Multnomah County

PLAN DOCUMENT
Flexible Spending Account

Effective: 1/1/2025

With Third Party Administrative Services Provided By:

IRC Section 125 requires that a Plan Document be kept on file.
This document explains all Components of an FSA.

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ARTICLE I. Introduction

1.01 Establishment of Plan

Multnomah County (the “Employer”) hereby adopts this Flexible Spending Account (the “Plan”), effective as of the date specified in Section II Your Plan at a Glance, of the Summary Plan Description, either as an initial establishment of a cafeteria plan or as the restatement of a previously implemented plan. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay for his or her share of Contributions under the Group Sponsored Insurance on a pre-tax Salary Reduction basis and to contribute on a pre-tax Salary Reduction basis to an account for reimbursement of certain Medical Care Expenses (Health FSA Accounts) and/or to an account for reimbursement of certain Dependent Care Expenses (Dependent Care Expense Account).

1.02 Legal Status

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

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

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, HIPAA, and COBRA. The Group Sponsored Insurance and Health FSA Component are intended to be part of an organized health care arrangement for purposes of HIPAA.

1.03 Limitations on Provisions

The provisions of the Plan and any benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other Employee benefit plan maintained by the Employer shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

ARTICLE II. Definitions

2.01 "Account(s)" means the HRE Account, the LFSA Account and the DCE Account described in Section 7.07 for Health FSA Component and Section 8.07 for DCAP Component.

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

2.03 "Benefits" means the Premium Payment Benefits, the Health FSA Benefits and the DCAP Benefits offered under the Plan.

2.04 "Carryover Provision" means unused amounts in a Participant's Health FSA Component may carry forward and remain available to reimburse eligible expenses incurred in later years.

2.05 "Cash-out" means allowing a Participant to receive non-elective Contributions in cash or as a taxable benefit.

2.06 "Change in Status" means any of the events described in Article XI.

2.07 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, described in Section 3.08.

2.08 "Code" means the Internal Revenue Code of 1986, as amended.

2.09 "Committee" means the Appeals Committee appointed by the Employer.

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

2.11 "Contributions" means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.02 for Premium Payment Benefits, Section 7.02 for Health FSA Benefits and Section 8.02 for DCAP Benefits.

2.12 "DCAP" means Dependent Care Assistance Program.

2.13 "DCAP Benefits" has the meaning described in Section 8.01.

2.14 "DCAP Component" means the component of this Plan described in Article VIII.

2.15 "DCE Account" means the account described in Section 8.07.

2.16 "Dependent" means: (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 as defined in Code §105(b), (2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27 (e.g. end of the year in which the child turns 26), and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCAP Component, a Qualifying Individual. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

2.17 "Dependent Care Expenses" has the meaning described in Section 8.03.

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

2.19 "Effective Date" of this Plan is the date specified in Section II Your Plan at a Glance, of the Summary Plan Description.

2.20 "Electronic Payment Card" means a debit card, stored value card, or credit card that allows a Participant to access funds in a flexible reimbursement arrangement to pay the service provider at the point-of-sale (i.e., the time a service or item is provided).

2.21 "Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 3.01.

2.22 "Employee" means any individual employed by the Employer, as identified by the Employer and reported to PacificSource Administrator.

2.23 "Employer" means the Employer specified in Section II Your Plan at a Glance, of the Summary Plan Description, along with any other entities belonging to a control group (Code §414(b) and (c)), or an affiliated service group (Code §414(m)), provided such entities are designated as participating Employers in Section II Your Plan at a Glance, of the Summary Plan Description.

2.24 "Enrollment Materials" means the actual or deemed paper or electronic agreement by a Participant authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of obtaining Benefits under the Plan.

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

2.26 "Federal Limit for Health FSA" means the limit on annual Salary Reduction Contributions to Health FSAs offered under cafeteria plans as imposed by Code §125 (i)(1). Such limitations shall be adjusted for inflation as provided in Code §125 (i)(2).

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

2.28 "FSA" means Flexible Spending Account.

2.29 "General-Purpose Health FSA Option" has the meaning described in Section 7.03(c).

