

**PLAN DOCUMENT  
AND  
SUMMARY PLAN DESCRIPTION  
FOR  
BAKER UNIVERSITY  
FLEXIBLE BENEFIT PLAN**

Restated Effective January 1, 2008

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# SECTION I

## INTRODUCTION

Effective July 1, 1987, Baker University established the Baker University Flexible Benefit Plan (the "Plan"). The purpose of the Plan is to allow an eligible Employee the right to reduce their Compensation and have the Employer pay, on the Employee's behalf, contributions for Health Plan Coverage (medical and dental) and to maintain accounts for reimbursement of certain Medical Care Expenses and Dependent Care Expenses. This Plan is revised and restated effective January 1, 2008.

This Plan is intended to qualify as a "cafeteria plan" under Code § 125, and regulations issued thereunder and will be interpreted in a manner consistent with the requirements of the Code.

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

Although reprinted within this document, the Health FSA Component and the DCAP Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§ 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of ERISA and COBRA.

# SECTION II

## ELIGIBILITY AND TERMINATION

### A. ELIGIBILITY TO PARTICIPATE

An individual is eligible to participate in this Plan on the first day of the month he is an Employee as defined by the Plan.

Eligibility for Premium Payment benefits will also be subject to the additional eligibility requirements, if any, specified in the Health Plan Coverage.

### B. TERMINATION OF PARTICIPATION

Participation in this Plan will cease upon the earlier of:

- the date this Plan terminates;
- the date the Participant no longer has an election in effect under the terms of this Plan;
- the date the Participant revokes his election as permitted under the terms of this Plan; or
- the date the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, etc.) to be eligible to participate in the Plan. Eligibility may continue for purposes of pre-taxing COBRA coverage for certain Employees for certain periods on the terms and subject to the restrictions described in this Plan Document Summary for Medical Insurance Benefits, Health FSA Benefits and DCAP Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections and terminate the Medical Insurance Benefits as of the date specified in the Health Plan Coverage. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to this Plan Document Summary.

### C. PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT OR LOSS OF ELIGIBILITY

If an Employee terminates employment with the Employer for any reason and is rehired within 30 days or less of the date of a termination, the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire. An election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Health Plan Coverage is reinstated.

### D. FMLA LEAVE OF ABSENCE

#### 1. Health Benefits

If a Participant goes on a qualifying leave under FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical Insurance Benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. Therefore, if the Participant elects to continue his coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require participants to continue all Medical Insurance Benefits and Health FSA Benefits coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions will be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his Medical Insurance Benefits and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contribution in one of the following ways:

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

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

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

## **2. Non-Health Benefits.**

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

## **E. NON-FMLA LEAVES OF ABSENCE**

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

# **SECTION III**

## **ELECTIONS, IRREVOCABILITY AND EXCEPTIONS**

### **A. ELECTION DURING INITIAL ENROLLMENT PERIOD**

An Employee who first becomes eligible to participate in the Plan at some time other than at the beginning of the Plan Year may begin participation on the first day of the month after the eligibility requirements have been satisfied, provided that an Election Form is completed and returned to the Plan Administrator prior to the date specified by the Plan Administrator. An Employee who does not elect to participate when first eligible may not enroll until the next Annual Open Enrollment Period, unless an event occurs that would justify a mid-year election change as described in this Section. Eligibility for Premium Payment benefits will be subject to the additional requirements, if any, specified in the Health Plan Coverage. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the Health Plan Coverage.

### **B. ELECTIONS DURING ANNUAL OPEN ENROLLMENT PERIOD**

Prior to the commencement of each Plan Year, during an Annual Open Enrollment Period, the Plan Administrator will provide an Election Form to each Employee who is eligible to participate in this Plan. The Election Form allows the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Form must be returned to the Plan Administrator on or before the date specified by the Plan Administrator, and will be effective on the first day of the next Plan Year. If an eligible Employee fails to return the Election Form during the Annual Open Enrollment Period, then the Employee may not elect any benefits under this Plan under the next Annual Open Enrollment Period, unless an event occurs that would justify a mid-year election change as described in this Section.

### **C. FAILURE TO COMPLETE AN ELECTION FORM**

If an Employee fails to return a completed Election Form to the Plan Administrator on or before the specified due date for completing elections for a Plan Year, it will be considered that the Employee has elected to continue participation in the Premium Payments Benefits with the same Benefit plan elections that were in effect on the last day of the Plan Year in which the Annual Open Enrollment Period occurred (adjusted to reflect any increase/decrease in applicable Contributions).

However, the Employee must make an election each Annual Open Enrollment Period in order to participate in the Health FSA Benefits or DCAP Benefits during the next Plan Year. Failure to return an Election Form to the Plan Administrator on or before the specified due date for completing elections for a Plan Year, will be considered a choice by the Employee to select taxable cash and to decline participation in the Health FSA or DCAP Components for such Plan Year.

### **D. IRREVOCABILITY OF ELECTIONS**

A Participant's election under the Plan is irrevocable for the entire Period of Coverage to which it relates, unless an exception is allowed by the Plan as provided in this Section.

### **E. PROCEDURES FOR CHANGING ELECTIONS**

#### **1. Time Period for Making New Election**

A Participant (or an eligible Employee who declined participation when first eligible) may make a new election within 30 days of the occurrence of an event described in this Section, but only if the election is made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status that results in a Dependent becoming ineligible for coverage under the Health Plan Coverage (e.g., a divorce or a Dependent losing student status) will automatically result in a corresponding election change in the Premium Payment Benefits, whether or not requested by the Participant within the normal 30-day period.

#### **2. Effective Date of the New Election**

Elections made in accordance with this Section will be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in for herein for HIPAA special enrollment rights in the event of birth, adoption or placement for adoption, all election changes will be effective on a prospective basis only.

