



A Division of TASC

## **Section 125 Cafeteria Plan Document**

As Adopted By Employer:

**KIMSTAFFHR, INC. DBA KTIMEHR**

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## Article 1 | Preamble

### **1.1 Purpose.**

The purpose of this Plan is to provide to Employees a choice between taxable benefits including cash and certain nontaxable welfare benefits.

### **1.2 Intent.**

This Plan is intended to qualify as a cafeteria plan under Section 125 of the Code, and is to be interpreted in a manner consistent with the requirements of Section 125.

If elected by the Employer, the Dependent Care Reimbursement Account is intended to qualify as a Code Section 129 dependent care assistance plan, the Health Flexible Spending Account is intended to qualify as a Code Section 105 medical expense reimbursement plan, and the Adoption Assistance Account is intended to qualify as a Code Section 137 adoption assistance plan. The Dependent Care Reimbursement Account, Health Flexible Spending Account, and Adoption Assistance Account are plans for administration, reporting and nondiscrimination requirements imposed by Sections 105, 129, and 137 of the Code and all applicable provisions of ERISA.

### **1.3 Supplemental Benefits.**

The Plan provides Supplemental Benefits. This Plan will not replace, reduce, eliminate or modify coverage under any other Plan of the Employer. This Plan is always secondary to any group or individual health coverage.

## Article 2 | Definitions

### **2.1 Definitions.**

The following words and phrases shall have the meanings stated below, unless a different meaning is clearly required by the context of the Plan.

- 2.1.1 **Account.** The individual Account and any subaccount established pursuant to Article 5. The Account is maintained for each Participant to record contributions allocated to and Benefits paid for a Participant.
- 2.1.2 **Administrator.** The Employer and/or other person or committee who has been so designated by the Employer which shall control and manage the operation and administration of the Plan as the named fiduciary.
- 2.1.3 **Adoption Agreement.** The document executed by the Employer and attached to and a part of this Plan Document, as amended from time to time. The Adoption Agreement is incorporated hereto by reference.
- 2.1.4 **Adoption Assistance Account.** A flexible spending account that provides Adoption Assistance Account Benefits as described in Article 9 of the Plan.
- 2.1.5 **Benefit Package Option.** A Qualified Benefit under Code Section 125(f) that is offered under the Plan or an option for coverage under an Underlying Plan of accident or health benefits (such as an indemnity option, an HMO option or a PPO option under an accident or health plan).
- 2.1.6 **Benefits.** Benefits are the benefit options available under the Plan as listed in Article 6 that have been elected by the Employer as set forth in the Adoption Agreement.
- 2.1.7 **Cafeteria Plan.** A plan that meets the requirements of Code Section 125 and applicable regulations.
- 2.1.8 **Claims Period.** The period of time during which Participants may submit claims for Benefits under the Plan as set forth in the Adoption Agreement.
- 2.1.9 **COBRA.** The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- 2.1.10 **Code.** The Internal Revenue Code of 1986, as amended from time to time.
- 2.1.11 **Compensation.** Total wages payable to an Employee during the taxable year for services rendered to the Employer, determined without regard to any reduction of wages elected under this Plan or other plans or arrangements that reduce W-2 wages.
- 2.1.12 **Dependent.** Except as otherwise specifically provided in this Plan, the Adoption Agreement or an Underlying Plan, an individual defined as a dependent in Code Section 152 without regard to Sections (b)(1), (b)(2) and (d)(1)(B) and as further modified by any ruling or regulation of the Internal Revenue Service. For the purposes of accident or health coverage, any child to whom Code Section 152(e) applies is treated as a dependent of both parents. Under Code Section 152, a dependent includes (but is not limited to), a lawful Spouse, a child, legally adopted child, child

placed for adoption, and step-child. Dependent shall also include a child of a Participant who is considered eligible under Code Section 105(b).

A Dependent for the purposes of the Health Flexible Spending Account also includes a child who is an alternate recipient under a qualified medical child support order as defined under Section 609 of ERISA.

For purposes of Dependent Care Reimbursement Account Benefits provided under this Plan, Dependent means a qualifying individual as defined in Code Section 21(b)(1), as amended.

- 2.1.13 **Dependent Care Reimbursement Account.** A flexible spending account that provides dependent care assistance Benefits as described in Article 8 of the Plan.
- 2.1.14 **Effective Date.** The date specified in the Adoption Agreement on which the Plan is applicable to Eligible Employees.
- 2.1.15 **Election Change Event.** Events as described in Article 4 which allow an election change during the Plan Year.
- 2.1.16 **Eligible Employee.** An Employee who is eligible for Benefits under the Plan as described in section 3.1 of the Plan.
- 2.1.17 **Employee.** Except as otherwise provided in the Adoption Agreement, any common law employee of the Employer. Unless otherwise specified in the Adoption Agreement, Employee shall not include a person classified by the Employer as an independent contractor, leased employee, contract worker, temporary employee or seasonal or casual employee, even if such classification is determined to be erroneous or is retroactively revised (such as by a governmental agency or court order). A person who the Administrator determines is not an Employee shall not be retroactively treated as an Employee under this plan solely because the person has been classified or reclassified as an employee of the Employer.
- Employee shall not include self-employed individuals as provided in Code Section 401(c)(2) such as sole proprietors, outside directors of a corporation, partners or more than 2% shareholders of an S Corporation.
- 2.1.18 **Employer.** The Employer as listed in the Adoption Agreement and any Related Employer (or operating unit of a Related Employer) which adopts the Plan, and any successor of the Employer. A delegate of the Employer may act on behalf of the Employer for the purposes of the Plan.
- 2.1.19 **Employer Credits.** Amounts, if any, provided to the Account of a Participant by the Employer to provide Benefits under the Plan.
- 2.1.20 **Enrollment Form.** The agreement(s) an Eligible Employee must complete to participate in the Plan as described in section 4.1 and the Adoption Agreement.
- 2.1.21 **Enrollment Period.** The period of time in which an Eligible Employee may enroll, as provided in Article 4.
- 2.1.22 **ERISA.** The Employee Retirement Income Security Act of 1974, as amended from time to time.

- 2.1.23 **Family Member Plan.** A Cafeteria Plan or Qualified Benefit Plan sponsored by the employer of the Employee's Spouse or the Employee's Dependent.
- 2.1.24 **Grace Period.** If elected by the Employer, the period specified in the Adoption Agreement up to two and one-half months after the end of the Plan Year during which any unused Benefits in a Participant's Account remaining at the end of the Plan Year may be paid or reimbursed to Participants for Reimbursable Expenses incurred during the Grace Period.
- 2.1.25 **Health Savings Account.** An account described in Section 223 of the Code that is established by an individual or an Employer on behalf of certain individuals for the purposes of paying qualified medical expenses.
- 2.1.26 **Health Flexible Spending Account.** A flexible spending account that provides medical expense reimbursement Benefits as described in Article 7 of the Plan.
- 2.1.27 **Health Flexible Spending Account Carryover.** If elected by the Employer, an exception to the use-or-lose-it rule that allows Participants a carryover up to \$500 of unused Health Flexible Spending Account Benefits to the following Plan Year.
- 2.1.28 **Participant.** An Eligible Employee who meets the requirements for participation described in Article 3.
- 2.1.29 **Plan.** This document as set forth herein, together with all documents incorporated by reference, including the Adoption Agreement, as amended from time to time.
- 2.1.30 **Plan Year.** The 12-month period commencing and ending on the dates indicated in the Adoption Agreement and each anniversary thereof. The initial Plan Year will commence on the Effective Date and may be for less than 12 months.
- 2.1.31 **Premium Benefits.** Benefits provided to Participants pursuant to Underlying Plans maintained by the Employer.
- 2.1.32 **Qualified Benefit Plan.** An employee benefit plan providing one or more benefits that are qualified benefits under Code Section 125(f).
- 2.1.33 **Premium Reimbursement Arrangement Benefits.** This Plan provides tax free reimbursement for amounts paid to maintain an individual insurance policy as described in section 6.6 of the Plan.
- 2.1.34 **Reduction Amount.** The amount of future Compensation the Participant agrees to exchange for Benefits on an Enrollment Form. The Reduction Amount will be withheld in approximately equal installments for each pay period during the Plan Year (or portion of the Plan Year the Administrator may designate).
- 2.1.35 **Reimbursable Expense.** Any expense that qualifies for reimbursement under a Reimbursement Benefit.
- 2.1.36 **Reimbursement Benefits.** The Health Flexible Spending Account Benefits, Dependent Care Reimbursement Account Benefits, and Adoption Assistance Account Benefits if elected by the Employer as specified in the Adoption Agreement.
- 2.1.37 **Related Employer.** A Related Employer shall mean:

- a) Any corporation, trade or business which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer;
- b) Any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer;
- c) Any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; or
- d) Any other entity required to be aggregated with the Employer pursuant to regulations under Code Section 414(o).

