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The BESTflex<sup>SM</sup> Plan helps you and your employees save money.

## ■ About the Plan Document

The *Plan Document* is the legal outline of your plan and must be followed according to your plan set-up as specified in the *Plan Adoption Agreement*, incorporated by reference herein. In the case of any conflict between this *Plan Document*, the *Summary Plan Description*, and/or any other reference materials provided to you or your Participants, this *Plan Document* will control. You should keep your *Plan Document* available at all times and, when necessary, use it as a reference tool. You must make the *Plan Document* available to your BESTflex Plan Participants upon request.

## Certificate of Resolution

The undersigned as an authorized representative of:

("Employer")

hereby certifies that on

Date (mm-dd-yyyy)

the governing body<sup>1</sup> of the Employer adopted the following resolutions:

(Choose only one)

### ☒ Entirely new Section 125 Cafeteria Plan

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

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

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

### ☐ Restated existing Section 125 Cafeteria Plan

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

☐ [Employer Name] Flexible Compensation Plan

☐ Previously established custom name:

Enter the custom name

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

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

## Please Sign and Date the Document

X

Employer: Signature

Date (mm-dd-yyyy)

Print Name

Title

<sup>1</sup> Board of directors, in the case of a corporation. Voting partners in the case of a partnership. Managers in the case of a limited liability.

## ■ Article 1 - Purpose

This document, together with the *Plan Adoption Agreement* as completed and adopted by the Employer, sets forth the Flexible Compensation Plan, hereinafter referred to as the "BESTflex<sup>SM</sup> Plan" or the "Plan." The purpose of the Plan is to furnish Participants an opportunity to receive certain nontaxable benefits provided by the Employer in lieu of taxable compensation.

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

## ■ Article 2 - Definitions

**Section 2.1: Administrator** means the Employer or a person or entity appointed by the Employer to be the Administrator.

**Section 2.2: Benefit Package Option** means a benefit offered under this Plan, or an option for coverage under an Underlying Medical Plan (such as an indemnity option, an HMO option, or a PPO option under a major medical plan).

**Section 2.3: Qualifying Event** means an event described in Treasury Regulations § 1.125-4(c)(2) and explained in Section 4.2.

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

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

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

- (a) for purposes of the Dependent Care FSA, Dependent means "qualifying individual" as defined in Code § 21(b)(1):
  - (1) a "qualifying child," as defined in Code § 152(a)(1), who is under the age of 13;
  - (2) a dependent who is physically or mentally incapable of caring for himself/herself and has the same principal place of abode as the Participant for more than half of the taxable year; and
  - (3) the Participant's spouse, if he/she is physically or mentally incapable of caring for himself/herself and has the same principal place of abode as the Participant for more than half of the taxable year; and

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

- (1) more than one-half of the child's support during the calendar year comes from one or both parents;
- (2) the child is in the custody of one or both parents for more than one-half of the calendar year; and
- (3) the child qualifies under Code § 152(c) or § 152(d) as a qualifying child or qualifying relative of one of the parents.

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

Nevertheless, Dependent Care Expenses do not include:

- (a) expenses incurred when the Employee is not a Participant in Dependent Care FSA under Article 5;
- (b) amounts paid to an individual with respect to whom a dependent-exemption deduction is allowable under Code § 151(a) to the Participant or his or her spouse;
- (c) amounts paid to the Participant's spouse;
- (d) amounts paid to a child of the Participant who is under 19 years of age at the end of the year in which the expenses were incurred; or
- (e) amounts paid for overnight camp or care that is primarily educational in nature.

**Section 2.8: Dependent Care FSA** is the account described in Section 5.16.

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



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

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

**Section 2.12: Eligible Employee** means an Employee eligible to participate in this Plan as provided in the section titled "Calculate FSA eligibility" of the *Plan Adoption Agreement*.

**Section 2.13: Employee** means an individual who is on the Employer's Form W-2 payroll. Employee does not include any individual not on the Employer's Form W-2 payroll, even if a governmental agency or a court later determines that he/she is a common-law employee who should have been included on the Employer's Form W-2 payroll. The preceding notwithstanding, to the extent elected by the Employer, Employee may include an individual who was on the Employer's Form W-2 payroll (i.e., former employees, retirees).

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

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

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

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

**Section 2.18: Group Insurance Premium Account** means Group Insurance Premiums under Article 5 of the Plan, providing for pre-tax treatment of employee premiums for coverage under an Underlying Plan.

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

**Section 2.20: Health Care FSA** means the account described in Section 5.9.

**Section 2.21: Health Savings Account** is the account described in Article 7.

**Section 2.22: HIPAA** means the Health Insurance Portability and Accountability Act of 1996 and any other similar state law to the extent applicable, as amended from time to time.

**Section 2.23: Individual Billed Premium ("IND") Account** means the account described in Section 5.5

**Section 2.24: Individual Billed Premium (IND) Expenses** means premium expenses for coverage under an individual (as opposed to group) insurance policy which is owned by the Participant and covers the Participant, and perhaps also the spouse, Dependent or Eligible Child of the Participant. This may also include dental, vision and other similar types of coverage.

**Section 2.25: Open Enrollment Period** with respect to a Plan Year means the period, occurring before the year begins, that the Administrator prescribes for an Eligible Employee to make an election to participate for the year.

**Section 2.26: Participant** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article 3.

**Section 2.27: Plan Year** is defined in BESTflex Plan Year of the *Plan Adoption Agreement*.

**Section 2.28: Qualified Reservist Distribution** means a taxable distribution from a Health Care FSA to an employee of all or a portion of the balance in the employee's Health Care FSA if:

- (a) the employee is a member of a reserve component (as defined in 37 U.S.C. § 101) who is ordered or called to active duty for a period of 180 days or more or for an indefinite period; and
- (b) the employee's active duty commences on or after June 18, 2008, or the employee's prior order or call to active duty continues beyond June 18, 2008; and



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

**Section 2.29: Spouse** means a person to whom an individual is legally married under the laws of a state or country and from whom the individual is not legally separated under a decree of divorce or separated maintenance.

**Section 2.30: Underlying Health Plan** means a plan identified in the section titled "Group Premium Accounts" of the *Plan Adoption Agreement* (under Payroll Deducted Premiums) that provides medical care as defined in Code § 213(d) to an Employee or an Employee's Dependent, whether directly, or through insurance, reimbursement or otherwise.

**Section 2.31: Underlying Plan** means a plan identified in the section titled "Group Premium Accounts" of the *Plan Adoption Agreement* (under Payroll Deducted Premiums).

**Section 2.32: Uniformed Services Leave** means a leave of absence governed by USERRA.

**Section 2.33: USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

## ■ Article 3 - Elections to Participate

**Section 3.1: Election to Participate.** For any Plan Year, an Eligible Employee may elect to participate in one or more Accounts of the Plan as set forth below. Such elections may be changed mid-year only as permitted by Article 4.