#### **3. Effect of New Election Upon Amount of Benefits**

For the effect of a changed election upon the maximum benefits under the Health FSA Component and DCAP Component as described in this Plan Document Summary .

## **F. CHANGE OF STATUS**

Change of Status means any of the events described below, and any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

### **1. Legal Marital Status**

A change in a Participant's legal marital status, including:

- marriage;
- divorce;
- death of Spouse;
- legal separation; and
- annulment.

### **2. Number of Dependents**

Events that change a Participant's number of Dependents, including:

- birth;
- adoption;
- placement for adoption; and
- death.

### **3. Employment Status**

Any of the following events that change the employment status of the Participant, or his or her Spouse or Dependents, including:

- a termination or commencement of employment;
- a strike or lockout;
- a commencement of or return from an unpaid leave of absence;
- a change of worksite; and
- if the eligibility conditions of this Plan or other employee benefit plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefit plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan.

### **4. Dependent Eligibility Requirements**

An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as:

- attaining the limiting age specified for such benefit;
- attaining or losing student status; or
- any similar circumstances.

### **5. Change in Residence**

A change in the place of residence of the Participant or his or her Spouse or Dependents.

## **G. EVENTS PERMITTING ELECTION CHANGES (EXCEPTIONS TO THE IRREVOCABILITY RULE)**

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

### **1. Leave of Absence (Applies to Premium Payment, Health FSA and DCAP Benefits)**

A Participant may change an election under the Plan upon FMLA leave and upon non-FMLA leave in accordance with this Plan Document Summary.

### **2. Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits and DCAP Benefits as Limited Below)**

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

Any reduction or cancellation to Health FSA coverage will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his election based on the specified Change in Status:

- (a) **Loss of Spouse or Dependent Eligibility; Special COBRA Rules.** For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment or legal separation, (b) the deceased Spouse or Dependent, or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with **ELIGIBILITY AND TERMINATION**), the Participant may increase his election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment or legal separation).
- (b) **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which a Participant or his Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.
- (c) **Special Consistency Rule of DCAP Benefits.** With respect to the DCAP Benefits, a Participant may change or terminate his election upon a Change in Status if (1) such change or termination is made an account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (2) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

**3. HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits but Not to Health FSA or DCAP Benefits).**

If a Participant or his Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group Health Plan Coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

- (a) a Participant or his or her Spouse or Dependent declined to enroll in group Health Plan Coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or
- (b) a new Dependent is acquired as a result of marriage, birth, adoption or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child will be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to birth, adoption or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of this part 3, the term "loss of eligibility" includes, but is not limited to, loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live or work in the service area because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

**4. Certain Judgments, Decrees and Orders (Applies to Premium Payment and to Health FSA Benefits, but Not to DCAP Benefits).**

If a judgment, decree or order (collectively an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

**5. Medicare and Medicaid (Applies to Premium Payment Benefits and Health FSA Benefits but Not to DCAP Benefits).**

If a Participant or his Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be reduced or canceled. Notwithstanding the foregoing, such reduction or cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

**6. Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits).**

For purposes of this part 6, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA, (2) an HMO and a PPO are considered to be similar coverage, and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

- (a) **Increase or Decrease for Insignificant Cost Changes.** Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their benefit package option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.
- (b) **Significant Cost Increases.** If the Plan Administrator determines that the cost charged to an Employee of a Participant's benefit package option(s) (such as the PPO) significantly increases during a Period of Coverage, the Participant may (1) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (2) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another benefit package option that provides similar coverage (such as an HMO, but not the Health FSA); or (3) drop coverage prospectively if there is no other benefit package option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.
- (c) **Significant Cost Decreases.** If the Plan Administrator determines that the cost of any benefit package option (such as the PPO) significantly decreases during a Period of Coverage, the Plan Administrator may permit the following election changes: (1) Participants who are enrolled in a benefit package option (such as the HMO, but not the Health FSA) other than the benefit package option that has decreased in cost may change their election on a prospective basis to elect the benefit package option that has decreased in cost (such as the PPO); and (2) Employees who are otherwise eligible under **ELIGIBILITY AND TERMINATION** may elect the benefit package option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the benefit package option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.
- (d) **Limitation on Change in Cost Provisions for DCAP Benefits.** The above "Change in Cost" provisions apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee.

For this purpose, a relative is an individual who is related as described in Code §§ 152(d)(2)(A) through (G), incorporating the rules of Code §§ 152(f)(1) and 152(f)(4).

**7. Change in Coverage (Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits).**

The definition of “similar coverage” in part 6 also applies to this part 7.

(a) **Significant Curtailment.** If coverage is “significantly curtailed” (as defined in subsection (1) below), Participants may elect coverage under another benefit package option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a “Loss of Coverage” (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide in accordance with prevailing IRS guidance, whether a curtailment is “significant,” and whether a Loss of Coverage has occurred.

(1) **Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that a Participant’s coverage under a benefit package option under this Plan (or the Participant’s Spouse’s or Dependent’s coverage under his or her employer’s plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another benefit package option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be “significantly curtailed” only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(2) **Significant Curtailment With a Loss of Coverage.** If the Plan Administrator determines that a Participant’s benefit package option (such as the PPO) coverage under this Plan (or the Participant’s Spouse’s or Dependent’s coverage under his or her employer’s plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and may either prospectively elect coverage under another benefit package option that provides similar coverage (such as the HMO, but not the Health FSA), or drop coverage if no other benefit package option providing similar coverage is offered by the Employer.

