes of this Section 12.3(i)(1), a “Loss of Coverage” means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:
    - a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in Medical Insurance Plan network or in an HMO);
    - a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
    - any other similar fundamental loss of coverage.
  - (iv) DCAP Coverage Changes. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.
- (2) Addition or Significant Improvement of a Benefit Package Option. If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.
- (3) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her

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

- (4) **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.
- (j) *Reduction of Hours to Below 30/Week. (Applies to Only to Medical Insurance Benefits.)* A Participant reasonably expected to average 30 hours of service or more per week who experiences an employment status change such that the Participant is no longer reasonably expected to average 30 hours of service or more per week may prospectively revoke an election for Medical Insurance Plan coverage upon the Plan Administrator's acceptance of the Participant's certification that the Participant and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform that is effective no later than the first day of the second month following the month that includes the date the Medical Insurance Plan coverage is revoked.
- (k) *Exchange Enrollment. (Applies to Only to Medical Insurance Benefits.)* A Participant that is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period may prospectively revoke an election for Medical Insurance Plan coverage upon the Plan Administrator's acceptance of the Participant's certification that the Participant and any related individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the Medical Insurance Plan coverage.

A Participant entitled to change an election as described in this Section 12.3 must do so in accordance with the procedures described in Section 12.2.

#### **12.4 [Reserved]**

#### **12.5 Election Modifications Required by Plan Administrator**

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from

having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the Plan Administrator determines the applicable requirement is satisfied.

### **ARTICLE XIII. Appeals Procedure**

#### **13.1 Procedure If Benefits Are Denied Under This Plan**

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. To the extent the administration of appeals has been delegated to a Committee or other person pursuant to the Plan Administrator's authority under Section 14.2, such Committee or person shall act on behalf of the Plan Administrator with respect to appeals.

#### **13.2 Claims Procedures for Health Insurance Benefits**

Claims and reimbursement for Health Insurance Benefits shall be administered in accordance with the claims procedures for the Health Insurance Benefits, as set forth in the plan documents and/or summary plan description for the Health Insurance Plans.

### **ARTICLE XIV. Recordkeeping and Administration**

#### **14.1 Plan Administrator**

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan and consistent with all applicable laws.

#### **14.2 Powers of the Plan Administrator**

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

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);
- (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

- (c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- (e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;
- (f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- (g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
- (h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- (i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- (j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

The Plan Administrator may delegate any of its discretionary or non-discretionary functions among one or more persons or entities, provided that any such delegation of functions that includes discretionary authority is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

#### **14.3 Reliance on Participant, Tables, etc.**

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

#### **14.4 Provision for Third-Party Plan Service Providers**

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

#### **14.5 Fiduciary Liability**

To the extent permitted by law, neither the Plan Administrator nor any any Employee shall incur any liability for any acts or for failure to act in connection with the administration of this Plan except for their own willful misconduct or willful breach of this Plan.

#### **14.6 Compensation of Plan Administrator**

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but, subject to Section 15.1, all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

#### **14.7 Bonding and Liability Insurance**

The Plan Administrator shall be bonded to the extent required by applicable law. Fiduciary liability insurance may also be obtained to insure each fiduciary against liability, to the extent permissible by law, at the Employer's expense.

#### **14.8 Inability to Locate Payee**

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

#### **14.9 Facility of Payment**

In the event any benefit under this Plan shall be payable to a person who is under legal disability or is in any way incapacitated so as to be unable to manage his or her financial affairs, the Plan Administrator may direct payment of such benefit to a duly appointed guardian, committee or other legal representative of such person, or in the absence of a guardian or legal representative, to a custodian for such person under a Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such person's benefit. If benefits remain unpaid, the Plan Administrator may choose to make direct payment to any of the following living relatives of the Employee: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of the Employee's estate. Any payment made in good faith pursuant to this provision will be in complete discharge of the liabilities of the Plan and the obligations of the Plan Administrator, its delegates, and the Employer.

#### **14.10 Effect of Mistake**

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

### **ARTICLE XV. General Provisions**

#### **15.1 Expenses**



All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 9.6 with respect to DCAP Benefits, and then by the Employer. The Employer may advance funds for the payment of ordinary operating expenses of the Plan (including the payment of benefits in accordance with the terms of the Plan and periodic premiums under an insurance contract) or for a purpose incidental to the ordinary operation of the Plan, to the extent otherwise permitted under applicable law.

### **15.2 No Contract of Employment**

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

### **15.3 Amendment and Termination**

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by a written instrument duly adopted by the Plan Sponsor or any of its authorized delegates, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

### **15.4 Governing Law**

This Plan shall be construed, administered, and enforced according to the laws of the State of Colorado (disregarding any state conflicts of laws rules), to the extent not superseded by the Code, or any other federal law.

### **15.5 Compliance With Code and Other Applicable Laws**

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

### **15.6 No Guarantee of Tax Consequences**

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

### **15.7 Indemnification of Employer**

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

**15.8 Non-Assignability of Rights**

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

**15.9 Headings**

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

**15.10 Plan Provisions Controlling**

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

**15.11 Severability**

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

\* \* \*

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the St. Vrain Valley School District Fringe Benefit Plan, St. Vrain Valley School District has caused this Plan to be executed in its name and on its behalf, on this \_\_\_\_ day of

\_\_\_\_\_.

ST. VRAIN VALLEY SCHOOL DISTRICT

By: \_\_\_\_\_

Title: \_\_\_\_\_

Assistant Superintendent of Human Resources

## Appendix A

[No Related Employers have adopted the Plan]

## Appendix B

### Exclusions—Medical Expenses That Are Not Reimbursable From the Health FSA

Exclusions: The following expenses are not reimbursable from the Health FSA, even if they meet the definition of “medical care” under Code §213(d) and may otherwise be reimbursable under legal requirements applicable to health FSAs:

- Premiums for other health coverage, including but not limited to premiums for any other plan (whether or not sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee’s or Dependent’s inability to perform physical housework).
- Custodial care.
- Medicines or drugs (other than insulin) available over-the-counter that have not been prescribed.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, and similar items of general personal care and grooming
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any kind, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code §213(d).
- Any item that is not reimbursable due to the rules in Prop. Treas. Reg. §1.125-5(k)(4) or other applicable law or regulations.