2.30 "Grace Period" means an extension of 2.5 months to incur expenses that can be reimbursed from the prior Plan Year account(s) before they become subject to the Use-It-or-Lose-It Rule and begins immediately following the last day of the Plan Year.

2.31 "Group Sponsored Insurance" means the Group Sponsored Insurance which may include health, medical, dental, vision, accident or other similar insurance, plan or coverage established pursuant to Section 6.01.

2.32 "Health FSA" means Health Flexible Spending Account, which consists of three options: the General-Purpose Health FSA Option, the Limited-Scope Health FSA Option and the Limited-Purpose Health FSA Option.

2.33 "Health FSA Benefits" has the meaning described in Section 7.01.

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

2.35 "High-Deductible Health Plan" means the High-Deductible Health Plan offered by the Employer as a Benefit Package Option under the Medical Insurance Plan that is intended to qualify as a High-Deductible Health Plan under Code §223(c)(2), as described in materials provided separately by the Employer.

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

2.37 "HMO" means the Health Maintenance Organization Benefit Package Option (if any) under the Medical Insurance Plan.

2.38 "HRE Account" means the account described in Section 7.07.

2.39 "HSA" means a Health Savings Account established under Code §223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian. Although funded by Salary Reduction under this Plan, the HSA is not part of or intended to be part of an ERISA-covered benefit plan.

2.40 "LFSA Account" means the account described in Section 7.07.

2.41 "Limited-Purpose Health FSA Option" has the meaning described in Section 7.03(e).

2.42 "Limited-Scope Health FSA Option" has the meaning described in Section 7.03(d).

2.43 "LSFSA Account" means the account described in Section 7.07.

2.44 "Medical Care Expenses" has the meaning described in Section 7.03(b).

2.45 "Medical Insurance Plan" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents who may be eligible under the terms of such

plan), providing major medical-type benefits through a group insurance policy or policies (including a High-Deductible Health Plan option). 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.

2.46 "Non-Elective Contributions" means funding contributed by the Employer, if any, to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured).

2.47 "Open Enrollment Period" with respect to a Plan Year means the month preceding the Plan Year, or such other period as may be prescribed by the Employer.

2.48 "Participant" means any Employee who has satisfied the eligibility requirements of Article 3.01, has elected to participate in the Plan, and has not, for any reason, become ineligible to participate in the Plan.

2.49 "Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.01; and (b) for Employees who cease to Participate during the middle of a Plan Year, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.02.

2.50 "Plan" means this cafeteria plan, together with any and all amendments and supplements required by the Code.

2.51 "Plan Administrator" means Multnomah County. The contact person is the Human Resources Manager for Multnomah County, who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Committee or other designated person(s) have the full authority to act on behalf of the Plan Administrator, as described in Section 13.01.

2.52 "Plan Year" means the period of time specified in Section II Your Plan at a Glance, of the Summary Plan Description.

2.53 "PPO" means the preferred provider organization Benefit Package Option (if any) under the Medical Insurance Plan.

2.54 "Premium Completion Agreement" means that upon Participant termination, an agreement can be made between the Employer and Participant allowing an extension of the eligibility period for the Health FSA Component as described in Section 3.08(b).

2.55 "Premium Payment Benefits" means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.01.

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

2.57 "Prior Plan Year Amounts" has the meaning described in Section 7.05, Section 8.05 and Section 9.05.

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

2.59 "Qualified Reservist Distribution" means a distribution to a Participant of all or a portion of the balance in the Participant's Health FSA Component as determined pursuant to Section 3.07.

2.60 "Qualifying Dependent Care Services" has the meaning described in Section 8.03(c).

2.61 "Qualifying Individual" means (a) a tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1); (b) a tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code §21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code §152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

2.62 "Related Employer" means any Employer affiliated with the Employer that, under Code §§414(b), 414(c), or 414(m), is treated as a single Employer with Multnomah County for purposes of Code §125(g)(4).

2.63 "Run-Out Period" means a period after the close of a Plan Year or other period during which Participants in a FSA may request reimbursement for expenses incurred during the Period of Coverage.