(3) **Definition of Loss of Coverage.** For purposes of this Section, a “Loss of Coverage” means a complete loss of coverage (including the elimination of a benefit package option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the benefit package option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the benefit package option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO or an HMO);
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(b) **Addition or Significant Improvement of a Benefit Package Option.** If during a Period of Coverage, the Plan adds a new benefit package option or significantly improves an existing benefit package option, the Plan Administrator may permit the following election changes: (1) Participants who are enrolled in a benefit package option other than the newly-added or significantly improved benefit package option may change their election on a prospective basis to elect the newly-added or significantly improved benefit package option; and (2) Employees who are otherwise eligible under **ELIGIBILITY AND TERMINATION** may elect the newly-added or significantly improved benefit package option on a prospective basis, subject to the terms and limitations of the benefit package option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a benefit package option in accordance with prevailing IRS guidance.

(c) **Loss of Coverage Under Other Group Health Coverage.** A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children’s health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable benefit package option(s).

- (d) **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (1) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (2) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.
- (e) **DCAP Coverage Changes.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (1) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and (2) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described in part E, above.

#### **H. ELECTION MODIFICATIONS REQUIRED BY PLAN ADMINISTRATOR**

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (1) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (2) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (3) maintain the qualified status of benefits received under this Plan; or (4) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

# SECTION IV

## BENEFITS AND FUNDING

### A. BENEFITS

During the initial enrollment period or an Annual Open Enrollment Period, Participants will be given the opportunity to elect one or more of the following Benefits:

- Premium Payment Benefits;
- Health FSA Benefits; and
- DCAP Benefits.

In no event will Benefits under the Plan be provided in the form of deferred compensation. Notwithstanding the foregoing, amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Health Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year. No Grace Period is currently available for DCAP benefits.

### B. EMPLOYER AND PARTICIPANT CONTRIBUTIONS

#### 1. Employer Contributions

For Participants who elect Medical Insurance Benefits described in this Plan Document Summary, the Employer will contribute a portion of the Contributions. There are no Employer contributions for Health FSA Benefits or DCAP Benefits.

#### 2. Participant Contributions

Participants who elect any of the Medical Insurance Benefits described in this Plan Document Summary, may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing an the Election Form. Participants who elect Health FSA Benefits or DCAP Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form.

### C. USING SALARY REDUCTIONS TO MAKE CONTRIBUTIONS

The annual contribution for the Benefits elected will be divided by the number of pay periods in the Period of Coverage to determine a Participant's Salary Reduction per pay period. However, the Contributions may be made on a different basis if agreed upon between the Employer and the Participant.

If a Participant increases his election under the Health FSA Component or the DCAP Component as permitted herein, the Salary Reductions per pay period will be, for the benefit affected, the new reimbursement limit less the Salary Reductions made prior to the change, divided by the number of pay periods remaining in the Period of Coverage.

When coverage terminates, if a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required contributions for the coverage, then the Employer will either return the excess to the Participant as additional taxable wages or recoup the amounts due through Salary Reduction from any remaining Compensation.

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

### D. FUNDING THIS PLAN

All of the amounts payable under this Plan will be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which benefits under the Plan are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third party paying agent to make Benefit payments on its behalf.

# SECTION V

## PREMIUM PAYMENT COMPONENT

### A. BENEFITS

The only Medical Insurance Benefits that are offered under the Premium Payment Component are benefits under the Health Plan Coverage, providing medical and dental benefits. The Medical Insurance Benefits are subject to the terms and conditions of the Health Plan Coverages, and no changes can be made with respect to such Medical Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can elect to pay his share of Contributions for Medical Insurance Benefits on a pre-tax Salary Reduction basis under the Premium Payment Component or to pay for his share of the premiums with after-tax deductions outside of this Plan. Such an election is irrevocable for the duration of the Period of Coverage unless an event occurs that would justify a mid-year election change, as described in this Plan Document Summary.

### B. MEDICAL INSURANCE BENEFITS

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

### C. MEDICAL INSURANCE BENEFITS AND COBRA

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

Contributions for such COBRA coverage for Medical Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable Compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (1) because the Employee ceases to be eligible because of a reduction in hours; or (2) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment or layoff), Contributions for such COBRA coverage for Medical Insurance Benefits will be paid on an after-tax basis (unless otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

# SECTION VI

## HEALTH FSA COMPONENT

### A. BENEFITS

An Eligible Employee can elect to participate in the Health FSA Component by electing to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA and to pay the Contributions for such Health FSA Benefits on a pre-tax Salary Reduction basis. Such an election is irrevocable for the duration of the Period of Coverage unless an event occurs that would justify a mid-year election change, as described in this Plan Document Summary.

### B. HEALTH FSA ACCOUNT

A Health FSA Account will be established and maintained by the Plan Administrator for each Participant who has elected to participate in the Health FSA Component, but will not create a separate fund or otherwise segregate assets for this purpose. The Account will be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures as described in this Section.

### C. MAXIMUM CONTRIBUTIONS

Notwithstanding any other provisions in this Plan Document Summary, there is no maximum dollar amount of Salary Reductions that a Participant can elect to allocate for reimbursement of Medical Care Expenses for any Period of Coverage. The amount of Salary Reductions will be contributed in equal installments throughout the Period of Coverage. The number of installments will equal the number of pay periods in the Period of Coverage.

### D. REIMBURSEMENT

The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) will be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account. A Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement will in no event exceed the maximum dollar amount elected by the Participant under this Plan. No reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA or is entitled to submit expenses incurred during a Grace Period as provided in this Section.

Any change in election (other than for FMLA leave) increasing contributions to the Health FSA Component will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits will be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the election change, to (2) the total contributions scheduled to be made by the Participant during the remainder of the Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any changes in an election for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

### E. ELIGIBLE MEDICAL CARE EXPENSES

#### 1. When Incurred

A Medical Care Expense will be deemed incurred as of the date the service is rendered or purchase is made, not when the Participant or his Spouse or Dependent is actually billed for, is charged for or pays for the medical expense. The Participant or his Spouse or Dependent must be able to provide adequate substantiation of the Medical Care Expense.