**Section 3.2: Automatic Election Under Pre-tax Premium Account.** An Eligible Employee is deemed to have elected to participate in the Pre-tax Premium Account for a Plan Year if:

- (a) he/she is covered under an Underlying Plan during the year;
- (b) the Employer requires him/ her to pay part or all of the cost of coverage under the Underlying Plan during the year (or pays him/her to forego such coverage); and
- (c) he/she does not elect to make such payments (or receive the coverage) on an after-tax basis (if allowed by the Employer). Such an election must be made before the year begins (or when he/she becomes an Eligible Employee, if that occurs after the year begins) and must be in writing acceptable to the Administrator.

If an Employee does not participate in the Pre-tax Premium Account for a Plan Year but is eligible for Underlying Plan coverage, then the Employee shall pay his/her share of the premiums for such coverage on an after-tax basis outside of this Plan (and the Employer's share of the premium shall be paid outside of this Plan).

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

- (a) **Election When First Eligible.** An Employee who first becomes an Eligible Employee after a Plan Year begins may, by submitting an acceptable Election Form to the Administrator before the first day he/she becomes an Eligible Employee, become a Participant for the remainder of the Plan Year. Except as otherwise permitted by Article 4, an Employee who does not elect to participate when first eligible may not enroll until the next Open Enrollment Period. Refer to Eligibility and Participation of the *Plan Adoption Agreement* for the Plan's eligibility requirements.
- (b) **Elections During Open Enrollment Period.** Before or during the Open Enrollment Period for each Plan Year, the Administrator shall provide each Eligible Employee with an Election Form on which he/she may elect to participate for the year. To participate for the year, the Employee must return the Election Form to the Administrator on or before the last day of the Open Enrollment Period. Except as otherwise permitted by Article 4, an Employee who does not make a timely election during an Open Enrollment Period may not elect to become a Participant until the next Open Enrollment Period.

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

- (a) the termination of this Plan;
- (b) the date on which the Participant ceases to be an Eligible Employee (or, if later, the date on which COBRA coverage under the Plan terminates); or
- (c) the date on which the Participant revokes his/her election as permitted under Article 4.

**Section 3.5: Rehire Following Termination of Employment.** If during a Plan Year, a Participant's employment with the Employer is terminated but, within 30 days of termination (but within the same Plan Year), the Participant is rehired by the Employer, then the Participant shall be treated

for the purposes of the Plan as if his or her employment had never been terminated, with a reinstatement of all elections that he or she had made for the Plan Year and that had been in effect at the time of termination. If instead, such a terminated Participant is rehired by the Employer more than 30 days after termination (but within the same Plan Year), then upon rehire he or she shall be treated as a new Employee and, subject to any waiting period set forth in the *Plan Adoption Agreement*, be permitted to make new elections under all parts of the Plan other than the Health Care FSA and Dependent Care FSA. Such a participant who is rehired more than 30 days after termination (but within the same Plan Year) cannot participate in the Health Care FSA (except to the extent required by COBRA) or the Dependent Care FSA until the next Plan Year.

**Section 3.6: FMLA Leave.** Notwithstanding any contrary provision in this Plan, if a Participant is on FMLA Leave, then to the extent required by FMLA, the Employer shall continue to maintain the coverage under the Underlying Medical Plan (and pay the Employer's share of the premiums) on the same terms and conditions as if the Participant were still an active Employee. A Participant in the Health Care FSA or Pre-tax Premium Account may elect to continue such participation during the FMLA Leave. If the Participant elects to continue such coverage while on leave, the Participant may pay his/her share of the premiums in one of the following ways:

- (a) with after-tax dollars, by sending monthly payments to the Employer;
- (b) with pre-tax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave (during the current Plan Year only) on a pre-tax salary reduction basis out of pre-leave compensation (by making a special election to that effect prior to the date that such compensation would normally be made available); or
- (c) under another arrangement that the Participant and the Employer agree upon (e.g., an arrangement whereby the Employer pays for coverage during the leave and withholds "catch-up" amounts upon the Participant's return).

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

**Section 3.7: Non-FMLA Leave.** When a Participant goes on a non-FMLA leave of absence, the Employer's usual procedures apply. The leave constitutes a change in employment status which, if it affects benefit eligibility, would be a qualifying event as described in Section 4.2(a)(3).

## ■ Article 4 - Events Permitting Election Changes

**Section 4.1: Irrevocability of Election.** Except as described in Section 4.2, a Participant's election under the Plan is irrevocable for the duration of the applicable Plan Year.

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

- (a) **Change in Status.** A Participant may change or terminate his/her actual or deemed election under the Plan as described in Treasury Regulations § 1.125-4(c) if the Administrator determines (based on prevailing IRS guidelines) that a change in status has occurred and the election change satisfies the consistency rule in Section 4.2(b). The change in status event events are:

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

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

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



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

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

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

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

**(2) Gain of Coverage Eligibility under Another Employer's Plan.** If, as a result of a change in marital status or employment status, a Participant (or his/her Spouse, Dependent or Eligible Child) gains eligibility for coverage under a plan that is sponsored by the employer of the Employee or Participant's Spouse, Dependent or Eligible Child and that provides qualified benefits under Code § 125, then the Participant may decrease or cancel coverage under this Plan only if coverage for the individual becomes applicable or is increased under the other plan.

**(3) Special Rule for Dependent Care FSA. A**

Participant may change his/her election under the Dependent Care FSA if the change is made on account of and corresponds with a qualifying event that affects (a) eligibility for coverage under that the Dependent Care FSA or (b) expenses described in Code § 129.

**(c) HIPAA Special Enrollment Rights.** As provided by Treasury Regulations § 1.125-4(b), if a Participant (or his/her Spouse, Dependent or Eligible Child) is entitled to a special enrollment right under an Underlying Health Plan or Health Care FSA (unless such plan is an excepted benefit under HIPAA's portability provisions; most non-major medical plans are excepted benefits) as required by Code § 9801(f), then the Participant may revoke a prior election under the Underlying Health Plan and make a new salary reduction election, provided that the new election corresponds with such special enrollment right. A special enrollment right might arise if coverage of the Participant (or his/her Spouse, Dependent or Eligible Child) under the Underlying Health Plan had been declined because of other coverage but eligibility for such other coverage was later lost due to divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, if a new Dependent or Eligible Child is acquired as a result of marriage, birth, or adoption, or, if the Participant (and/or Dependent or Eligible Child) loses eligibility under the Children's Health Insurance Program (CHIP) or Medicaid programs, or becomes eligible for premium assistance under CHIP or Medicaid. For purposes of this provision,

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

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

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



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

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

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

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

**(1) Automatic cost changes.** As provided by Treasury Regulations § 1.125-4(f)(2)(i), if during the Plan Year there is an increase or decrease in the cost of a qualified benefit charged to a Participant under the Plan and, under the terms of the underlying plan, covered employees are required to make a corresponding change in their payments, then

the Administrator shall, on a reasonable and consistent basis (and in accordance with prevailing IRS guidance), make a corresponding, prospective change to the Participant's salary reduction contributions to the Plan.