2.1.38 **Spouse.** A Spouse means an individual who is legally married to the Participant under applicable state law and the Code. For the purposes of the Dependent Care Reimbursement Program, a Spouse is also subject to the rules under Code Section 21(e)(2), (3) and (4).

2.1.39 **Underlying Plan.** A Qualified Benefit Plan underlying a Premium Benefit offered through the Plan. The plan document of any Underlying Plan is incorporated by reference. If the terms of this Plan differ from the terms of an Underlying Plan, the Underlying Plan shall control.

2.1.40 **Paid Time Off Conversion.** An arrangement, if elected by the Employer, as set forth in the Adoption Agreement, by which Participants may increase their Benefits hereunder by electing fewer paid time off days.

2.1.41 **Paid Time Off Purchase Program.** An arrangement, if elected by the Employer, as set forth in the Adoption Agreement, by which Participants elect additional paid time off days in lieu of taxable compensation.

## 2.2 Construction.

Words used in the masculine gender shall include the feminine and words in the singular shall include the plural, as appropriate. Any mention of "Articles," "sections" and subdivisions thereof, unless stated specifically to the contrary, refers to Articles, sections or subdivisions in the Plan. Headings of Articles, sections and subsections are for convenient reference. The headings are not part of the Plan and are not to be considered in its construction. All references to statutory sections shall include the section as amended from time to time.



## Article 3 | Participation

### **3.1 Eligibility Requirements**

An Employee who has satisfied the Eligibility Requirements as set forth in the Adoption Agreement, is eligible to participate in the Plan on the dates set forth in the Adoption Agreement. An Employee shall be eligible for the specific Benefits as specified in the Adoption Agreement. Eligibility for a component Qualified Benefit Plan is subject to the additional requirements, if any, specified in the applicable governing documents for the Qualified Benefit Plan. The provisions of this Plan are not intended to override any inclusion, eligibility requirement, or waiting period specified in the applicable Qualified Benefit Plan.

### **3.2 Plan Participation.**

To participate, an Eligible Employee must complete an Enrollment Form and file it with the Administrator during an Enrollment Period, except for automatic enrollment as provided in the Adoption Agreement.

### **3.3 Termination of Participation.**

A Participant ceases to participate as of the dates set forth in the Adoption Agreement.

### **3.4 Reinstatement.**

3.4.1 If a former Participant again becomes an Eligible Employee pursuant to section 3.1, he or she may elect to receive Benefits by completing the requirements for Plan Participation described in section 3.2.

3.4.2 However, if a Participant terminates employment and is rehired by the Employer within 30 days, the Participant must either continue the election in effect before she or he terminated employment or elect no participation. This restriction shall not apply if there is an Election Change Event.

### **3.5 Qualified Leave Under Family and Medical Leave Act ("FMLA")(if applicable).**

3.5.1 **Health Benefits.** If applicable to the Employer, a Participant who takes an unpaid FMLA leave may revoke coverage or may continue coverage under a group health plan by making required payments.

The Employer, however, may continue group health plan coverage for a Participant on unpaid FMLA leave by paying both the Employer's and the Participant's share of the contributions. The Employer may recover the Participant's share when the Participant returns from leave. If the Participant fails to return from leave, the Employer may recover the Participant's and Employer's share under the circumstances set forth by the Department of Labor in 29 C.F.R. § 825.213(a).

The Administrator will choose one or more of the following payment alternatives for health coverage, which must be offered on terms at least as favorable as those offered to Employees not on FMLA leave.

- a) **Prepayment Option.** A Participant may prepay contributions due during the FMLA leave. Prepayments of contributions that apply to the current Plan Year may be made on a pre-tax basis

- b) to the extent that pre-leave Compensation is available. Prepayments of contributions that apply to a new Plan Year must be made on an after-tax basis.
- c) Pay-As-You-Go Option. A Participant may pay contributions on an after-tax basis on the same schedule as payments are made by active Participants, on the same schedule as COBRA payments, under the Employer's existing rules for payment for unpaid leaves or on any schedule voluntarily agreed upon by the Administrator and the Participant.
- c) Catch-Up Option. The Employer may allow the Participant to pay for Benefits when the Participant returns from the FMLA leave. Catch-up contributions will be taken on a pre-tax basis to the extent permitted by applicable regulations.

If the Employer continues a Participant's coverage during an FMLA (if applicable to Plan) leave, and the Participant does not make contributions on either a Pre-Payment or Pay-As-You-Go basis, then the Employer may use the Catch-Up Option to recoup contributions made on the Participant's behalf for the leave period.

**3.5.2 Non-health Benefits.** If a Participant goes on qualifying leave under FMLA, entitlement to non-health benefits such as Dependent Care Reimbursement is determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave. The Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the FMLA leave.

### **3.5.3 Reinstatement After FMLA Leave (if applicable).**

- a) In General. If a Participant revokes his or her Plan enrollment in advance of an FMLA leave, or if the enrollment terminates due to non-payment of contributions, the enrollment can be reinstated on exactly the same terms upon the Participant's return from FMLA leave. A Participant cannot change his or her enrollment during or upon returning from FMLA leave unless the Participant experiences an Election Change Event as described in Article 5 of the Plan, or during an Open Enrollment Period.
- b) Reimbursement Account Benefits. If a Participant's election of Reimbursement Benefits ceases during an FMLA leave, the Participant will not be entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon return from FMLA leave, the Participant may elect to resume coverage as follows:
  - 1) Health Flexible Spending Account Benefits. The Participant may elect to resume coverage at the level in effect before the FMLA leave and make up unpaid contributions. Alternatively, the Participant may resume coverage without making up contributions, but Benefits will be reduced proportionately for the period during which no contributions were paid.
  - 2) Other Reimbursement Account Benefits. The Participant may resume coverage, but Benefits will be available only to the extent for which contributions are paid.

### **3.6 Paid Leave or Non-FMLA Leave.**

3.6.1 **Paid Leave.** If a Participant is taking a paid leave (FMLA or other leave), payments for the Plan will be deducted on a pretax basis. A Participant may change or revoke his or her enrollment only as allowed under Article 4.

3.6.2 **Unpaid Non-FMLA Leave.** If a Participant is permitted to continue Benefits while on an unpaid non-FMLA leave, the Administrator will decide what payment option will apply. When the Participant returns from a non FMLA leave, he or she may re-enroll for Benefits only as allowed by the Employer.

### **3.7 Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") Leave.**

This Plan intends to comply with USERRA. Notwithstanding any provision to the contrary in this Plan, a Participant may revoke or continue Benefits when he or she is absent due to "uniformed service," in accordance with USERRA. A Participant who is absent due to "uniformed service" shall be entitled to all Benefits and rights provided by the Employer under this Plan to other Participants on leave of absence. To continue health coverage, the Participant shall be responsible for continuing payments under the procedure established by the Employer for a FMLA unpaid leave, pursuant to section 3.5.1. A Participant may continue health coverage under the Plan from the date the leave begins for the lesser of 24 months or until one day after the person fails to apply for or return to employment in accordance with USERRA. For a leave of fewer than 31 days, the Employee will be charged the normal Employee share of the health premium. For a leave of 31 days or longer, a Participant may be required to pay the full health premium (plus permitted administrative charges) for coverage in the same manner as COBRA. The right to continue coverage under COBRA is concurrent with the rights described in this provision to continue coverage under USERRA, and the administrative procedures with regard to notice, election and payment apply to continued coverage under USERRA. If a Participant does not maintain health Benefits, a Participant may re-enroll for Benefits for unpaid FMLA leaves if the Employee's reemployment meets USERRA requirements. Re enrollment for non-health Benefits is subject to the Employer's policy for other types of leaves.

## Article 4 | Elections and Enrollment Period

### **4.1 Enrollment Form**

The Enrollment Form is a written or electronic agreement consisting of the following.