#### 2. Medical Care Expenses

A Participant may receive reimbursement for Medical Care Expenses as defined in Code § 213 (d) which means amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Medical Care Expenses do not include expenses that are excluded under Appendix A to this Plan, nor any expense that is reimbursed under the Health Plan Coverage or any other insurance or accident or health plan.

Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's Health FSA Account in a single calendar month, stockpiling is not permitted. Appendix A includes a list of some Medical Care Expenses that usually qualify for reimbursement along with details and limitations regarding OTC drugs.

## **F. GRACE PERIODS**

An individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year Health FSA Amounts), if he or she is either: (1) a Participant with Health FSA coverage that is in effect on the last day of that Plan Year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

- Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.
- Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with this Section will be reimbursed first from any available Prior Plan Year Health FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card or similar arrangement), Medical Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year Health FSA Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year Health FSA Amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Health FSA Amounts.
- Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than the March 15 following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health FSA Amounts. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period will not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures as described in this Section.

## **G. REIMBURSEMENT PROCEDURES**

### **1. Time Period for Submission**

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

Reimbursement requests must be received no later than the March 31 following the close of the Plan Year in which the Medical Care Expense was incurred. However, Participants that cease to be eligible to participate must submit their reimbursement requests no later than ninety (90) days after the date that eligibility ceases.

### **2. Claim Documentation**

All requests for reimbursement must have adequate substantiation to provide the Claim Supervisor with verification that the expense has been incurred and is an eligible Medical Care Expense. An application for reimbursement should be submitted in writing to the Claim Supervisor in such form as the Plan Administrator prescribes setting forth:

- the person(s) who incurred the Medical Care Expenses;
- the type of Medical Care Expenses;
- the date of the Medical Care Expenses;
- the amount of the requested reimbursement;
- a statement that such Medical Care Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the Medical Care Expenses that may be requested by the Claim Supervisor in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The application should be submitted with bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Claim Supervisor may request.

If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card or similar arrangement), some expenses may be validated at the time the expense is incurred (e.g., medical care copayments and prescription drug program copayments). For other expenses, the card payment is only conditional and the Participant will be required to provide adequate claim substantiation as requested by the Plan Administrator or the Claim Supervisor as instructed by the Plan Administrator in accordance with Rev. Rul. 2003-43 or other IRS guidance.

### **3. Claim Denial**

If reimbursement claims are denied see the appeals procedures for how to appeal the denial.

### **4. Claim Ordering; No Reprocessing**

All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

## **H. FORFEITURES (USE-IT-OR-LOSE-IT-RULE)**

Except as otherwise provided in this Section (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace period), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance will not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant will forfeit all rights with respect to such balance.

All forfeitures under this Plan will be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan year (all such administrative costs will be documented by the Plan Administrator); and third, to provide increased benefits or Compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred will be forfeited and applied as described above.

## **I. TERMINATION OF PARTICIPATION; COBRA**

When a Participant ceases to be a Participant, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in this Section (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), the Participant cannot receive reimbursements for Medical Care Expenses incurred after the end of the day on which his employment terminates or the Participant otherwise ceases to be eligible. However, the Participant (or his estate) can claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled as provided in this Section, provided that the Participant (or his estate) files a claim within ninety (90) days after the date that the Participant ceases to be a Participant.

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

Contributions for such COBRA coverage for Health FSA benefits may be paid on a pre-tax basis for current Employees receiving taxable Compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (1) because the Employee ceases to be eligible because of a reduction in hours or (2) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment or layoff), Contributions for such COBRA coverage for Health FSA benefits will be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

**J. COORDINATION OF BENEFITS**

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

# SECTION VII

## DEPENDENT CARE (DCAP) COMPONENT

### A. BENEFITS

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis. Such an election is irrevocable for the duration of the Period of Coverage unless an event occurs that would justify a mid-year election change, as described in this Plan Document Summary.

### B. DCAP ACCOUNT

A DCAP Account will be established and maintained by the Plan Administrator for each Participant who has elected to participate in the DCAP Component, but will not create a separate fund or otherwise segregate assets for this purpose. The Account will be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures.

### C. MAXIMUM CONTRIBUTIONS

The maximum dollar amount of Salary Reductions that a Participant can elect to allocate for reimbursement for Dependent Care Expenses for any period of coverage is \$5,000 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

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

The amount of Salary Reductions will be contributed in equal installments throughout the Period of Coverage. The number of installments will equal the number of pay periods in the Period of Coverage.

For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator and will be communicated to Employees through the Election Form or another document. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as described in this Plan Document Summary, there will be no proration rule, i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

### D. REIMBURSEMENT

The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by any prior reimbursements during the Period of Coverage) will only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account (i.e., no reimbursement will exceed the balance in the Participant's Account at the time of the reimbursement). A Participant's DCAP Account may not have a negative balance during the Period of Coverage.

Any change in election affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by this Section. Such maximum reimbursement benefits for the balance of the Period of Coverage will be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the election change, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the entire Period of Coverage.

## **E. ELIGIBLE DEPENDENT CARE EXPENSES**

### **1. When Incurred**

A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of May are not fully incurred until May 31 and cannot be reimbursed in full until then.)

### **2. Dependent Care Expenses**

A Participant may receive reimbursement for Dependent Care Expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any), and expenses for incident household services, if paid for by the eligible Employee to obtain Qualifying Dependent Care Services. Dependent Care Expenses will not include any expense that is reimbursed through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Section.