**(2) Significant cost changes.** As provided by Treasury Regulations § 1.125-4(f)(2)(ii), if the cost charged to a Participant for a Benefit Package Option significantly increases or significantly decreases during a Plan Year, then the Participant may make a corresponding change in election under the Plan. Changes that can be made include (a) electing to begin participation in the Plan (in the case of a decrease in the cost of a Benefit Package Option) or (b) revoking a Benefit Package Option election and, in lieu thereof, either receiving prospective coverage under another Benefit Package Option providing similar coverage or dropping coverage if no other Benefit Package Option providing similar coverage is available (in the case of an increase in the cost of a Benefit Package Option). The Administrator, in its sole discretion, shall decide (in accordance with prevailing IRS guidance) whether a cost increase or decrease is "significant" and whether a substitute Benefit Package Option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

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

**(1) Significant curtailment without loss of coverage.** As provided in Treasury Regulations § 1.125-4(f)(3)(i), if coverage is significantly curtailed (e.g., a significant increase in a deductible, co-pay, or out-of-pocket cost sharing limit under an Underlying Health Plan) then an affected Participant may revoke his/her old election and make a new election on a prospective basis. Coverage may not be entirely dropped. Coverage under a Benefit Package Option is deemed "significantly curtailed" only if there is an overall reduction in coverage so as to constitute reduced coverage to Participants generally. The Administrator (in its sole discretion) shall decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant" and whether a substitute Benefit Package Option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

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

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

**(4) Change in Coverage under Another Plan.** As provided in Treasury Regulations § 1.125-4(f)(4), to avoid "election lock," a Participant may make a prospective election change that is on account of and corresponds with a change made under another employer's plan (including a plan of the same employer or of another employer), so long as (a) that plan permits its participants to make an election change that would be permitted under Treasury Regulations § 1.125-4 or (b) the new election is for a Plan Year that is different from the Plan Year under the other plan. The Administrator (in its sole discretion) shall decide, in accordance with prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under such other plan.

**(5) Loss of Coverage under Plan of Governmental or Educational Institution.** As provided in Treasury Regulations § 1.125-4(f)(5), an Eligible Employee may make an election on a prospective basis to add coverage under the Plan for the Employee

(or his/her Spouse, Dependent or Eligible Child), if the Employee (or Spouse, Dependent or Eligible Child) loses coverage under any group health plan maintained by a governmental or educational institution, including: a children's health insurance program maintained by a state under Title XXI of the Social Security Act; a medical care program of an Indian tribal government, the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a foreign government group health plan.

**(h) HSA Election Changes.** Employees may start or stop the HSA election or increase or decrease the election at any time as long as the change is effective prospectively (i.e., after the request for change is received) as described in Section 7.4.

**Section 4.3: New Elections.** An Employee who was eligible to elect Underlying Plan, IND Account, Health Care FSA or Dependent Care FSA coverage, but who declined to do so during the initial election period or any Open Enrollment Period, or a Participant who is entitled to make a new election in accordance with Section 4.2, may make a new election as long as the Election Form is submitted within 30 days (or 60 days for a Medicaid/State Children's Health Insurance Plan event) of the occurrence of an event described in Section 4.2, as long as the election under the new Election Form is made on account of and is consistent with the event. Except for a special enrollment election to add Underlying Plan coverage for a newborn or newly adopted Dependent or Eligible Child pursuant to section 4.2(b), a new election shall be effective on the latter of the event date or the date the new election is made. New elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event described in Section 4.2 allows a further election change. Any new election for a Plan Year cannot reduce a Health Care FSA or Dependent Care FSA to a point where the total amount of reimbursement available for the Plan Year is less than the amount already reimbursed for the Plan Year. The amount of reimbursement available under the Health Care FSA or Dependent Care FSA for the remainder of a Plan Year after a new election shall include the balance (positive or negative) of the Health Care FSA or Dependent Care FSA immediately before the effective date of the new election. Further, the maximum reimbursement for the period after a new election shall not exceed the total contributions made by the Participant for the period prior to the new election plus the total expected Participant contributions for the balance of the Plan Year.

**Section 4.4 Mid-year Marketplace Elections.** If an employee has, under the Plan, elected coverage under an employer's group health plan that is not a health flexible spending arrangement ("FSA") and that provides minimum essential coverage as defined in Internal Revenue Code section 5000A(f)(1), then the employee may prospectively revoke the election of such coverage, if either of the following alternative sets of conditions (a) or (b) are satisfied:

**(a) Conditions for Revocation Due to Reduction in Hours of Service:**

- (1) The employee has been in an employment status under which the employee was reasonably expected to average at least 30 hours of service per week and the status has changed so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the group health plan; and
- (2) The revocation of the election of the coverage under the group health plan corresponds to the intended enrollment of the employee (and any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

**(b) Conditions for Revocation due to Enrollment in a Qualified Health Plan:**

- (1) The employee is eligible for a special enrollment period to enroll in a Qualified Health Plan through a Marketplace (pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance) or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and
- (2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee (and any related individuals who cease coverage due to the revocation) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the date immediately following the last day of the original coverage that is revoked.

## ■ Article 5 - Plan Accounts

### ■ Group Insurance Premium Account

**Section 5.1: Description of Group Insurance Premium Account.**

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

**Section 5.2: Description of Cash-In-Lieu-Of-Medical** (Group Insurance Premium Account). The Employer may choose to have this Group Insurance Premium Account apply if the Employer pays employees to forego coverage under an Underlying Health Plan. Economically (and for purposes of this Plan), such an arrangement is the same as the Group Insurance Premium Account.

**Section 5.3: Participant Contributions to Group Insurance Premium Account.** An Eligible Employee who, under Section 3.2, is a Participant in this Group Insurance Premium Account shall, by salary reduction, make annual (or more frequent) contributions to the Employer under rules established by the Administrator. The amount of the contribution shall equal the premium paid by the Participant for Underlying Plan coverage as described in Section 5.1 (or the cash that the Participant could have received under Section 5.2 in lieu of Underlying Plan coverage). The Administrator shall apply the Participant contributions toward the cost of the Underlying Plan coverage. If group term life insurance is one of the Underlying Plans, then the pre-tax treatment under the Plan shall apply only to the salary reduction contributions that are used to purchase up to \$50,000 of such insurance coverage (or any higher limit provided by Code § 79).