- 4.1.1 **Election of Premium Benefits**. An Eligible Employee will be deemed to have elected Premium Benefits to pay contributions for coverage under the Underlying Plans with pre-tax dollars unless he or she declines enrollment on the Enrollment Form prior to the effective date. This is an agreement to reduce his or her future Compensation for the Plan Year by the amount necessary to cover these contributions, and to direct the Employer to allocate the amount to the Participant's Account.
- 4.1.2 **Election of Reimbursement Benefits**. An Eligible Employee elects Reimbursement Benefits by agreeing on the Enrollment Form to reduce his or her future Compensation for the Plan Year by a specified amount, and directs the Employer to allocate the amount to the Participant's Account. The Eligible Employee must allocate the amount by which Compensation is reduced to each Reimbursement Benefit.
- 4.1.3 **Election of Other Benefit Options**. An Eligible Employee elects any other Benefits by completing the applicable section of the Enrollment Form relating to such Benefits.
- 4.1.4 **Deemed Benefit Election**. In the event an Eligible Employee fails to return a properly completed Enrollment Form within the applicable Enrollment Period, the Participant will be deemed to have made the elections specified in the Adoption Agreement. An Eligible Employee's election or deemed election will continue in effect for the time period specified in the Adoption Agreement.

### **4.2 Enrollment Period**

An Employee can select Benefits during an Enrollment Period as follows.

- 4.2.1 **Initial Enrollment Period**. The first time an Employee may enroll for Benefits is the initial enrollment period specified in the Adoption Agreement.
- 4.2.2 **Open Enrollment Period**. A period that may be specified by the Administrator during which an Eligible Employee or Participant may execute a new Enrollment Form for the next Plan Year.
- 4.2.3 **Election Change Period**. The period following an Election Change Event during which a Participant may change or revoke the Enrollment Form as described in Section 4.5.5.

### **4.3 Timing of Elections**

Except as provided in sections 4.4 and 4.5, an Employee must elect contributions and Benefits for the entire Plan Year. The Employee must make the election during the Enrollment Period before the election becomes effective.

#### **4.4 Partial Period of Coverage.**

4.4.1 **Initial Participation.** A Participant who becomes eligible during the Plan Year may participate for the remainder of the Plan Year. For that Participant, references to the Plan Year shall include the partial Plan Year.

4.4.2 **Changes in Election.** A Participant whose election terminates shall have a partial Plan Year ending on the date of termination of coverage. For that Participant, references to the Plan Year shall include the partial Plan Year.

**4.5 Election Change Events.** A Change In Status Event allows a Participant to revoke or change their pre-tax election during the Plan Year, and outside of the scheduled open enrollment period. The Employer allows all of the Change In Status Events published by the IRS for this type of Plan under 26 CFR 1.123-4, as amended. A Participant who becomes eligible under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") for coverage under an accident or health benefit offered by the Employer will be allowed to make a consistent election, or election change under this Plan.

##### **4.5.1 Administrative Change.**

- a) **Cost.** The Administrator may automatically adjust the Reduction Amount elected under the Enrollment Form.
- b) **Non-Discrimination.** If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement or limitation imposed by the Code, the Administrator shall take such action(s) as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of the election of an Employee determined to be a Highly Compensated Employee or Key Employee without the consent of such Employee.
- c) **Tax Qualification.** The Administrator may automatically adjust the Reduction Amount elected under the Enrollment Form to prevent any Employee or class of Employees from having more income for federal income tax purposes from the receipt of Benefits under the Plan than would otherwise be recognized or to maintain the qualified status of Benefits received under this Plan.
- d) **Errors.** The Administrator may automatically adjust the Reduction Amount elected under the Enrollment Form to rectify erroneous reductions and credits with appropriate notice to the Participant.

## Article 5 | Benefit Accounts

### **5.1 Accounts**

The Administrator shall maintain a bookkeeping Account for each Participant. The Account records contributions made and Benefits paid on behalf of the Participant. Accounts are not funded.

### **5.2 Crediting Accounts**

The Administrator shall credit enrollment contributions on behalf of a Participant to the appropriate subaccounts. The Account shall not earn interest.

### **5.3 Debting of Accounts**

The Administrator shall debit the appropriate subaccounts to reflect Benefits provided to a Participant.

### **5.4 Assignment of Benefits**

The Participant or any other individual may not assign, transfer or alienate any interest in the Participant's Account.

### **5.5 Forfeiture of Accounts.**

#### **5.5.1 Premium Accounts.**

Amounts credited to the Participant's Premium Account will automatically be debited by the Employer to pay contributions for Premium Benefits incurred during the Plan Year.

#### **5.5.2 Forfeiture of Unused Contributions.**

Any amounts remaining in a Participant's Account attributable to elections for Reimbursement Benefits for which a Participant has not submitted a valid Claim for Benefits within the applicable Claim Period for Reimbursable Expenses incurred during the Plan Year and any applicable Grace Period shall be forfeited. If elected in the Adoption Agreement, Health Flexible Spending Account Carryover amounts are not forfeited and may be used in the following Plan Year.

#### **5.5.3 Forfeiture of Unclaimed Reimbursement Checks.**

Any Reimbursement Account Benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the expense was incurred shall be forfeited.

#### **5.5.4 Use of Forfeitures.**

Forfeitures shall be used to offset administrative expenses or any use that is permitted within applicable law.

## Article 6 | Benefit Options

### **6.1 Benefits Available**

A Participant may elect one or more of the Benefits described in this Article 6 if elected by the Employer as set forth in the Adoption Agreement.

### **6.2 Premium Benefits**

A Participant may allocate amounts that may be used to purchase Premium Benefits. The allocations shall be governed by the terms of the Underlying Plans providing the Premium Benefits. The Employer will provide Participants with the Reduction Amount required to pay for the Premium Benefit for a Participant during any Plan Year in the Enrollment Form or other written or electronic notice provided to the Participant.

### **6.3 Health Flexible Spending Account Benefits**

Health Flexible Spending Accounts are subject to the requirements stated in Article 7.

### **6.4 Dependent Care Reimbursement Account Benefits**

Dependent Care Reimbursement Account Benefits are subject to the requirements stated in Article 8.

### **6.5 Adoption Assistance Account Benefits**

Adoption Assistance Account Benefits are subject to the requirements stated in Article 9.

### **6.6 Premium Reimbursement Arrangement Benefits**

A Participant may allocate amounts for Premium Reimbursement Arrangement Benefits to reimburse the cost of premiums paid by a Participant for an individual insurance, providing accident and health benefits as defined under Sections 105 and 106 of the Code. The individual insurance plan is owned by the Participant. This can include a plan provided through Participant owned insurance policy(ies) issued by an insurance company, or a contract(s) with a health maintenance organization or point of service organization. Coverage offered through the Marketplace, (a state or federal plan under the Affordable Care Act), does not qualify. The following individual plans can be covered under the Premium Reimbursement Arrangement Benefit:

- Health insurance or HMO coverage for health expenses
- Dental insurance
- Eye care insurance
- Medicare premium
- Medigap or Medicare Supplemental premium
- Tricare premium
- Accidental death and dismemberment insurance
- Long-term or short-term disability insurance

The Premium Reimbursement Arrangement Benefit is not subject to the Employee Retirement Income Security Act of 1974 (ERISA). The individual plans purchased by the Participants are not Employer-Sponsored Welfare Plans as defined by ERISA, and as such are not subject to ERISA.

The maximum and minimum Premium Reimbursement Arrangement Benefits for a Participant during any Plan Year and other requirements for the Premium Reimbursement Arrangement Benefits are determined by the Employer and are stated in the Enrollment Form or other written or electronic notice provided to the Participant.

## 6.7 Health Savings Account

A Participant may elect to contribute to a Health Savings Account. Contributions to a Health Savings Account during the Plan Year may not exceed the aggregate of the monthly limits for such months the individual is a Participant in this Plan. The election for Health Savings Account Benefits may be changed at any time and for any reason provided the change is made prospectively and takes effect no sooner than the beginning of the month following the election change. Any change that meets these requirements can be made including increasing, decreasing, beginning or eliminating contributions.

## 6.8 Paid Time Off Purchase Plan

A Participant may elect to receive paid time off days in addition to their regular paid time off days by reducing their Compensation for the type or types of paid time off listed in the Adoption Agreement. For each Plan Year, a Participant may elect to purchase additional paid time off days up to the maximum described in the Adoption Agreement. The purchase or purchases shall occur at such time(s) and in such manner as is determined by the Administrator. All purchases must be completed before enrollment, and no purchases will be permitted during the Plan Year even in the event of an Election Change Event.