### **3. Qualifying Individual**

A Qualifying Individual means:

- a tax dependent of the Participant as defined in Code § 152 who is under the age of thirteen (13) and who is the Participant's qualifying child as defined in Code § 152(a)(1);
- a tax dependent of the Participant as defined in Code § 152 who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced parents, a Qualifying Individual who is a child will, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)(3)(A) and will not be treated as a Qualifying Individual with respect to the non-custodial parent.

### **4. Qualifying Dependent Care Services**

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

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services), then the center must comply with all applicable state and local laws and regulations.

Dependent Care Expenses do not include amounts paid to:

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

## **F. REIMBURSEMENT PROCEDURES**

### **1. Time Period for Submission**

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

Reimbursement requests must be received no later than 3 months following the close of the Plan Year in which the Dependent Care Expense was incurred. However, Participants that cease to be eligible to participate must submit their reimbursement requests no later than ninety (90) days after the date that eligibility ceases.

### **2. Claim Documentation**

All requests for reimbursement must have adequate substantiation to provide the Claim Supervisor with verification that the expense has been incurred and is an eligible Dependent Care Expense. An application for reimbursement should be submitted in writing to the Claim Supervisor in such form as the Plan Administrator prescribes setting forth:

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

The application should be submitted with bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Claim Supervisor may request.

If the DCAP is accessible by an electronic payment card (e.g., debit card, credit card or similar arrangement), some expenses may be validated at the time the expense is incurred. For other expenses, the card payment is only conditional and the Participant will be required to provide adequate claim substantiation as requested by the Plan Administrator in accordance with Rev. Rul. 2003-43 or other IRS guidance.

### **3. Claim Denial**

If reimbursement claims are denied see the appeals procedures for how to appeal the denial.

## **G. FORFEITURES (USE-IT-OR-LOSE-IT-RULE)**

Any balance remaining in a Participant's DCAP Account for a Period of Coverage after all reimbursements have been made will be forfeited. Balances cannot be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant will forfeit all rights with respect to such balances. All forfeitures under this Plan will be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing DCAP benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering this DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs will be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred will be forfeited and applied as described above.

#### **H. REIMBURSEMENTS AFTER TERMINATION OF PARTICIPATION**

When a Participant ceases to be a Participant, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which employment terminates or the Participant otherwise ceases to be eligible. However, the Participant (or his estate) may claim reimbursement for any Dependent Care Expenses incurred in the month following termination of employment or other cessation of eligibility if such month is in the current Plan Year, as long as the Participant (or his estate) files a claim within ninety (90) days after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible.

#### **I. END OF YEAR REPORT**

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

# SECTION VIII

## HIPPA PROVISIONS FOR HEALTH FSA

### A. PROVISION OF PROTECTED HEALTH INFORMATION TO EMPLOYER

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Section:

**Protected Health Information.** Protected Health Information means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer will have access to PHI from the Health FSA only as permitted under this Section or as otherwise required or permitted by HIPAA.

### B. PERMITTED DISCLOSURE OF ENROLLMENT/DISENROLLMENT INFORMATION

The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

### C. PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending or terminating the Health FSA.

**Summary Health Information.** Summary Health Information means information (1) that summarizes the claims history claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (2) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

### D. USES AND DISCLOSURES OF PHI FOR PLAN ADMINISTRATION PURPOSES

Unless otherwise permitted by law, and subject to the conditions of disclosure described in this Plan Document Summary, the Health FSA may disclose PHI to the designated personnel at the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. Plan administration purposes means administration functions performed by the Employer on behalf of this Plan, such as quality assurance, claims processing, auditing and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event will the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

### E. CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer will:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by the law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

- make its internal practices, books and records relating to the use and disclosure of PHI received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA's privacy requirement;
- if feasible, return or destroy all PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that made the return or destruction of the information infeasible; and
- ensure that the adequate separation between the Health FSA and the Employer (i.e., the firewall), required in 45 CFR § 504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health FSA, it will implement, administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

#### **F. ADEQUATE SEPARATION BETWEEN PLAN AND EMPLOYER**

The Employer will allow the following employees or classes of employees who need access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll and appeals).

1. Kelly Newton - Director of Human Resources
2. Connie Deel - Assistant Director of Human Resources
3. Jo Adams - Vice President of Finance

No other persons will have access to PHI. These specified employees (or classes of employees) will only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee will be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

#### **G. CERTIFICATION OF PLAN SPONSOR**

The Health FSA will disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in this Plan Document Summary.

# SECTION IX

## APPEALS PROCEDURE

### A. INSURANCE PLAN CLAIMS

Claims for benefits under any Health Plan Coverage will be administered in accordance with the claims and appeal procedures for the Medical Insurance Benefit, as set forth in the plan documents and/or summary plan descriptions for the Health Plan Coverage.

### B. PROCEDURES IF BENEFITS ARE DENIED UNDER THIS PLAN

If (1) a claim for reimbursement under the Health FSA or DCAP Components of the Plan is wholly or partially denied, or (2) a Participant is denied a benefit under the Plan (i.e., the ability to pay for Medical Insurance, Health FSA or DCAP Benefits on a pre-tax basis) due to an issue germane to the coverage under the Plan (e.g., a determination of: a Change in Status; a “significant” change in Contributions charged; or eligibility and participation matters under the Plan), then the claims procedures described below will apply.

If a Participant’s claim is denied in whole or in part, the Participant will be notified in writing by the Claim Supervisor within 30 days of the date the Claim Supervisor received the claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Claim Supervisor, including cases where a claim is incomplete. The Claim Supervisor will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Claim Supervisor is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow a Participant 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for the Participant to validate the claim and an explanation of why such material or information is necessary; and
- appropriate information about the steps to be taken if the Participant wishes to appeal the Claim Supervisor’s decision, including his or her right to submit written comments and have them considered, the Participant’s right to review (upon request and at no charge) relevant documents and other information, and the Participant’s right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of the claim.