**Section 5.4: Underlying Plan Benefits.** A Participant's right to benefits under an Underlying Plan shall be determined under the provisions of the Underlying Plan (not under the provisions of this Plan).



**Section 5.5: Individual Billed Insurance Premiums (IND):** If chosen as an option by the Employer, a Participant may elect to reduce his or her salary, on a pre-tax basis, in order to pay for an individual billed insurance policy (IND) premiums. The normal reimbursement rules (outlined in Article 6) shall apply with respect to this benefit unless the Employer pays the premiums directly to the insurance company (where allowable by law).

**Section 5.6: COBRA Premiums.** If chosen as an option by the Employer, an Eligible Employee may elect to reduce his or her salary, on a pre-tax basis, in order to pay for premiums for group health plan continuation coverage procured through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar state law.

**Section 5.7: Vacation Days/PTO.** If chosen as an option by the Employer, a Participant may choose to receive cash in lieu of vacation or paid time off (PTO) benefits to which the Participant is otherwise entitled. The cash received would be fully taxable compensation to the Participant. Conversely, the Participant may elect to reduce his or her salary, on a pre-tax basis, in order to purchase additional days or weeks of vacation/PTO. The Employer has the discretion to determine how many days or weeks may be purchased. Purchased vacation/PTO shall be available for use by a participant only after all other vacation/PTO is used, and may not be carried over from one Plan Year to the next. The Employer shall determine whether unused purchased vacation/PTO is paid out in cash or forfeited.

## ■ Health Care FSA

**Section 5.8: Description of Health Care FSA (Including "limited purpose health FSA").** The Employer may choose to have this Health Care FSA apply if the Employer wants to enable employees to pay their Health Care Expenses on a pre-tax basis by means of salary reduction. The salary reduction amounts are contributed to a Health Care FSA and, from that account, Health Care Expenses are reimbursed as set forth below. The Employer may, alternatively, choose to offer a "limited purpose health FSA," which is a type of Health Care FSA that reimburses only Health Care Expenses that are for dental care or vision care. A "limited purpose health FSA" is designed to accommodate individuals who are otherwise eligible to make contributions to a Health Savings Account, as described in further in Article 7. Any subsequent reference in this Article 5 to the term "Health Care FSA" similarly applies to a "limited purpose health FSA." In addition, any reference to the term "Health Care Expenses" shall apply only to Health Care Expenses for dental care and vision care if reimbursement is sought through a "limited purpose health FSA."

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

**Section 5.9: Health Care FSA.** With respect to each Participant in the Health Care FSA for each Plan Year, the Administrator shall maintain a Health Care FSA. Consistent with Section 9.3, the account shall be a bookkeeping account only. As of the beginning of each Plan Year (or, if later, the beginning of the Participant's participation in the Health Care FSA), his/her Health Care FSA shall be credited with the salary-reduction amounts that he/she elected to contribute for the year plus the Employer's contribution, if any. A Participant's Health Care FSA shall be debited with the amounts of reimbursements made to the Participant for Health Care Expenses incurred during the Plan Year.

**Section 5.10: Participant Contributions (Health Care FSA).** The maximum amount that a Participant may contribute to his/her Health Care FSA for any Plan Year is the lesser of (a) the limit set forth in the section titled "Set your Flexible Spending Account annual limits" of the *Plan Adoption Agreement* or (b) the statutory limit as established in § 125(i) as amended by the Patient Protection and Affordable Care Act.

**Section 5.11: Uniform Coverage (Maximum Available Amount).** The maximum amount of reimbursement under the Health Care FSA for a Participant for a Plan Year shall be available at all times during the year, regardless of any salary reduction of amounts credited to his/her Health Care FSA through any particular date during the year. As a result, a Participant's Health Care FSA will have a negative balance if reimbursements (debits) for a year through a particular date have exceeded salary reduction amounts (credits) through that date. The maximum reimbursement available at any time during a year shall be reduced, however, by the amount of reimbursements previously made for the same year.

**Section 5.12: Use It Or Lose It (Health Care FSA).** Except as provided in Section 6.4 or 6.5, if any balance remains in the Participant's Health Care FSA for a Plan Year after all reimbursements have been made for the year, then the Participant shall forfeit all rights with respect to the unused balance. Except as provided in Section 6.4

or 6.5, the unused balance shall not be carried over for reimbursement of Health Care Expenses incurred during a subsequent Plan Year or for reimbursement of Dependent Care Expenses. The forfeiture shall be used as set forth in Section 9.4.

**Section 5.13: Reimbursement Procedure (Health Care FSA).** If a Participant (or his/her spouse, Dependent or Eligible Child) incurs Health Care Expenses during the Plan Year, then he/she may apply to the Administrator for reimbursement and, if the Administrator determines that the application is proper and complete, the Administrator shall cause the Participant to be reimbursed for the amount of the expenses, subject to the rules set forth in Article 6.

**Section 5.14: COBRA.** The Health Care FSA is a "group health plan" as defined in Code § 4980B(g)(2) for purposes of COBRA, which requires a Participant (and his/her Spouse, Dependents and Eligible Children) whose coverage under the Health Care FSA would otherwise terminate due to a "qualifying event" to be offered continuation coverage for a limited period on an after-tax basis. Nevertheless, the Health Care FSA for a Participant shall be entitled to the special COBRA treatment afforded by Treasury Regulations § 54.4980B-2(b)(Q/A8) if:

- (a) the maximum reimbursements available for the Plan Year do not exceed the greater of (1) two times his/her salary reduction election amount for the year or (2) his/her salary reduction election amount for the year plus \$500, and
- (b) the Participant has other major medical coverage available for the year under a group health plan maintained by the Employer. Under the special COBRA treatment:
  - (1) COBRA coverage shall be offered only if, on the date of the qualifying event (taking into account all reimbursement applications submitted before that date), there is a positive balance in the Participant's Health Care FSA, and
  - (2) if COBRA coverage is elected, it will be available only for the Plan Year in which the qualifying event occurs and will cease at the end of that year.

**Section 5.15 The Heroes Earnings And Relief Tax Act of 2008 ("HEART Act").** the Cafeteria Plan may allow certain Cafeteria Plan Participants to elect a distribution of unused amounts from their Health Care FSA. A Participant may elect to receive a Qualified Reservist Distribution only once per Plan Year. Further, a Participant's right to submit claims to

the Health Care FSA shall terminate following a Qualified Reservist Distribution. A participant may elect to receive a Qualified Reservist Distribution in an amount equal to the balance in the Healthcare FSA calculated by subtracting the reimbursements-to-date from contributions-to-date.