The actual use and scheduling of purchased paid time off days is subject to staffing requirements and approval of the Employer and any other Employer policies. Any paid time off days purchased will be considered used only after the Participant has completely used the regular paid time off days. Any unused amounts must be paid in cash to the Participant prior to the end of the Plan Year, if permitted by the Employer, or forfeited.

## 6.9 Paid Time Off Conversion

A Participant may elect to increase Benefits under this Plan by electing fewer paid time off days as permitted under the Employer's paid time off policies for the type or types of paid time off listed in the Adoption Agreement. Paid time off conversion shall be credited when the converted paid time off is considered accrued under the Employer's paid time off policies. Once a paid time off day is converted, it cannot be bought back even in the event of an Election Change Event.

## 6.10 Cash Benefits

To the extent that a Participant does not elect to have Compensation included as a Reduction Amount, such amount not elected will be paid to the Participant in the form of normal Compensation payments, provided however, that Employer Credits may not be received in the form of Cash Benefits unless otherwise provided in the Adoption Agreement.

## 6.11 Incurred Amounts

6.12.1 **Premium Benefits.** Amounts for Premium Benefits may only be paid for expenses incurred during the Plan Year and any Grace Period elected by the Employer and paid from contributions specifically allocated to those Benefits on the Enrollment Form.

6.12.2 **Health Flexible Spending Account Benefits.** Amounts for Health Flexible Spending Account Benefits may only be paid for eligible Medical Expenses incurred during the Plan Year and any Grace Period elected by the Employer. Eligible Health Flexible Spending Account Benefits shall be considered incurred when the medical care is provided and not when the Participant is formally billed for, charged for or pays for the expenses.

6.12.3 **Dependent Care Reimbursement Account Benefits.** Amounts for Dependent Care Reimbursement Account Benefits may only be paid for expenses incurred during the Plan Year and any Grace Period elected by the Employer. Dependent Care Expenses shall be considered incurred when the Dependent



Care is provided and not when a Participant is formally billed for, charged for or pays for the expenses. Amounts for Dependent Care Reimbursement Account Benefits may only be paid from contributions allocated specifically to those Benefits on the Enrollment Form.

6.12.4 **Premium Reimbursement Arrangement Benefits.** Amounts for Premium reimbursement Arrangement Benefits may only be paid for expenses during the Plan Year and any Grace Period elected by the Employer. Amounts for Premium reimbursement Arrangement Benefits may only be paid from contributions allocated specifically to those Benefits on the Enrollment Form.

6.12.5 **Adoption Assistance Reimbursement Account Benefits.** Amounts for Adoption Assistance Reimbursement Account Benefits may only be paid for expenses during the Plan Year and any Grace Period elected by the Employer. Amounts for Adoption Assistance Reimbursement Account Benefits may only be paid from contributions allocated specifically to those Benefits on the Enrollment Form.

## Article 7 | Health Flexible Spending Account

### **7.1 General**

If elected by the Employer in the Adoption Agreement, a Participant covered by the Health Flexible Spending Account may submit claims for payment up to the total amount allocated for Health Flexible Spending Account Benefits for the Plan Year and any Health Flexible Spending Account Carryover amount. The Health Flexible Spending Account will reimburse the Participant directly. Except as specified in this Article, the general provisions of the Plan shall govern contributions, elections and Benefits. Eligibility, enrollment and termination of participation under the Plan as provided in Article 4 shall constitute enrollment and termination of participation under the Health Flexible Spending Account.

### **7.2 Maximum and Minimum Benefit**

The maximum and minimum Health Flexible Spending Account Benefit during the Plan Year shall be determined by the Employer and specified in the Adoption Agreement. The maximum Reduction Amount for Health Flexible Spending Account Benefits shall not exceed the limitation specified in Code Section 125(i) for the Plan Year.

### **7.3 Covered Expenses**

The Health Flexible Spending Account covers Medical Expenses (as defined below) which a Participant incurred during the Plan Year and any Grace Period and while the Participant's enrollment electing Health Flexible Spending Account Benefits is in effect. Medical Expenses shall be considered incurred when the medical care is provided and not when the Participant is formally billed, charged or pays the Medical Expenses.

### **7.4 Definitions of Medical Expenses**

For purposes of this Article, except as may be further narrowed in the Adoption Agreement, Medical Expenses shall be amounts incurred by or on behalf of a Participant, a Participant's Spouse or a Participant's Dependents for the following items to the extent they are covered by Code Section 213(d) and are not covered by insurance or other group benefits paid to or available to the Participant and are not claimed as a tax deduction:

- a) The diagnosis, cure, medication, treatment or prevention of disease, affecting any structure or function of the body.
- b) Transportation primarily for and essential to the medical care as referred to in (1) above.
- c) Expenses incurred for a medicine or a drug shall be treated as Medical Expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

Medical Expenses do not include expenses for long-term care services or any premium paid for medical or long-term care coverage.

## 7.5 Limited Health FSA

If a Participant is covered by a high deductible health plan ("HDHP") as defined by Code Section 223(c)(2), the Plan shall only reimburse Medical Expenses that do not fall within the annual deductible minimum of the HDHP, except as specifically permitted in guidance from the IRS.

## 7.6 Nondiscrimination

The Health Flexible Spending Account must comply with the nondiscrimination rules under Code Section 105(h), and its regulations.

## 7.7 Coordination of Benefits

The Health Flexible Spending Account is intended to pay Benefits solely for otherwise unreimbursed Medical Expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its Benefits shall not be taken into account when determining benefits payable under any other plan.

## 7.8 Claims Procedures

The following claims procedures apply only to the Health Flexible Spending Account:

- a) **Administration of Claims Procedures.** The following claims procedures shall govern the filing of Benefit claims, notification of benefit determinations and appeal of adverse benefit determinations. These procedures shall not be construed in any manner which would unduly inhibit or hamper the initiation or processing of any claim for Benefits. All Benefit determinations made pursuant to these procedures shall be made in accordance with the documents governing the Plan and, where appropriate, shall be applied consistently with respect to similarly situated Participants. These claims procedures are intended to comply with Section 503 ERISA and Department of Labor ("DOL") regulations.

A claim denial (or "adverse Benefit determination") includes any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan.

- b) **Claims for Benefits.** A Participant (or his or her authorized representative) who has elected to receive Health Flexible Spending Account Benefits for a Plan Year may apply to the Administrator for reimbursement of Medical Expenses by providing the following information in such form as the Administrator may prescribe:
  - 1) The amount, the date and nature of each expense;
  - 2) The amount of the requested reimbursement;
  - 3) The name of the person, organization or entity to which the expense was or is to be paid;
  - 4) The name of the person for whom the expense was incurred and, if such person is not the Participant requesting the Benefit, the relationship of such person to the Participant;
  - 5) The amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense;
  - 6) A statement that the expense (or the portion of the expense for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any

other health plan coverage. If the expense is insurable, the Participant must provide an explanation of benefits ("EOB"); and

- 7) Bills, invoices, receipts, canceled checks or other statements that the Administrator may request to substantiate a claim for Benefits. The application may be made after the Participant has incurred the expense.

Notwithstanding the foregoing, the substantiation for debit or stored card payments of Medical Expenses under the Health Flexible Spending Account is provided in subsection (c) below.

- c) **Debit Card Payments.** Subject to procedures established by the Administrator and in accordance with IRS guidance in Revenue Ruling 2003-43, Notice 2006-69, Notice 2007-2, Notice 2010-59, Notice 2011-5, proposed Treasury Regulation section 1.125-6 and any subsequent IRS guidance, a Participant may use a debit and/or credit (stored value) card (the "card") provided by the Administrator and the Plan for payment of Medical Expenses, as follows:
  - 1) **Payment of Medical Expenses.** Each Participant issued a card shall enter into a written agreement to certify that such card shall only be used for Medical Expenses that have been incurred. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits. The Participant must also agree to obtain and maintain sufficient documentation for Medical Expenses paid with the card.
  - 2) **Card Issuance.** The card shall only be issued to a Participant upon participation in the Health Flexible Spending Account. The card shall be automatically cancelled upon the Participant's death or termination of employment, if the Participant is no longer enrolled in the Health Flexible Spending Account or withdraws from the Health Flexible Spending Account due to a change in status, or if the Participant uses the card for impermissible expenses pursuant to subsection (6) below.
  - 3) **Maximum Dollar Amount.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year.
  - 4) **Limitation on Use.** The Administrator shall limit the use of the card to medical care providers and certain stores allowed under IRS guidance for card payments of Medical Expenses permitted under such guidance.
  - 5) **Substantiation.** A Participant's use of the card for Medical Expenses shall be subject to substantiation to the Administrator, usually by submission of a receipt from a medical provider or certain stores describing the service, the date and the amount in accordance with subsection (b) above. All charges shall be conditional pending confirmation and substantiation. Notwithstanding the foregoing, the submission of receipts for card payments is not required for Medical Expenses that are substantiated copayment matches, certain recurring Medical Expenses, real-time substantiation of Medical Expenses at the time of sale and Medical Expenses substantiated through an inventory information approval system if IRS requirements for these types of substantiations are satisfied.
  - 6) **Correction Methods.** If a Participant fails to provide the Administrator with requested substantiation for a Medical Expense or if a Participant's card purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator and/or Employer, in its discretion, shall use one or more of the following correction methods to make the Plan whole:
    - i) Deactivate the card until the amount of the improper payment is recovered;
    - ii) Require the Participant to repay the improper amount;