### C. APPEALS BY PARTICIPANT

If a Participant’s claim is denied in whole or part, the Participant (or his or her authorized representative) may request review upon written application to the Claim Supervisor. The Participant’s appeal must be made in writing within 180 days his or her receipt of the notice that the claim was denied. If the Participant does not appeal on time, he or she will lose the right to appeal the denial and the right to file suit in court. The Participant’s written appeal should state the reasons that the claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support the claim. The Participant will have the opportunity to ask additional questions and make written comments, and the Participant may review (upon request and at no charge) documents and other information relevant to the appeal.

### D. DECISION ON REVIEW

The Participant’s appeal will be reviewed and decided by the Claim Supervisor or other entity designated in the Plan in a reasonable time not later than 60 days after the Claim Supervisor receives the request for review. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of the Participant’s right to review (upon request and at no charge) relevant documents and other information;
- if an “internal rule, guideline, protocol or other similar criterion” is relied on to make the decision on review, a description of the specific rule, guideline, protocol, other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied on and a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the Participant upon request; and
- a statement of the Participant’s right to bring suit under ERISA § 502(a) (where applicable).

# **SECTION X ADMINISTRATION**

## **A. PLAN ADMINISTRATOR**

The administration of this Plan will be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

## **B. FIDUCIARY LIABILITY**

To the extent permitted by law, the Plan Administrator will not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

## **C. POWERS AND DUTIES**

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

- to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;
- to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- to prepare and distribute information explaining this Plan and the benefits under this Plan in such a manner as the Plan Administrator determines to be appropriate;
- to request and receive from all Employees and Participants such information as the Plan Administrator will from time to time determine to be necessary for the proper administration of this Plan;
- to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;
- to receive, review and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
- to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- to maintain the books or accounts, records and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

## **D. RELIANCE ON PARTICIPANT, TABLES, ETC.**

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

## **E. INSURANCE CONTRACTS**

The Employer will have the right (1) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (2) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract will not be assets of the Plan but will be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

**F. CLAIM SUPERVISOR**

The Plan Administrator may retain, at its option, a Claim Supervisor to be responsible for all or any portion of the day-to-day administration of the Plan, within the provisions, interpretations and rules made by the Employer and stated herein, including determination of claims. Unless otherwise provided in the service agreement, obligations under this Plan will remain the obligation of the Employer.

**G. EXPENSES OF ADMINISTRATION**

Any expense incurred by the Plan Administrator relative to the administration of the Plan will be paid by the Employer.

**H. EFFECT OF MISTAKE**

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

**I. INABILITY TO LOCATE PAYEE**

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

# **SECTION XI**

## **GENERAL PROVISIONS**

### **A. EXPENSES**

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided herein with respect to Health FSA Benefits and DCAP Benefits, and then by the Employer.

### **B. HEADINGS**

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

### **C. LIMITATION OF RIGHTS**

Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving any Participant or other person any legal or equitable right against the Employer except as expressly provided herein.

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

### **D. AMENDMENT AND TERMINATION**

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

### **E. GOVERNING LAW**

This Plan will be construed, administered and enforced according to the laws of the State of Kansas, to the extent not superseded by the Code, ERISA or any other federal law.

### **F. INDEMNIFICATION OF EMPLOYER**

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

### **G. NO GUARANTEE OF TAX CONSEQUENCES**

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

### **H. NO CONTRACT OF EMPLOYMENT**

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

### **I. SEVERABILITY**

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

# SECTION XII

## ERISA RIGHTS

### **CERTAIN EMPLOYEE RIGHTS UNDER ERISA**

The Flexible Benefit Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act (ERISA). However, the Health FSA Component and the Health Plan Coverage are governed by ERISA. As a Participant in an ERISA-covered benefit plan, a Participant is entitled to certain rights and protections under ERISA.

#### **Participant Rights**

As a Participant in this Plan an individual is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

#### **COBRA and HIPAA Rights**

A Participant has a right to continue the Health Plan Coverage (and, in some cases, a Participant's Health FSA coverage) for himself or herself if there is a loss of coverage under the Plan as a result of a qualifying event. The Participant and his or her Dependents may have to pay for such coverage. Review this plan document and summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

A Participant has rights regarding reduction or elimination of exclusionary periods of coverage for pre-existing conditions under his or her group health plan if the Participant has creditable coverage from another plan. The Participant should be provided a certificate of creditable coverage, free of charge, from his or her group health plan or health insurance issuer when the Participant loses coverage under the plan, when the Participant becomes entitled to elect COBRA continuation coverage, when the Participant's COBRA continuation coverage ceases, if the Participant requests it before losing coverage, or if the Participant requests it up to 24 months after losing coverage. Without evidence of creditable coverage, a Participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after his or her enrollment date in his or her coverage. (This does not apply to the Health FSA, which is an "excepted benefit" under HIPAA.)

#### **HIPAA Privacy Rights**

Under another provision of HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. The Participant may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies.

#### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participant and other Plan Participants and beneficiaries. No one, including the Participant's Employer, or any other person, may fire a Participant or otherwise discriminate against him or her in any way to prevent him or her from obtaining a plan benefit or exercising his or her rights under ERISA.

#### **Enforce a Participant's Rights**

If a Participant's claim for a benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that a Participant can take to enforce these rights. For instance, if a Participant requests a copy of plan documents or the latest annual report (if any) from the Plan and does not receive them within 30 days, he or she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Participant has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or Federal court (but only if the Participant has first filed his or her claim under the Plan's claims procedures, and, if applicable, filed a timely appeal of any denial of the claim).