## ■ Dependent Care FSA

**Section 5.16: Description of Dependent Care FSA.** The Employer may choose to have this Dependent Care FSA apply if the Employer wants to enable employees to pay their Dependent Care Expenses on a pre-tax basis by means of salary reduction. The salary reduction amounts are contributed to a Dependent Care FSA and, from that account, Dependent Care Expenses are reimbursed as set forth below. Because the employee has a choice between cash (an unreduced salary) and a nontaxable benefit (reimbursement of the Dependent Care Expenses), the employee would be treated as having "constructively received" the cash and used it to purchase the reimbursements on an after-tax basis, if not for Code § 125 and this Plan. The Dependent Care FSA constitutes a dependent care assistance plan whose benefits are intended to be tax free under Code § 129.

**Section 5.17: Dependent Care FSA.** With respect to each Participant in the Dependent Care FSA for each Plan Year, the Administrator shall maintain a Dependent Care FSA. Consistent with Section 9.3, the account shall be a bookkeeping account only. The Dependent Care FSA shall be credited with the Participant's salary reduction amounts at the time that they would otherwise be paid to the Participant. The Dependent Care FSA shall also be credited with the Employer's contribution, if any, at the time determined by the Employer. A Participant's Dependent Care FSA shall be debited with the amounts of reimbursements made to the Participant for Dependent Care Expenses incurred during the Plan Year.

**Section 5.18: Participant Contributions (Dependent Care FSA).** The amount that a Participant may contribute to his/her Dependent Care FSA for any taxable year shall not exceed the maximum amount that Code § 129 permits to be excluded from gross income. Currently, such amount is the smallest of:

- (a) \$5,000 (\$2,500 if the Participant is married but files separately);
- (b) the Participant's Earned Income; or
- (c) if the Participant is married at the end of the taxable year, the spouse's Earned Income. As set forth in Code § 129(b);

- (1) if the Participant is married and his/her spouse is a full-time student at an educational institution (or is physically or mentally incapable of caring for himself/herself), then the spouse is deemed to have Earned Income of \$250 per month (\$500 per month if there are 2 or more Dependents). If contributions are made in excess of the maximums, the Employer shall report the excess as set forth in Section 5.18.

**Section 5.19: Maximum Available Amount (Dependent Care FSA).** The maximum amount of reimbursement available under the Dependent Care FSA to a Participant at any time for a Plan Year shall be limited to the balance in his/her Dependent Care Account for the year. As a result, a Participant's Dependent Care FSA should never have a negative balance.

**Section 5.20: Use It Or Lose It (Dependent Care FSA).** If any balance remains in the Participant's Dependent Care FSA for a Plan Year after all reimbursements have been made for the year, then the Participant shall forfeit all rights with respect to the unused balance. The unused balance shall not be carried over for reimbursement of Dependent Care Expenses incurred during a subsequent Plan Year or for reimbursement of Health Care Expenses. The forfeitures shall be used as set forth in Section 9.4.

**Section 5.21: Reimbursement Procedure (Dependent Care FSA).** If a Participant (or his/her spouse or Dependent) incurs Dependent Care Expenses during the Plan Year, then he/she may apply to the Administrator for reimbursement and, if the Administrator determines that the application is proper and complete, the Administrator shall cause the Participant to be reimbursed for the amount of the expenses, subject to the rules set forth in Article 6.

**Section 5.22: Form W-2 Reporting (Dependent Care FSA).** The Employer shall report the Dependent Care Expense reimbursements as required by the instructions to IRS Form W-2. Currently, the instructions require tax-free reimbursements to be reported in box 10 of the form and taxable reimbursements (e.g., from Participant contributions in excess of the Code § 129 maximums) in box 1.

## ■ Individual Billed Premium (IND) Account

**Section 5.23 Description of IND Account.** The Employer may choose to have this IND Account apply if the Employer wants to enable employees to pay their IND Expenses on a pre-tax basis by means of salary reduction. The salary reduction amounts are contributed to an IND Account and, from that account, IND Expenses are reimbursed as set forth below. Because the employee has a choice between cash (an unreduced salary) and a nontaxable benefit (reimbursement of the IND Expenses), the employee

would be treated as having "constructively received" the cash and used it to purchase the reimbursements on an after-tax basis, if not for Code § 125 and this Plan.

**Section 5.24 IND Account.** With respect to each Participant who elects to reduce his/her salary to pay for IND Expenses for each Plan Year, the Administrator shall maintain an IND Account for that Participant. Consistent with Section 9.3, the account shall be a bookkeeping account only. The IND Account shall be credited with the Participant's salary reduction amounts at the time that they would otherwise be paid to the Participant. The IND Account shall also be credited with the Employer's contribution, if any, at the time determined by the Employer. A Participant's IND Account shall be debited with the amounts of reimbursements made to the Participant for IND Expenses incurred during the Plan Year.

**Section 5.25 Use It Or Lose It (IND Account).** If any balance remains in the Participant's IND Account for a Plan Year after all reimbursements have been made for the year, then the Participant shall forfeit all rights with respect to the unused balance. The unused balance shall not be carried over for reimbursement of IND Expenses incurred during a subsequent Plan Year or for reimbursement of Health Care Expenses or Dependent Care Expenses. The forfeitures shall be used as set forth in Section 9.4.

**Section 5.26 Reimbursement Procedure (IND Account).** If a Participant (or his/her spouse, Dependent or Eligible Child) incurs IND Expenses during the Plan Year, then he/she may apply to the Administrator for reimbursement and, if the Administrator determines that the application is proper and complete, the Administrator shall cause the Participant to be reimbursed for the amount of the expenses, subject to the rules set forth in Article 6.

**Section 5.27 Eligible IND Expenses.** Participants may be reimbursed for eligible dental, vision, disability, accidental death and dismemberment, cancer or hospital indemnity insurance premiums for the employee, spouse and dependent. Health insurance is not eligible for reimbursement.

## ■ Article 6 - Reimbursement Rules

**Section 6.1: Incurrence of Expenses.** An expense is incurred at the time the goods or services giving rise to the expense are furnished, not when the expense is billed or paid. The preceding notwithstanding, certain orthodontic expenses may be reimbursed at the time of payment (even if services are not yet performed) if the health care provider requires pre-payment as a condition for service. The Administrator may require proof that such pre-payment is mandatory.



**Section 6.2: Form of Reimbursement Application.** The application for reimbursement shall be in a form acceptable to the Administrator and shall set forth:

- (a) the name of the person on whose behalf the expenses were incurred;
- (b) a description of the expenses incurred;
- (c) the date(s) services were incurred;
- (d) the amount of the requested reimbursement; and
- (e) a statement that the expenses have not otherwise been paid (and are not expected to be paid) from any other source. The application shall be accompanied by bills, invoices, or other statements from an independent third party showing the amounts of the expenses, together with any additional documentation that the Administrator may request.

**Section 6.3: Timing of Reimbursement Applications.** Applications for reimbursement of expenses incurred during the Plan Year (or during the Grace Period described in Sec. 6.4, if applicable) shall be submitted to the Administrator no later than 3 months following the end of the Plan Year.