- iii) If the Participant fails to repay the improper amount, withhold the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
  - iv) If the amount remains unpaid, offset future claims until the amount is repaid; and
  - v) If the amount continues to remain unpaid, treat the improper payment as any other business indebtedness of the Employer.
- d) **Timing of Claims Determination.** After a Participant (or his or her authorized representative), has properly filed a claim for Benefits, the Administrator will notify the Participant within 30 days of receiving the claim whether the claim has been approved, denied or if further information is required. The 30 days may be extended to 45 days, if the Administrator notifies the Participant within the initial 30 days of the circumstances beyond the Plan's control that require an extension of the time period, and the date by which the Plan expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a Benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

If the extension is necessary due to a failure of the claimant to submit information necessary to decide the election, the Participant will have 45 days from the receipt of the notice to provide the necessary information. If the Participant submits the necessary information within the designated time period, the Administrator will complete the claims determination within 15 days from the date the Administrator receives the information. If the Participant fails to submit any information within the designated time period, the Participant's claim will be denied within 15 days of the deadline. In such case, the Participant may appeal the claim in accordance with the Plan's procedures. The denial must comply with the content requirements for the notification of a claims denial in paragraph (d) below.

- e) **Notice of Claims Denial.** If the Administrator denies the claim, in whole or in part, for any reason, the Administrator will provide the Participant (or his or her authorized representative) with a written or electronic notice containing the following information:
- 1) The reason(s) why the claim or a portion of it was denied;
  - 2) Reference to Plan provision on which the denial was based;
  - 3) If the denial was based in whole or in part on any internal rules, guidelines, exclusion or limit or protocol, a statement that the Participant may request a copy of the rule, guideline or explanation of a medical judgment or protocol, which will be provided free of charge;
  - 4) What additional information, if any, is required to perfect the claim and why the information is necessary; and
  - 5) What steps the Participant may take if he or she wishes to appeal the decision and that the Participant may file an action in federal court under Section 502 of ERISA, if the Participant disagrees with the Plan's decision on appeal.
- f) **Claims Appeal.** If a Participant (or his or her authorized representative) disputes a denial of Benefits, the Participant may file a written appeal within 180 days of receipt of the denial notice containing the Participant's name and address, the reasons for making the appeal, and the facts supporting the appeal.

In addition, the Participant may submit with the appeal written comments, documents, records, and other information relating to the claim for Benefits. The Participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other

information relevant to the claim for Benefits. A document, record or other information shall be considered "relevant" to the claim if such document, record, or other information was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the Benefit determination; demonstrates compliance with the administrative processes and safeguards required in making the Benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied Benefit for the Participant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The Administrator will answer the appeal in writing within 60 days, stating whether it has been granted or denied. The Administrator's determination on review shall be binding on all parties. The review will be subject to the following rules.

- 1) The Administrator's review of the claim shall take into consideration all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
  - 2) The review on appeal will not defer to the initial adverse Benefit determination.
  - 3) The review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse Benefit determination nor the subordinate of such individual.
- g) **Claims Denial.** If the Administrator denies the appeal, partially or completely, the Administrator will provide the Participant (or his or her authorized representative) with a written or electronic notice containing the following information:
- 1) The specific reasons for the appeal denial;
  - 2) Reference to the specific Plan provisions on which the denial is based;
  - 3) A statement that the Participant may request reasonable access to and copies of all documents, records and other information relevant to his or her appealed claim for Benefits, which shall be provided to the Participant without charge;
  - 4) If the appeal was based in whole or in part on any internal guidelines or protocols, a statement that the Participant may request a copy of the guideline or protocol, which will be provided to the Participant without charge; and
  - 5) A statement regarding the Participant's right to bring an action under Section 502(a) of ERISA.
- h) **Further Action.** A Participant (or his or her authorized representative) may not begin any legal action, including proceedings before administrative agencies, until the Participant has followed these procedures and exhausted the internal appeal opportunities described in this section. The Participant may, at his or her own expense, have legal representation at any stage of these review procedures. These review procedures shall be the exclusive mechanism through which determinations of eligibility and Benefits may be appealed. If, after the review process, the Participant is not satisfied with the result, he or she must file any legal action within 180 days of receiving the final review notice under these procedures. If the time limitation in this section of the Plan is less than that required by law, such limitation is hereby extended to conform to the minimum period permitted by law.
- i) **Calculation of Time Periods.** The period of time for making a Benefit determination shall begin when a claim is filed in accordance with the filing procedures of the Plan, without regard to

whether all of the information necessary to decide the claim accompanies the filing. Days are measured in calendar days.

- j) **Deemed Exhaustion of Remedies.** If the Plan fails to follow these procedures in accordance with applicable law, a Participant shall be deemed to have exhausted the administrative remedies available under the Plan. The Participant shall be entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of a claim.
- k) **Authorized Representative of Participant.** The Plan's Claims Procedures do not preclude an authorized representative of a Participant from acting on behalf of such Participant in pursuing a benefit claim or appeal of an adverse benefit determination. The Plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the Participant. In the absence of contrary direction from the Participant, the Administrator will direct all information and notifications to the representative authorized to act on the Participant's behalf.

### 7.9 COBRA (if applicable)

A Participant who loses coverage under the Health Flexible Spending Account may have the right to continue Benefits as a "qualified beneficiary" (defined below) under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). The Employer provides information about COBRA and any other health continuation requirements with health plan information. The rules in this paragraph do not apply to an individual who is covered under USERRA continuation coverage. Instead, the USERRA provisions in section 3.7 apply.

Under federal law the covered employee may have the option to continue Health Flexible Spending Account coverage under this Plan that they would otherwise lose due to the "qualifying events" described below.

	Qualifying Events	Qualified Beneficiaries
1	Participant's termination of employment for other than gross misconduct	Participant Covered Spouse Covered Children
2	Participant's reduction of hours below the level necessary to be eligible for coverage	Participant Covered Spouse Covered Children

To qualify for continuation coverage, the qualified beneficiary must have been covered by the Health Flexible Spending Account on the day before the qualifying event occurred. Children who are born to or placed for adoption with a covered Participant, who properly elects coverage for them during a period of COBRA continuation, will also be qualified beneficiaries.

- a) **Cost of Coverage.** A qualified beneficiary may continue to participate in this Plan with premiums paid on an after-tax basis. The cost of this continued coverage is paid entirely by the individual electing such coverage.
- b) **Duration of Coverage.** In the event this Plan qualifies as an excepted benefit under Treasury Regulations Section 54.4980B-2 Q&A 8, a qualified beneficiary may continue coverage through the end of the Plan Year, provided that the qualified beneficiary has "underspent" his or her Health Flexible Spending Account. A qualified beneficiary has underspent his or her Account when the unused Health Flexible Spending Account Benefits for the Plan Year at the time of the qualifying event

are greater than the amount the qualified beneficiary would be required to pay for Health Flexible Spending Account Benefits for the remainder of the Plan Year.

The Administrator will provide qualified beneficiaries with information regarding the duration of their coverage.

- d) **Termination of Coverage.** Coverage will be terminated before the end of the maximum period when the earliest of the following occurs:
- 1) The last day of the period for which the individual last made timely payment, if the individual fails to make a timely payment under the Plan; or
  - 2) The date that all Health Flexible Spending Account coverage provided by the Employer ends.

The Administrator will provide the qualified beneficiaries with an early termination notice.

- e) **Final Pay Election in Lieu of COBRA.** If permitted by the Employer, a Participant may elect to continue coverage for the remainder of the Plan Year by electing such continuation, electing to deduct the full amount of the remaining Reduction Amount for the remainder of the Plan Year in a lump sum from final pay, and waiving continuation under COBRA by executing such forms and following such procedures as required by the Administrator.