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his rights, the Participant may seek assistance from the U. S. Department of Labor, or he or she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person he or she has sued to pay these costs and fees. If the Participant loses, the court may order him or her to pay these costs and fees if, for example, it finds the Participant's claim is frivolous.

**Assistance with Participant Questions**

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

# SECTION XIII

## DEFINITIONS

As used herein, the following words and phrases, when capitalized, will have the following meaning unless a different meaning is plainly required by the context.

### **Account(s)**

The Health FSA Accounts and the DCAP Accounts described in this Plan Document Summary.

### **Annual Open Enrollment Period**

The period of time in the year preceding the Plan Year as prescribed by the Plan Administrator.

### **Benefits**

The Premium Payment Benefits, the Health FSA Benefits and the DCAP Benefits offered under the Plan.

### **Change in Status**

Change of Status means change in legal marital status, number of Dependents, employment status, Dependent eligibility requirements, or residence, each of which is discussed further in Section III.

### **Claim Supervisor**

The Epoch Group, L.C., 2020 W. 89<sup>th</sup> Street, Leawood, KS, 66202; or P. O. Box 12170, Overland Park, KS 66282-2170; Kansas City Area: (913) 362-0040; Toll Free: 1-800-255-6065; Fax: (913) 362-0041.

### **COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

### **Code**

The Internal Revenue Code of 1986, as amended.

### **Compensation**

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

### **Contributions**

The amount contributed to pay for the cost of Benefits as calculated for Premium Payment Benefits, Health FSA Benefits and DCAP Benefits.

### **DCAP**

Dependent Care Assistance Program.

### **DCAP Account**

The account described herein for the Dependent Care Assistance Program.

### **DCAP Component**

The component of this Plan that describes the Dependent Care Assistance Program.

### **Dependent**

Any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component), (1) a dependent is defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents; and (b) for purposes of the DCAP Component, a dependent means a Qualifying Individual as defined in the Dependent Care Assistance Program. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent".

### **Dependent Care Expenses**

Dependent Care Expenses has the meaning described under the Dependent Care Assistance Program.

### **Earned Income**

All income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any DCAP established under Code § 129; or (b) any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

**Election Form**

The enrollment form provided by the Plan Administrator for the purpose of allowing an eligible Employee to participate and make Benefit selections and by which the Employee may authorize the Employer to reduce his Compensation.

**Employee**

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

**Employer**

Baker University

**ERISA**

The Employee Retirement Income Security Act of 1974, as amended.

**FMLA**

The Family and Medical Leave Act of 1993, as amended.

**Grace Period**

The period that begins immediately following the close of a Plan Year and ends on the day that is two months plus 15 days following the close of that Plan Year.

**Health FSA**

The health flexible spending arrangement.

**Health FSA Account**

The account described in Section VI.

**Health FSA Component**

The component of this Plan described in Section VI.

**Health Plan Coverage**

Any of the medical plans, including dental plans, that the Employer maintains for its Employees (and for their Dependents that may be eligible under the terms of such plan), providing health benefits through a group insurance policy or policies. The Employer may substitute, add, subtract or revise at any time the menu of such plans and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

**HIPAA**

The Health Insurance Portability and Accountability Act of 1996, as amended.

**Medical Care Expenses**

Medical Care Expenses has the meaning defined in Section VI, E.

**Medical Insurance Benefits**

The Employee's Health Plan Coverage for purposes of this Plan.

**Participant**

Any eligible Employee who completes and delivers an Election Form to the Employer during an election period as described in this Plan Document Summary.

**Period of Coverage**

The Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it will mean the portion of the Plan Year following the date participation commences; and (b) for Employees who terminate participation, it will mean the portion of the Plan Year prior to the date participation terminates.

**Plan**

The Baker University Flexible Benefit Plan as set forth herein and as amended from time to time.

**Plan Administrator**

The administration of the Plan will be under the supervision of the Employer, as Plan Administrator. It will have the principal duty to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

**Plan Year**

The calendar year period beginning on January 1 and ending on December 31 and each succeeding calendar year thereafter.

**Premium Payment Component**

The Component of this Plan described in Section V.

**QMCSO**

A judgment, decree or order meeting the requirements of ERISA § 609(a) and requiring enrollment of a child in a Health Plan option.

**Qualifying Dependent Care Services**

Qualifying Dependent Care Services has the meaning described in Section VII, E, 4.

**Qualifying Individual**

Qualifying Individual has the meaning described in Section VII, E, 3.

**Related Employer**

Any employer affiliated with the Employer that, Code § 414(b), (c), or (m), is treated as a single employer with the Employer for purposes of Code § 125(g)(4). There are no Related Employers.

**Salary Reduction**

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

**Spouse**

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

**Student**

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

## APPENDIX A

### A. MEDICAL CARE EXPENSES

The following is a list of some Medical Care Expenses that usually qualify for reimbursement under the Health FSA Component:

- abortion, if legal;
- acupuncture services as treatment of a medical condition;
- alcoholism treatment;
- ambulance expenses;
- artificial limbs;
- Braille books/magazines for visually-impaired person (only the amount that is more than the price of regular printed editions);
- chiropractors;
- contact lenses for medical reasons;
- contraceptives
- crutches;
- dental treatment;
- dentures;
- diagnostic services, including laboratory and x-ray services;
- drug addiction treatment;
- drugs and medical supplies (see item B below for information and limitations regarding over-the-counter (OTC) drugs);
- eye examinations and eyeglasses;
- fertility treatment;
- flu shots;
- guide dog or other animal for physically disabled person;
- hearing examinations, hearing aids and hearing aid batteries;
- hospital services;
- immunizations;
- lead-based paint removal from surfaces inside the home, but only if surfaces are in poor repair and within a child's reach and cost of repainting is not covered;
- medical monitoring and testing devices, e.g., blood pressure monitors, syringes, glucose kit, etc.;
- medical services;
- nursing services provided by a nurse or other attendant;
- orthodontia fees, unless for cosmetic procedures;
- physical exams;
- psychiatric care;
- psychologist or psychoanalysis, if for medical care;
- smoking cessation programs;
- special schools and education for mentally impaired or physically disabled persons;
- surgery, except cosmetic procedures;
- vision correction procedures, including laser procedures such as Lasik and radial keratotomy;
- weight-loss programs and/or drugs prescribed to induce weight loss, if recommended by a physician to treat an existing disease and not simply to improve general health;
- wheelchair.