**Section 6.4: 2-1/2 Month Grace Period for Health Care FSA, Dependent Care FSA and IND Account.** As permitted by Internal Revenue Service Notice 2005-42, if the Employer has elected to have this Section apply, participants in the Health Care FSA, Dependent Care FSA and/or IND Account may have an additional 2-1/2 months after the end of each year in which to incur (and be reimbursed for) qualifying Health Care Expenses, Dependent Care Expenses or IND Expenses, as applicable:

- (a) **Grace Period.** Notwithstanding any contrary provision of this Plan, with respect to each Plan Year, the Health Care FSA, Dependent Care FSA and IND Account portions of this Plan shall have a "Grace Period" extending until the 15th day of the third calendar month after the end of the Plan Year. Health Care Expenses, Dependent Care Expenses and/or IND Expenses incurred during the Grace Period, if entitled to reimbursement, shall be reimbursed from any balance in a Participant's Health Care FSA, Dependent Care FSA or IND Account (as applicable) remaining unused at the end of the immediately preceding Plan Year. Only to the extent the Health Care Expenses, Dependent Care Expenses or IND Expenses incurred during the Grace Period exceed that year-end balance shall they be reimbursable from the Participant's Health Care FSA, Dependent Care FSA or IND

Account with respect to the following Plan Year. If any balance remains in the Participant's Health Care FSA, Dependent Care FSA or IND Account for a Plan Year after all reimbursements have been made for Health Care Expenses, Dependent Care Expenses and IND Expenses, respectively, incurred during the Plan Year and Grace Period, then the Participant shall forfeit all rights with respect to the unused balance.

- (b) **No Effect on Run-Out Period.** The establishment of a Grace Period shall have no effect on the three-month run-out period under this Plan. As provided by Section 6.4 of this Plan, applications for reimbursement of expenses incurred during the Plan Year or the Grace Period must be submitted to the Administrator no later than three months following the end of the Plan Year.

**Section 6.5 \$500 Carryover for Health Care FSA.** As permitted by Internal Revenue Code Notice 2013-71, if the Employer has elected to have this Section apply, then the unused amount (but not more than \$500) remaining at the end of a Plan Year in a Participant's Health Care FSA will be carried over to (and be available for reimbursements of qualifying Health Care Expenses incurred in) the following Plan Year.

- (a) **No Effect on Run-Out Period.** The availability of a rollover amount under this Section shall have no effect on the three-month run-out period under this Plan.
- (b) **\$500 Carryover or Grace Period (Not Both).** An Employer may not elect to have Section 6.4 provide for a Grace Period in the Plan Year to which the Employer permits unused Health Care FSA amounts to be carried over under this Section 6.5.

**Section 6.6: Post-Termination Expenses.** Notwithstanding any Plan provision limiting reimbursements to expenses incurred when an individual is employed by the Employer, a Dependent Care FSA Participant may obtain reimbursement of qualifying Dependent Care Expenses incurred (a) after the Participant's employment with the Employer is terminated but (b) before the end of the Plan Year in which the termination occurred. And, as provided in Section 5.14 certain Participants may elect COBRA for the Health Care FSA and thereby extend the period of its coverage for a limited period. Other than as set forth in the previous two sentences, no reimbursement shall be made for any expense incurred after participation in the applicable part of the Plan has terminated for any reason (such as because the Participant has terminated employment or has revoked his/her election after a Permitted Election Change under Section 4.2).

Expenses incurred during the period of coverage before termination of participation may only be reimbursed post-termination if application is made within the runout period for mid-Year Participant terminations specified in the *Plan Adoption Agreement*.

**Section 6.7: Recoupment of Overpayments or Erroneous Payments.** To the extent that the Plan has made a reimbursement to a Participant that is later determined to be an overpayment, an erroneous payment, or a payment which cannot be substantiated, the Administrator shall have the power and discretion to offset such overpayment against future reimbursements. If no further reimbursements are forthcoming, the Administrator may demand repayment from the Participant, or direct the Employer to include the amount of overpayment as IRS Form W-2 compensation to the Employee.

## ■ Article 7 - Health Savings Account (HSA)

**Section 7.1: Employee Election of HSA Contributions.** With respect to any calendar month beginning on or after the HSA Effective Date (as defined in the *Plan Adoption Agreement*) for which an Employee of the Employer is an "Eligible Employee" as defined in Code § 223(c)(1), the Employee may, before the month begins, elect to have the Employer withhold an amount from the Employee's salary for the month and contribute it, as an Employer contribution, to a health savings account ("HSA") as defined in Code § 223(d) with the Employee as "account beneficiary" as defined in Code § 223(d)(3). The election shall be on a form acceptable to the Administrator.

**Section 7.2: Employer Discretionary Contributions.** The Employer may, at its discretion, contribute additional amounts to the HSA of an eligible Employee. As provided in IRS Notice 2004-50, Q/A-47, the Employer may also, at its discretion, make "matching" contributions through the cafeteria plan to the HSA of an eligible Employee in an amount equal to the Employee's HSA contribution (or a percentage of the amount of the Employee's HSA contribution), subject to the Code § 125 nondiscrimination rules. As provided in IRS Notice 2004-50, Q/A-60, the Employer may also contribute amounts through the cafeteria plan to an Employee's HSA to cover qualified medical expenses incurred by an Employee in excess of the Employee's current HSA balance, but any such accelerated contribution made by the Employer shall be equally available to all participating Employees through the cafeteria plan year and shall be provided to all participating Employees on the same terms and the Employee shall repay the amount of the accelerated contribution by the end of the cafeteria plan year.

**Section 7.3: Limit on Contribution Amounts.** The amounts contributed to an HSA for any Employee for any month shall not exceed the limit set forth in Code § 223(b).

**Section 7.4: Change of Employee Election.** As provided in IRS Notice 2004-50, Q/A-58, because the eligibility requirements and contribution limits for HSAs are determined on a month-by-month basis, an Employee who elects to make HSA contributions under the cafeteria plan may start or stop the election or increase or decrease the election at any time as long as the change is effective prospectively (i.e., after the request for the change is received).

**Section 7.5: Restriction of Health FSA to Dental or Vision.** If the cafeteria plan includes a Health Care FSA, then, notwithstanding any contrary provision of the cafeteria plan, for each cafeteria plan year that begins on or after the HSA Effective Date, as to each Employee for whom an HSA contribution will be made for any month during that year, the Employer shall set up such an Employee's Health Care FSA as a "limited purpose health FSA" as described in IRS Revenue Ruling 2004-45, and the only Health Care Expenses that shall be reimbursable under the Health Care FSA shall be expenses for dental care or vision care as permitted by Code § 223(c)(1)(B)(ii).