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

2.65 "Section 125" means Section 125 of the Code, including the proposed regulations, any final regulations, and all other authoritative guidance thereunder.

2.66 "Special Limited COBRA" means continuation of coverage after termination of employment or loss of eligibility through the end of the current Plan Year, as described in Section 3.08(a).

2.67 "Spouse" means an individual who is treated as a Spouse for federal tax purposes. Notwithstanding the above, for purposes of the DCAP Component, the term Spouse shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who is married to the Participant and files a separate federal income tax return, where (i) the Participant maintains a household that constitutes a Qualifying Individual's principal place of abode for more than one-half of the taxable year, (ii) the Participant furnishes more than half of the cost of maintaining such household, and (iii) during the last 6 months of such taxable year, the individual is not a member of such household.

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

2.69 "Third Party Administrator" means PacificSource Administrators, Inc. ("PSA") as described in Section 13.04.

2.70 "Use-It-or-Lose-It Rule" means unused amounts that remain in a Participant's account after all reimbursements have been made for the Period of Coverage; the balance shall not be carried over to reimburse the Participant expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

2.71 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended; as described in Section 3.06.

ARTICLE III. Eligibility and Participation

3.01 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual: (a) is an Employee; and (b) has met the Plan's eligibility requirements. The Employee may elect coverage effective as of the Entry date as specified in Section III Participation in the Plan, of the Summary Plan Description.

Eligibility for the Health FSA Component further requires the individual to be eligible for the Medical Insurance Plan (whether or not coverage under such plan has been elected). Eligibility for Group Sponsored Insurance shall also be subject to the additional requirements, if any, specified in the insurance plan documents.

3.02 Termination of Participation

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

(a) the termination of this Plan;

(b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee as specified in Section III Participation in the Plan, of the Summary Plan Description; or

(c) the first day of a Plan Year for which the Participant declines to participate in any components provided under the Plan.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Group Sponsored Insurance will terminate as of the date(s) specified in the insurance Plan Documents. Reimbursements from the Health FSA Accounts and DCE Account after termination of participation will be made pursuant to Section 7.10 for Health FSA Benefits and Section 8.10 for DCAP Benefits.

3.03 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired or if an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason, including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee could then be reinstated as a Participant if and when he or she again satisfies the eligibility requirements.

Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Group Sponsored Insurance is reinstated.

3.04 FMLA Leaves of Absence

(a) **Health Benefits**. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Group Sponsored Insurance Benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions. An Employer may require Participants to continue all Group Sponsored Insurance Benefits and Health FSA Benefits coverage while they are on paid leave, provided that Participants on non-FMLA paid leave are required to continue such coverage. If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

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

- **Pay-as-you-go:** with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

- **Pre-Pay:** with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

- **Catch-up:** under another arrangement agreed upon between the Participant and the Employer (e.g., the Employer 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 Group Sponsored Insurance Benefits and Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Employer and the Participant through a written notice to the Employer.

If a Participant's Group Sponsored Insurance Benefits or Health FSA Benefit coverage ceases while on FMLA leave (e.g., for non-payment of required Contributions), then the Participant is permitted to re-enter the Group Sponsored Insurance Benefits or Health FSA Benefits, as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required

by the FMLA. In addition, the Plan may require Participants whose Group Sponsored Insurance Benefits or Health FSA Benefit coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased (e.g., Participant revokes coverage or chooses the Pay-as-you-go option and then fails to pay a required contribution) then the Participant is not entitled to reimbursement for claims incurred during the period when the coverage is not in effect and the Participant may not retroactively elect Health FSA coverage for claims incurred during the period when coverage was not in effect. However, the Participant may elect 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 with a corresponding reduction to that coverage level. 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 per-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 and the election will be reduced by the value missed.

(b) **Non-Health Benefits.** If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when Participants are on non-FMLA leave, as described in Section 3.05. If such policy permits a Participant to discontinue Contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Employer and the Participant, or as the Employer otherwise deems appropriate. The Participant is not entitled to reimbursements for claims incurred during the period when coverage is not in force.