### B. OVER-THE-COUNTER (OTC) DRUGS

IRS Revenue Ruling 2003-102 provides that over-the-counter (OTC) drugs may be reimbursed through Health FSAs. Therefore, OTC drugs will be reimbursed by the Plan in accordance with the following limitations.

- OTC drugs needed solely or primarily for medical care will be reimbursed in reasonable quantities without verification from a physician. An adequate receipt and a statement from the Participant must be submitted to the Plan. The receipt must state the name of the medicine or drug, the date and the amount paid. The Participant's statement must include the name of the patient (if not on the receipt) and need not include the precise medical condition. Examples of OTC drugs that have solely or primarily a medical purpose include, but are not limited to:
  - Most items that used to be prescribed drugs;
  - Antacids, allergy medicine, pain reliever and cold medicine;
  - Anti-diarrhea medicine, laxatives like Ex-Lax;

- Menstrual cycle products for pain and cramp relief;
- Cough drops, throat lozenges, sinus medications, nasal sinus sprays;
- Nicotine gum or patches for stop-smoking purposes;
- Special ointment or cream for sunburn (not just regular skin moisturizers);
- BenGay, Tiger Balm and similar products for muscle pain or joint pain;
- Pedialyte for an ill child's dehydration;
- First aid cream, Bactine, special diaper rash ointments, calamine lotion, bug bite medication, wart remover treatment;
- Visine and other such eye products;
- Suppositories and creams for hemorrhoids;
- Sleeping aids for occasional insomnia (regular use will require a physician's note);
- Motion sickness pills;
- Band-aids, bandages, gauze pads, first aid kits, cold/hot packs for injuries, rubbing alcohol, liquid adhesive for small cuts, reading glasses, contact lens cleaning solution, carpal tunnel wrist supports, pregnancy test kits, condoms, spermicidal foam, thermometers (ear or mouth), incontinence supplies, nasal strips, etc.
- Dual-purpose OTC drugs that may have both a medical purpose and a personal/cosmetic or general health purpose will not be reimbursed without a physician's note stating that the Participant has a specific medical condition and that the OTC drug is recommended to treat it and that the treatment is not a cosmetic procedure. Examples of OTC drugs that require a physician's diagnosis and recommendation include, but are not limited to:
  - Weight-loss drugs to treat a specific disease (including obesity), however, items that replace normal food consumption generally are not covered;
  - Pills for Participants who are lactose intolerant;
  - Nasal sprays for snoring;
  - Orthopedic shoes and inserts (for orthopedic shoes, only the extra cost over buying non-orthopedic shoes is reimbursable);
  - Feminine hygiene products;
  - Sunscreen;
  - Acne treatment;
  - Glucosamine/Chondroitin for arthritis or other medical condition;
  - St. John's Wort for depression;
  - Hormone therapy and treatment for menopause to treat symptoms such as hot flashes, night sweats, etc.
  - Dietary supplement or herbal medicines to treat a **specific** medical condition;
  - Prenatal vitamins;
  - Fiber supplements to treat a **specific** medical condition for a limited time;
  - Medicated shampoos and soaps to treat a **specific** scalp infection (not just dry scalp or dandruff) for a limited period of time;
- OTC items that are not reimbursable under any circumstances and are excluded from reimbursement by the Plan include, but are not limited to:
  - Toothpaste or toothbrushes (electric or otherwise), even if a dentist recommends special ones to treat a condition;
  - Chapstick;
  - Face cream, moisteners and suntan lotion;
  - One-a-day vitamins.

### C. EXCLUDED MEDICAL EXPENSES

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under regulations governing Health FSAs:

- health insurance premiums for any other plan (including a plan sponsored by the Employer);
- long-term care services;
- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- the salary expense of a nurse to care for a healthy newborn at home;
- funeral and burial expenses,
- household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- custodial care;

- cost for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods;
- social activities, such as dance lessons (even though recommended by a physician for general health improvement);
- bottled water;
- Cosmetics, toiletries, toothpaste, etc.;
- uniforms or special clothing, such as maternity clothing;
- automobile insurance premiums;
- marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician;
- any item that does not constitute “medical care” as defined under Code § 213(d);
- any item that is not reimbursable under Code § 213(d) due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations.

# ERISA INFORMATION

**PLAN NAME:** Baker University Flexible Benefit Plan

**PLAN ID. NO.:** 48-0543766

**PLAN SPONSOR:** Baker University  
618 Eighth Street  
P.O. Box 65  
Baldwin City, Kansas 66006  
(785) 594-6451

**PLAN NUMBER:** 503

**TYPE OF PLAN:** Flexible Benefit Plan

**TYPE OF ADMINISTRATION:** Employer administration

**PLAN ADMINISTRATOR:** Baker University  
618 Eighth Street  
P.O. Box 65  
Baldwin City, Kansas 66006  
(785) 594-6451

**AGENT FOR SERVICE OF LEGAL  
PROCESS:** Baker University  
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**PLAN YEAR:** January 1 through December 31.



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