**Section 7.6: Exemption of HSA from ERISA.** The Employer intends that HSAs established by Employees to receive contributions through the cafeteria plan not be an "employee welfare benefit plan" for purposes of Title I of ERISA. Consistent with Department of Labor Field Assistance Bulletin 2004-1; therefore, the establishment of HSAs is completely voluntary on the part of Employees and the Employer shall not:

- (a) limit the ability of Employees to move their funds to another HSA beyond restrictions imposed by the Code;
- (b) impose conditions on utilization of HSA funds beyond those permitted under the Code;
- (c) make or influence the investment decisions with respect to funds contributed to an HSA;
- (d) represent that the HSAs are an employee welfare benefit plan established or maintained by the Employer; or
- (e) receive any payment or compensation in connection with an HSA.



## ■ Article 8 - Decisions on Benefit Applications

**Section 8.1: Approval/Denial of Applications.** Within a reasonable period of time after the Administrator receives a reimbursement (or other benefit) application (but in any case within 30 days after receipt), the Administrator shall either approve or deny the application and, if approves, make the reimbursement or, if denies, notify the Participant of the denial. The Administrator may extend the 30-day period, once, for up to 15 days, if the Administrator determines that the extension is necessary due to circumstances beyond the control of the Administrator and, before the expiration of the initial 30-day period, notifies the applicant of those circumstances and the date by which the Administrator expects to render a decision.

**Section 8.2: Manner of Providing Denials.** If a reimbursement (or other benefit) application is denied, the Administrator shall provide the denial to the applicant either electronically or in writing. If the denial is provided electronically, then:

- (a) the Administrator shall take appropriate measures to ensure that the system for furnishing the denial results in actual receipt by the applicant;
- (b) the Administrator shall notify the applicant, through electronic means or in writing, of the significance of the denial and the applicant's right to request and receive, free of charge, a paper copy of the denial; and
- (c) upon request of the applicant, the Administrator shall furnish, free of charge, a paper copy of the denial.

**Section 8.3: Content of Denials.** A denial shall set forth, in a manner calculated to be understood by the applicant (and in a culturally and linguistically appropriate manner):

- (a) the specific reason for the denial;
- (b) reference to the specific Plan provisions upon which the denial is based;
- (c) a description of any additional material or information necessary for the applicant to perfect the application (and an explanation of why such material or information is necessary);
- (d) a statement describing the appeal procedures below and the time limits applicable to such procedures, including a statement of the applicant's right to bring a civil action following an adverse decision on appeal; and
- (e) a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the denial.

**Section 8.4: Appeals.** A denial may be appealed by notifying the Administrator within 180 days following receipt of the denial.

**Section 8.5: Decisions on Appeals.** Within a reasonable period of time after the Administrator receives an appeal (but in any case within 60 days after receipt), the Administrator shall have the appeal decided by a decision maker who shall not afford deference to the initial denial and who is not the individual (or a subordinate of the individual) who made the denial. The appellant shall have the opportunity to submit written comments, documents, records, and other information relating to the appeal. The appellant shall be provided, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the appeal. The decision maker shall take into account all comments, documents, records, and other information relating to the appeal, without regard to whether such information was submitted or considered in the initial denial.

**Section 8.6: Manner of Providing Adverse Decisions on Appeals.** If an appeal is denied, the Administrator shall provide the denial to the applicant either electronically or in writing. If the denial is provided electronically, then:

- (a) the Administrator shall take appropriate measures to ensure that the system for furnishing the denial results in actual receipt by the applicant;
- (b) the Administrator shall notify the applicant, through electronic means or in writing, of the significance of the denial and the applicant's right to request and receive, free of charge, a paper copy of the denial; and
- (c) upon request of the applicant, the Administrator shall furnish, free of charge, a paper copy of the denial.

**Section 8.7: Content of Adverse Decisions on Appeals.** An adverse decision on an appeal shall set forth, in a manner calculated to be understood by the applicant (and in a culturally and linguistically appropriate manner): (a) the specific reason for the decision; (b) reference to the specific Plan provisions upon which the decision is based; and (c) a statement that the applicant is entitled to receive, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the appeal.

**Section 8.8: Compliance With Law.** The claims and appeals process will be applied in a manner that complies with all applicable laws and regulations, including regulations under the Patient Protection and Affordable Care Act (PPACA) of 2010.



**Section 8.9: Limitation on Claims.** To the extent that a Participant is affected by any denial of a benefit under this Plan, including any benefit covered by ERISA, legal action may not be taken by any Participant against the Plan or Administrator until after all administrative procedures outlined in this Plan Document have been exhausted. Once such procedures have been exhausted, no legal claim may be filed after 12 months following the date the Adverse Decision on Appeal is provided to Participant.

## ■ Article 9 - General Provisions

**Section 9.1: Powers of the Administrator.** Benefits under the Plan shall be paid only if the Administrator decides in its discretion that the applicant is entitled to them. The Administrator shall have such powers as are necessary or appropriate for the Administrator to discharge its duties under the Plan. The Administrator may, at any time, require any Participant to amend the amount of his/her salary reductions for a Plan Year if the Administrator determines that such action is necessary in order to satisfy any of the Code's nondiscrimination requirements.

**Section 9.2: Third Party Administrator.** The Employer or Administrator may, by a separate written agreement, engage a third party administrator or service provider, such as Employee Benefits Corporation, to perform certain duties of the Administrator under the Plan, including review and payment of qualified claims under a Health Care FSA or a Dependent Care FSA.

**Section 9.3: Funding the Plan.** All benefits payable under the Plan shall be paid from the general assets of the Employer or from policies of insurance purchased under the Plan. No funds are required to be set aside for the payment of benefits. To the extent any funds are set aside, they shall be subject to claims of general creditors of the Employer. Funds held by a third party administrator or service provider, such as Employee Benefits Corporation, for the payment of benefits under the Plan shall be assets of the Employer, subject to claims of general creditors of the Employer.

**Section 9.4: Forfeitures.** All forfeitures under Sections 5.12, 5.20 or 5.25 shall be used as follows: (a) first, forfeitures shall be used to offset any losses that the Employer experiences during the Plan Year as a result of providing benefits (reimbursing a Participant in excess of the amounts contributed by the Participant through salary reductions); (b) second, excess forfeitures shall be used to reduce the Employer's cost of administering the Plan during the Plan Year; (c) third, excess forfeitures shall be used to provide increased benefits or compensation to Participants in subsequent years in any manner that the Administrator deems appropriate, consistent with Proposed Treasury Regulations § 1.125-5(o).

**Section 9.5: Tax Consequences.** The Plan is intended to qualify as a "cafeteria plan" under Code § 125. Coverage and benefits under the Plan are intended to be excluded from Participants' gross income as described above. Any Plan provision that conflicts with the Code shall be deemed amended to comply with the Code. Nevertheless, the Employer and the Administrator do not guarantee any particular tax consequences.