## 7.10 HIPAA Privacy

This section applies to the extent the Health Flexible Spending Account is subject to the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The intent of this Article is to extend privacy rights required by HIPAA. To the extent these rights are not required under HIPAA, this section shall be void.

7.10.1 **Application of Privacy Regulations.** The Plan protects the privacy of an Employee's medical information. The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan Sponsor for Plan administration purposes. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

### 7.10.2 **Disclosure of PHI.**

- a) **Disclosures by Plan.** The Plan may disclose PHI to Authorized Employees of the Plan Sponsor as identified in the Adoption Agreement to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.
- b) **Disclosures by Business Associates.** The Plan's Business Associates may disclose PHI to the Authorized Employees to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.
- c) **Disclosures by Other Covered Entities.** A Covered Entity that provides health benefits to Individuals covered by the Plan may disclose PHI to the Authorized Employees of the Plan Sponsor to the extent necessary for the Plan Sponsor to perform the following Plan administration functions:



- 1) The Plan's Payment activities,
- 2) Those Health Care Operations designated in 45 C.F.R. Section 164.506(c)(4) with respect to the Plan, and
- 3) All of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Medical Arrangement under the Privacy Regulations.

7.10.3 **Uses and Disclosures of PHI by the Plan Sponsor.** The Authorized Employees of the Plan Sponsor shall use and/or disclose PHI only to the extent necessary to perform Plan administration functions that qualify as Payment or Health Care Operations, or as otherwise permitted or required by the Privacy Regulations.

7.10.4 **Privacy Safeguards.** The Plan Sponsor agrees to:

- a) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;
- b) Ensure that any subcontractors or agents to whom the Plan Sponsor provide PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- c) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;
- d) Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;
- e) Report to the Plan any use or disclosure of PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the Plan;
- f) Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;
- g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
- h) Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
- i) Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;
- j) If feasible, return or destroy all PHI that the Plan Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Plan Sponsor. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and
- k) Ensure that adequate separation between the Plan and the Plan Sponsor is established, as described below.

7.10.5 **Adequate Separation.** In accordance with HIPAA, only the Authorized Employees may be given access to PHI, and such information will be used only for Plan administration activities, not for employment-related activities.

7.10.6 **Limitations of PHI Access and Disclosures.** The Authorized Employees may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan as described above.

7.10.7 **Noncompliance Issues.** If the Authorized Employees do not comply with these privacy requirements, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

## 7.11 HIPAA Security

This section applies to the extent the Health Flexible Spending Account is subject to the security regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The intent of this Article is to extend security protections as required by HIPAA. To the extent these rights are not required under HIPAA, this Article shall be void.

7.11.1 **Application of the Security Regulations.** The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (1) it receives pursuant to an appropriate authorization (as described in 45 C.F.R. Section 164.504(f)(1)(ii) or (iii)), or (2) that qualifies as Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. Section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations (or as interpreted by the Center for Medicare and Medicaid Services "CMS").

7.11.2 **Security Safeguards.** The Plan Sponsor shall, in accordance with the Security Regulations:

- a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan.
- b) Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any Employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's disciplinary procedure.
- c) Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.
- d) Report to the Plan any Security Incident of which it becomes aware in accordance with the Plan's security policy.

7.11.3 **Security Official.** The Plan shall designate a Security Official, in accordance with 45 C.F.R. Section 164.308(a)(2), who will be responsible for the development and implementation of the policies and procedures required under the Security Regulations.

## 7.12 Qualified Reservist Distributions

If elected by the Employer in the Adoption Agreement, and notwithstanding anything in the Plan to the contrary, the Plan may provide "qualified reservist distributions" as provided in the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act). In accordance with the HEART Act, such qualified reservist distributions are subject to the following requirements:

- a) **Eligibility.** Qualified reservist distributions are available to any Participant who is a member of a "reserve component" as defined in section 101 of title 37 of the United States Code who, by reason of being a member of a reserve component, has been ordered or called into active duty for (i) 180 days or more or (ii) an indefinite period ("Reservist").
- b) **Timing.** Qualified reservist distributions must be requested during the period beginning on the date the Reservist is ordered or called into active duty ("Call-Up Date") and ending on the last day of the Plan Year and any Grace Period including the Call-Up Date. The request must be made on forms and following procedures established by the Administrator and must include a copy of the order or call to duty. Qualified reservist distributions will be made no later than 60 days after request.
- c) **Maximum Distribution.** Qualified reservist distributions may not exceed the amount specified in the Adoption Agreement for Health Flexible Spending Account Benefits less the Health Spending Account Benefits received by the Reservist up to the date of the qualified reservist distribution.

## Article 8 | Dependent Care Reimbursement Account

### **8.1 General**

If adopted by the Employer in the Adoption Agreement, a Participant covered by the Dependent Care Reimbursement Account may submit claims for payment from contributions allocated to the Participant's subaccount for Dependent Care Reimbursement Account Benefits. The Dependent Care Reimbursement Account will reimburse the Participant directly. Except as specified in this Article, the general provisions of the Plan shall govern contributions, elections, Benefits and claims. Eligibility, enrollment and termination of participation in the Plan as provided in Article 4 shall constitute enrollment and termination of participation under the Dependent Care Reimbursement Account.

### **8.2 Covered Dependent Care Expenses**

The Dependent Care Reimbursement Account shall cover Dependent Care Expenses (as defined below) incurred during the Plan Year and any applicable Grace Period, and to the extent contribution amounts are available in the Participant's Account. Dependent Care Expenses are incurred when the dependent care is provided and not when the Participant is formally billed, charged or pays for the Dependent Care Expenses.

### **8.3 Limitation on Benefits**

To determine whether the program meets the applicable nondiscrimination requirements under the Code, all employees who are treated as employed by a single employer under subsection (b), (c), (m) or (o) of Code Section 414, including leased employees under Code Section 414(n), must be taken into account.

- a) **Discrimination as to Eligibility, Contributions or Benefits.** Contributions or Dependent Care Reimbursement Account Benefits provided under the Dependent Care Reimbursement Account or eligibility to participate in the Dependent Care Reimbursement Account shall not discriminate in favor of Highly Compensated Individuals or their Dependents in violation of Section 129 of the Code.
- b) **Consequences of Discrimination.** If the Program is found to be discriminatory, then Highly Compensated Employees shall be taxed on their Dependent Care Reimbursement Account Benefits.

### **8.4 Maximum and Minimum Benefit**

The maximum and minimum Dependent Care Reimbursement Account Benefits shall be determined by the Employer and specified in the Adoption Agreement. The maximum Dependent Care Reimbursement Account Benefit during any Plan Year and calendar year shall not exceed the least of:

- a) The Earned Income of the Participant for the calendar year;
- b) The Earned Income of the Participant's Spouse for the calendar year;
- c) The deemed Earned Income of the Participant's Spouse if the Spouse is a Student or is physically or mentally incapacitated; or
- d) \$5,000 for each taxable year (for a married person filing separately, the maximum Dependent Care Reimbursement Account Benefit is \$2,500).

The deemed Earned Income for a Spouse who is a Student or incapacitated is \$250 per month for one Dependent and \$500 per month for two or more Dependents. In the case of any husband or wife, the preceding sentence shall apply with respect to only one Spouse for any one month.

#### **8.5 Prohibition of Certain Benefits**

A Participant may not receive Dependent Care Reimbursement Account Benefits when the individual providing the dependent care is:

- a) A Dependent of the Participant or the Participant's Spouse for federal income tax purposes under Code Section 151(c); or
- b) A child of the Participant (within the meaning of Code Section 151(f)(1)) under the age of 19 at the close of the taxable year.

#### **8.6 Outside the Household Services**

- a) Certain Dependents. Dependent Care Reimbursement Account Benefits shall not be paid for services outside a Participant's household unless the services are provided for the care of:
  - 1) A Dependent within the meaning of section 8.9(a)(1); or
  - 2) Any other Dependent who regularly spends at least eight hours each day in the Participant's household.
- b) Dependent Care Centers. Dependent Care Reimbursement Account Benefits shall not be paid for services provided outside a Participant's household by a facility that provides care for more than six individuals other than individuals who reside at the facility, and receive a fee,  
  
payment or grant for providing services for any of these individuals, unless such facility complies with all applicable laws and regulations of the applicable state or unit of local government and the requirements of section 8.6(a) are met.