**Section 9.6: Records.** The Employer shall maintain records of the Covered Expenses that are reimbursed for the current Plan Year and the most recent six Plan Years. The Employer shall make available to each Participant the records of the reimbursements made to him or her for those years.

**Section 9.7: Nondiscrimination Rules.** If, during a Plan Year, the Plan is discriminating in favor of highly compensated participants in violation of Code §§ 105(h), 129(d), or 125, as described below, then the Employer shall report the appropriate amounts of additional income on the Forms W-2 of such Participants. Discriminatory practices include those which disproportionately advantage:

- (a) Highly compensated individuals as to eligibility to participate, or
- (b) Highly compensated participants as to contributions and benefits.
  - i. Amounts paid to a highly compensated individual under a self-insured medical reimbursement plan as defined in Code § 105(h) must be included in income if the Plan discriminates in favor of highly compensated individuals as to eligibility to participate or benefits provided.
  - ii. Amounts paid to a highly compensated individual under a dependent care assistance program as defined in Code § 129(d) must be included in income if the Plan discriminates in favor of highly compensated employees as to eligibility to participate or benefits provided. Unless the Employer elects otherwise in writing, for purposes of the Code § 129(d) nondiscrimination tests, an employee shall not be treated as a highly compensated employee for a year unless he or she is in the group consisting of the top 20% of employees when ranked on the basis of compensation paid during the year.
  - iii. Amounts paid to a highly compensated individual under a cafeteria plan as defined in Code § 125 must be included in income if the Plan discriminates in favor of highly compensated employees or key employees as to eligibility to participate or

benefits provided. Unless the Employer elects otherwise in writing, for purposes of the Code §125 nondiscrimination tests, an employee shall not be treated as a highly compensated employee for a year unless he or she is in the group consisting of the top 20% of employees when ranked on the basis of compensation paid during the year.

**Section 9.8: Subrogation and Refund.** If an individual is reimbursed under this Plan for medical expenses incurred due to illness or injuries caused by the act or omission of a third party, the individual (a) automatically assigns to the Plan any rights he or she has to recoveries from the third party up to the full amount of the reimbursements and (b) must repay to the Plan the reimbursements paid on his or her behalf out of any recovery. This subrogation right allows the Plan to pursue any claim that the individual has against any third party, whether or not the individual chooses to pursue that claim. The Plan may make a claim directly against the third party, but in any event, the Plan has an equitable lien on any amount of the individual's recovery, whether or not designated as payment for medical expenses. By accepting reimbursements under this Plan, the individual agrees to hold recoveries in a constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full. If the individual dies as a result of his/her injuries and a wrongful death or survivor claim is asserted against a third party, the Plan's subrogation and refund rights shall apply. This Plan expressly disavows and repudiates the "make whole" doctrine, which, if applicable, would prevent the Plan from receiving a recovery unless a covered individual has been "made whole" with regard to illness or injury that is the responsibility of a third party. This Plan also expressly disavows and repudiates the "common fund" doctrine, which, if applicable, would require the Plan to pay a portion of the attorney fees and costs expended in obtaining a recovery. These doctrines have no application to this Plan, because the Plan's refund rights apply to the first dollars payable by a third party. To carry out the terms of this section, all individuals covered by the Plan are required to cooperate with the Administrator; and, in particular, are required to:

- (a) Cooperate with the Plan, or any representatives of the Plan, in protecting the Plan's rights, including discovery, attending depositions, and/or providing testimony at trial;
- (b) Provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information;

- (c) Take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- (d) Do nothing to prejudice the Plan's rights of subrogation and refund;
- (e) Promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received; and
- (f) Not settle or release, without the prior consent of the Plan, any claim to the extent that the individual may have recovery rights against any third party.

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

**Section 9.9: ERISA Consequences.** The Health Care FSA is a "welfare plan" as defined in ERISA § 3(1). Therefore, unless the Plan is a "governmental plan" or "church plan" exempt from Title I of ERISA (as set forth in Section 2.14), the Administrator is required to comply with Title I of ERISA. For example, Title I of ERISA requires a summary plan description to be provided to Eligible Employees.

**Section 9.10: HIPAA.** The Health Care FSA shall comply with all applicable HIPAA provisions, such as:

- (a) Privacy: Except as otherwise permitted by law, access to "protected health information" shall be restricted to
  - (1) the Plan and its Business Associates, including Employee Benefits Corporation, and any other vendors or subcontractors operating under a duly-executed Business Associate Agreement.

- (2) the "privacy official" (the Employer's employee who oversees the administration of the Health Care FSA), and
  - (3) his or her assistants. (An exception for self-administered plans with fewer than 50 participants does not apply to plans that are administered by third parties such as Employee Benefits Corporation.)
- (b) Portability: Unless the Health Care FSA is an "excepted benefit," the Health Care FSA shall comply with the HIPAA group market portability rules. The Health Care FSA is an "excepted benefit" if:
- (1) the maximum benefit payable for a Participant under the Health Care FSA for the year does not exceed two times the Participant's salary reduction election under the Health Care FSA for the year (or, if greater, the amount of the Participant's salary reduction election under the Health Care FSA for the year plus \$500);
  - (2) the Participant has other coverage available under a group health plan of the Employer for the year; and
  - (3) the other coverage is not limited to benefits that are "excepted benefits" as defined by HIPAA.
- (c) Security: The Employer agrees that, if it creates, receives, maintains, or transmits any electronic "protected health information" (other than enrollment/disenrollment information and summary health information) on behalf of the Health FSA, the Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic information and will ensure that any Business Associates, agents and subcontractors to whom it provides such information agree to do likewise.

**Section 9.11: Annual Report (Form 5500).** The Employer shall file an annual report (Form 5500) for the Plan only if required by Title I of ERISA and applicable Department of Labor regulations, which generally require annual reports for Health Care FSAs with 100 or more Participants at the beginning of the Plan Year.

**Section 9.12: No Contract of Employment.** Nothing in this Plan shall be construed to create a contract to employ anyone.

**Section 9.13: Assignability of Rights.** No Participant may assign to any third party (and no creditor of any Participant may take) the Participant's right to receive any benefit under the Plan.

**Section 9.14: Amendment and Termination.** The Employer may amend or terminate this Plan at any time. Unless otherwise provided, any such amendment or termination shall automatically extend to the Plan as adopted by any employer affiliated with the primary Employer.

**Section 9.15: Employer Reorganization.** In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate unless the Plan is continued by the successor to the Employer in accordance with a resolution of its board of directors or other managing body.

## ■ Contact Employee Benefits Corporation

Contact Employee Benefits Corporation if you have any questions about your BESTflex Plan.

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