#### **8.7 Report to Participants**

The Administrator shall submit to each Participant, on or before January 31 of each calendar year, a statement showing the amount paid or expenses incurred by the Employer in providing dependent care assistance on behalf of such Participant during the previous calendar year. For such purpose, the Employer shall provide on each Employee's Form W-2 the amount paid or expenses incurred by the Employer in providing dependent care assistance during the preceding calendar year. The Form W-2 must be provided to Employees by January 31 following the calendar year for which the Form W-2 relates.

#### **8.8 Reimbursement or Payment of Dependent Care Expenses**

The Administrator shall reimburse a Participant for Dependent Care Expenses incurred during the Plan Year for which the Participant submits the following documentation.

- a) The amount and date of the expenses;
- b) The name of the person, organization or entity to which the expense was or is to be paid; and
- c) Such other information as the Administrator may require.

A Participant must submit the name, social security number or tax identification number of the person, organization or entity to which the expense was or is to be paid in order to receive reimbursement or payment of Dependent Care Expenses.

In addition, a Participant shall submit any bills, invoices, receipts, or other statements showing the amount of such expense and any additional documentation that the Administrator may require. All information shall be submitted in such form as the Administrator prescribes.

The Administrator shall not reimburse or pay Dependent Care Expenses that exceed the balance of the Participant's Dependent Care subaccount at the time of reimbursement or payment.

In the event a Participant ceases employment as an Eligible Employee during a Plan Year, the Participant may utilize any remaining balance of the Participant's Dependent Care subaccount as of the date of termination of employment to continue to receive reimbursement or payment of Dependent Care Expenses incurred during the remainder of the Plan Year.

## 8.9 Definitions

For purposes of this Article, the following special definitions shall apply.

a) **Dependent**. Any individual who is a qualifying individual under Code Section 21(b)(1), as amended:

- 1) A Dependent (as defined in Code Section 152(a)(1)) of a Participant who is under the age of 13; or
- 2) A Dependent (as defined in Code Section 152(a) without regard to Sections (b)(1), (b)(2) and (d)(1)(B)) or Spouse of the Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half the calendar year.

In determining whether an individual is a Dependent of the Participant, the special dependency rules of Code Section 21(e)(5) shall be taken into account, where applicable.

b) **Dependent Care Expenses**. Amounts paid or incurred by or on behalf of a Participant for household services or for the care of a Dependent, either inside or outside of the Participant's home, subject to the limitations in sections 8.4 and 8.5, to enable the Participant to be gainfully employed for any period for which he or she has a Dependent.

c) **Earned Income**. All amounts as defined in Section 32(c)(2) of the Code (excluding any amount paid or incurred by the Employer for Dependent care).

d) **Highly Compensated Employee**. Any Employee who:

- 1) Was a 5% owner of the Employer at any time during the year or the preceding year, or
- 2) For the preceding year, had Compensation from the Employer in excess of \$80,000 (as indexed). The indexed amount is \$115,000 for 2012 Plan Year.

In addition, if the Employer elects (pursuant to Code Section 414(q)(1)(B)(ii)) to limit the Highly Compensated Employees under section 8.9(d)(2) to the top paid group of employees for the preceding year (consisting of the top 20% of employees ranked on the basis of compensation) for purposes of another employee benefit plan sponsored by the Employer, such limit shall also apply to this Plan.

- e) **Student.** An individual who, during each of five 5 calendar months during a Plan Year, is a full-time student at any college or university:
- 1) The primary function of which is the presentation of formal instruction;
  - 2) Which maintains a regular faculty and curriculum; and
  - 3) Which normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

## Article 9 | Adoption Assistance Account

### 9.1 General

If elected by the Employer in the Adoption Agreement, the Adoption Assistance Account provides Adoption Assistance Benefits to Eligible Employees of the Employer who participate in the Employer's Cafeteria Plan ("Plan") and who pursuant to the election procedures set forth in the Plan, choose to make contributions to an Adoption Assistance Account. It is intended that the Adoption Assistance Account meet the requirements of Section 137 of the Internal Revenue Code and that Benefits paid to each Participant under the Adoption Assistance Account constitute a qualified benefit under Code Section 125 and are excludable from the Participant's gross income to the maximum extent allowable under Code Section 137. The purpose of the Adoption Assistance Account is to reimburse Participants for all or a portion of the cost of certain adoption expenses in conjunction with the Participant's Reduction Amount under the Plan. Except as specified in this Article, the general provisions of the Plan shall govern contributions, elections, Benefits and claims. Eligibility enrollment and termination of participation in the Plan as provided in Article 4 will constitute enrollment and termination of participation under the Adoption Assistance Account.

### 9.2 Definitions

Unless otherwise specified, terms that are capitalized in this Article 9 have the same meaning as the defined terms in the Plan. The definitions of terms used in this Article 9, but not defined in Article 2 of the Plan shall be applicable only with respect to this Article 9. To the extent a term is defined both in the Plan and in this Article 9, the term as defined in the Plan shall govern the interpretation of the Plan and the term as defined in this Article 9 shall govern the interpretation of this Article 9.

- a) **Adoption Expenses.** Adoption Expenses means reasonable and necessary adoption fees, costs, attorneys fees, and other expenses that are: (i) directly related to and the principal purpose of which is for, the legal adoption of an Eligible Child by the Participant, (ii) not incurred in violation of state or federal law, or in carrying out any surrogate parenting arrangement, (iii) not for the adoption of the child of the Participant's Spouse, and (iv) not reimbursed by another source (e.g., grants, another employer).
- b) **Eligible Child.** An eligible child is any individual who, at the time the adoption expenses are incurred, is under the age of 18 or is physically or mentally incapable of caring for himself or herself.

### 9.3 Participation

9.3.1 **Commencement of Participation.** Each Employee who satisfies the Eligibility Requirements set forth in the Adoption Agreement shall be eligible to participate in this Adoption Assistance Account on the dates set forth in the Adoption Agreement.

9.3.2 **Ineligible Employees.** Notwithstanding anything to the contrary in this section 9.3, an Employee shall not be eligible to participate in the Adoption Assistance Account during any calendar year in which: (i) the Employee's adjusted gross income (as defined in accordance with Code Section 137(b)(3)) for the current or the immediately preceding year exceeds the limitation under Code Section 137; (ii) the Employer is an S corporation in which the Employee owns more than 2 percent of the stock or stock with more than 2 percent of the voting power; or (iii) the employee is a more than 5 percent owner of the Employer.



#### 9.4 Adoption Assistance Accounts

The Adoption Assistance Account will be debited for reimbursement amounts dispersed to the Participant in accordance with this Article 9. In the event that the amount in the Adoption Assistance Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into the following months (within the same Plan Year), to be paid out as the Adoption Assistance Account balance becomes adequate. In no event will the amount of reimbursements of Adoption Assistance Expenses exceed the amount elected to be credited to the Adoption Assistance Account for any Plan Year. Any amount allocated to the Adoption Assistance Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Adoption Assistance Expense Reimbursements for the Plan Year or any Grace Period set forth in the Adoption Agreement.

#### 9.5 Amount of Reimbursements

9.5.1 **Maximum and Minimum Benefits.** The maximum and minimum Adoption Assistance Account Benefits shall be determined by the Employer and specified in the Adoption Agreement. The Adoption Assistance Account may not exceed the limitation provided in Code Section 137 (“Maximum Reimbursement Limit”) in Adoption Assistance Account Benefits for the adoption of a child. The Adoption Assistance Account Benefits provided by the Adoption Assistance Account shall be in the form of reimbursements for Adoption Expenses. Notwithstanding the above, the Reimbursement is limited to the lesser of:

- a) The balance of the Participant's actual Adoption Expenses; or
- b) The balance of the Participant's Adoption Assistance Account.

Amounts incurred in an unsuccessful attempt to adopt a child before successfully adopting another child count towards the Maximum Reimbursement Limit.

9.5.2 **Reimbursement Limitation.** Notwithstanding subsection 9.5.1, the Maximum Reimbursement Limit under the Adoption Assistance Account shall be subject to an inflation adjustment under Code Section 137(f) and a reduction under Code Section 137(b)(2).

9.5.3 **Special Needs Adoptions.** A Participant adopting a child with special needs is entitled to the Maximum Reimbursement regardless of whether the Eligible Employee actually has any Adoption Expenses and notwithstanding anything in section 9.5.2 to the contrary. For this purpose, the Employee’s Adoption Expenses in the year the adoption of a child with special needs is finalized, shall equal the difference between the Maximum Reimbursement Limit (as adjusted for inflation under Code Section 137(f)) and the total actual qualified expenses for the adoption incurred during that year and all prior taxable years. A child with special needs is an Eligible Child who is a citizen or resident of the United States who a state has determined: (i) cannot or should not be returned to the birth parents' home; and (ii) has a specific factor or condition (such as the child's ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions, or physical, mental, or emotional handicaps) because of which the child cannot be placed with adoptive parents without adoption assistance.

9.5.4 **International Adoptions.** In the case of an adoption of a child who is not a citizen or resident of the United States at the time the adoption effort commenced, any such expense which is paid or

incurred before the taxable year in which such adoption becomes final shall be taken into account as if such expense were paid or incurred during the year the adoption becomes final. No such expense shall be taken into account in a taxable year before the adoption becomes final.

## 9.6 Reimbursement Procedures

No Adoption Assistance Account Benefits shall be approved by the Administrator and paid under the Adoption Assistance Account unless a Participant has first submitted a written or electronic claim for Benefits to the Administrator on a form specified by the Administrator and pursuant to procedures established by the Administrator. The Administrator will provide notice in writing if a claim for Benefits is denied and the Administrator will provide a review of that claim if requested. Any claim for Benefits will be processed in accordance with procedures established by the Administrator, in its sole discretion.

## 9.7 Tax Treatment

9.7.1 **Exclusion from Income.** Benefits under this Adoption Assistance Account are designed to be excludable from gross income under Code Section 137. However, Benefits are subject to both the Social Security and Medicare portions of the Federal Insurance Contributions Act ("FICA").

9.7.2 **Tax Mitigation.** The Adoption Assistance Account is intended to provide tax-free Adoption Assistance Account Benefits to Eligible Employees pursuant to Code Section 137. However, subject to section 9.8, Benefits described in this Adoption Assistance Plan will be provided even if such Benefits are taxable or are in excess of the amount excludable under Code Section 137. Provided further, however, that no such benefit will be provided to an individual if the benefit would cause the Adoption Assistance Account to become discriminatory.

9.7.3 **Filing Requirements for Married Employees.** Participants who are married must file a joint federal income return to treat the Adoption Expense Reimbursements as excludable from gross income. For purposes of the Adoption Assistance Account and this income exclusion, a Participant who is legally separated under a decree of divorce or separate maintenance is not considered married.

9.7.4 **Tax Liability.** The tax liability on any payments made under the Adoption Assistance Account is the sole responsibility of each Participant.

## 9.8 Discrimination

9.8.1 **Limitation of Benefits for More-than-5 Percent Owners.** No more than 5 percent of the amounts paid or incurred under this Adoption Assistance Account for any Plan Year may be provided for the class of individuals who are shareholders or owners (or the spouses and dependents of such shareholders or owners), each of whom own more than 5 percent of the stock or capital or profits interest in the Employer. For purposes of determining stock ownership, the attribution rules of Code Section 1563(d) and (e) (without regard to Code Section 1563(e)(3)(C)) apply.

9.8.2 **Nondiscrimination.** The Adoption Assistance Account is intended not to discriminate in favor of certain highly compensated employees as defined in Code Section 414(q). If in the judgment of the Administrator, the operation of the Adoption Assistance Account in any Plan Year would result in such prohibited discrimination, then the Administrator shall, in its full discretion, select and exclude from eligibility and/or coverage under the Adoption Assistance Account for such Employees as shall be necessary to assure that, in the judgment of the Administrator, the Plan does not discriminate. Alternatively, the Administrator may, at any time, require any Employee to amend the amount of pre-tax salary reduction contributions made through the Plan if the Administrator determines that such action is necessary or advisable in order to satisfy the Code Section 137 nondiscrimination requirements or maintain the qualified status of Benefits received under this Plan.

## Article 10 | Administration of Plan

### **10.1 Administrator**

The Administrator shall be responsible for managing the operation and administration of the Plan.

### **10.2 Records and Reports of the Administrator**

The Administrator is responsible for keeping necessary records.

### **10.3 Administrative Powers and Duties**

The Administrator's duties and powers include, but are not limited to, the following:

- a) To interpret the Plan. Its interpretation made in good faith is final and conclusive on all persons claiming Benefits under the Plan;
- b) To decide all questions as to eligibility to participate in the Plan and as to the rights of Participants under the Plan;
- c) To file or cause to be filed all annual reports, returns, schedules, descriptions, financial statements and other statements as may be required by any federal or state statute, agency, or authority;
- d) To obtain from the Employer and Employee such information as shall be necessary to the proper administration of the Plan;
- e) To determine the amount, manner and time of payment of Benefits;
- f) To contract with third party administrators, insurance carriers, or others as may be necessary to provide for Benefits;
- g) To communicate to any third party administrator, insurer or other contract supplier of Benefits under this Plan in writing all information required to carry out the provisions of the Plan;
- h) To notify Plan Participants in writing of any Plan amendment or change in any Benefits available under the Plan, in the manner and to the extent required by applicable law;
- i) To prescribe such forms as may be required for Employees to make elections under the Plan; and
- j) To do such other acts as it deems reasonably required to administer the Plan in accordance with its provisions, or as may be provided for or required by law.

### **10.4 Claims Denial**

When a Participant has properly filed a claim for Benefits other than Health Flexible Spending Account Benefits, the Administrator will make a determination as to eligibility and the amount of Benefits payable, if any. The Administrator's decision is final. The claims procedure for the Health Flexible Spending Account is described in section 7.8.

## Article 11 | Amendment or Termination

### **11.1 Amendment or Termination**

The Employer may amend or terminate the Plan. A participating Employer may withdraw from participation in the Plan, but may not amend or terminate the Plan.

### **11.2 Preservation of Rights**

A Plan amendment shall not apply to Benefits incurred prior to the amendment. If the Employer terminates the Plan, the Administrator shall reimburse or pay Benefits treating the termination date as the last day of the Plan Year.

## Article 12 | General

### **12.1 Limitation of Rights**

The Plan and Plan amendments shall not be construed as giving an Employee or other person any legal or equitable right against the Administrator, or any participating Employer, except as stated in this Plan. Nothing in the Plan shall be construed as a contract of employment or as a limitation of the Employer's right to discharge Employees.

### **12.2 Nonassignment of Rights**

An Employee's right to receive Benefits shall not be alienable by the Employee, by assignment or any other method, and shall not be subject to the Employee's creditors. No participating Employer shall be subject to debts, contracts or torts of any Employee.

### **12.3 Benefits from General Assets**

The Employer shall pay Benefits from its general assets, from a trust or from insurance contracts. The Plan does not require the Employer or Administrator to maintain a fund or segregate any amount for an Employee. No Employee or other person has any claim against any fund, account or Employer assets from which Benefits under the Plan may be made.

### **12.4 No Guarantee of Tax Consequences**

The Administrator and the Employer do not guarantee that Benefits will be excluded from the Participant's gross income for federal or state income tax purposes, or that any other tax treatment will be available to the Participant.

### **12.5 Incompetency**

Every Participant receiving or claiming Benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Administrator shall receive a written or electronic notice, in a form and manner acceptable to the Administrator, that such Participant is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his or her estate has been appointed. If, however, the Administrator shall find that any person to whom a Benefit is payable under the Plan is unable to care for his or her affairs because of any mental or physical incompetency or because he or she is a minor, any payment due (unless a prior claim shall have been made by a duly appointed legal representative of his or her estate) may be paid to the Spouse, a child, a parent, or a brother or sister, or beneficiary or to any person with whom he or she is residing, or to any other person or institution deemed by the Administrator to have incurred expense for such person otherwise entitled to payment.

In the event a guardian, conservator or other person legally vested with the care of the estate of any Participant receiving or claiming Benefits under the Plan shall be appointed by a court of competent jurisdiction, payments shall be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Administrator. To the extent permitted by law, any such payment so made shall be a complete discharge of any liability therefore under the Plan.

### **12.6 Right of Recovery**

If any Participant receives one or more payments or reimbursements that are not properly payable under the Plan, the Employer shall have the right to recoup such amount from the Participant or any other party who received the benefit or to offset any future Benefits paid on the same Participant's behalf. These rights shall not limit any other rights the Employer or Administrator may have.

### **12.7 Illegality of Particular Provision**

The illegality of any particular provision of this Plan shall not affect any other provision, but the Plan shall be construed in all respects as if such invalid provision were omitted.