3.05 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 Employer.

If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 11.03(d) will apply.

3.06 Uniformed Services Employment and Reemployment Rights Act (USERRA)

Notwithstanding any provision of the Plan to the contrary, Contributions, service, and Benefits with respect to qualified military service will be provided in accordance with Section 414(u) of the Code and the regulations thereunder. In the event a Participant takes an unpaid USERRA leave of absence, each elected healthcare benefit shall continue for the lesser of the period of the leave or twenty-four (24) months, provided that applicable Contributions for such benefits are timely paid by the Participant. The Participant may elect to pay the Contributions on an

after-tax basis as due or on a pre-tax basis prior to commencing the leave. If the applicable Contributions for the elected healthcare benefits are not paid in a timely manner, the elected healthcare benefit shall be suspended during the period of unpaid leave. Upon return from an unpaid USERRA leave before the end of the Plan Year in which the leave commenced active participation in the Plan shall be reinstated and Compensation reduction Contributions and benefits shall resume in accordance with the Enrollment Materials in effect immediately prior to the leave. Upon return from an unpaid USERRA leave after the end of the Plan Year the Participant shall be treated as a newly Eligible Employee and Section 3.01 shall apply.

If a Participant does not return to active employment at the conclusion of an unpaid USERRA leave, the Participant shall no longer be considered an Eligible Employee and Section 3.01 shall apply.

3.07 Qualified Reservist Distributions

(a) A Participant who is, by reason of being a member of a reserve component (as defined in 37 U.S.C. §101), ordered or called to active duty for a period of 180 days or more or for an indefinite period may request a Qualified Reservist Distribution by delivering a copy of such order or call to active duty to the Employer. The Employer may rely on the order or call to determine the period that the Participant has been ordered or called to active duty. If the order or call specifies that the period of active duty is for 180 days or more or is indefinite, the Participant is eligible for a Qualified Reservist Distribution, and the Participant's eligibility is not affected if the actual period of active duty is less than 180 days or is otherwise changed. If the period specified in the order or call is less than 180 days, a Qualified Reservist Distribution is not allowed. However, subsequent calls or orders that increase the total period of active duty to 180 days or more will qualify a Participant for a Qualified Reservist Distribution. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the Spouse of the Participant.

(b) The amount available as a Qualified Reservist Distribution under this Section 3.07 shall be the amount contributed to the Health FSA Component as of the date of the Qualified Reservist Distribution request minus the reimbursements received by the Participant for the Plan Year as of the date of such request.

(c) With respect to expenses incurred after the date a Qualified Reservist Distribution is requested, the Participant may continue to submit claims for reimbursement under the Health FSA Component for the remainder of the Plan Year (and Grace Period, if applicable); provided that the amount reimbursed is not greater than the amount elected for contribution to the Health FSA Component for the Plan Year, less amounts previously distributed and less amounts previously reimbursed.

(d) A Participant must request a Qualified Reservist Distribution on or after the date of the order or call to active duty, and before the last day of the Plan Year (or Grace Period) during which the order or call to active duty occurred. The Employer must pay the Qualified Reservist Distribution to the Participant within a reasonable time, but within 60 days after the request for a Qualified Reservist Distribution has been made. A Qualified Reservist Distribution may not be made with respect to a Plan Year ending before the order or call to active duty.

(e) A Qualified Reservist Distribution is included in the gross income and wages of the Employee, and is subject to employment taxes. The Employer must report the Qualified Reservist Distribution as wages on the Employee's Form W-2 for the year in which the Qualified Reservist Distribution is paid to the Employee.

3.08 Coverage Continuation (if applicable)

A Participant who loses coverage under the Health FSA Component as a result of a qualifying event (i.e. the Participant's termination of employment or cessation of eligibility because of a reduction in hours of employment) may be entitled to elect coverage continuation under the Health FSA to the extent required by federal law.

A Participant cannot be forced to repay or voluntarily repay the Employer for any amounts exceeding his or her Health FSA account balance (under most circumstances, individuals who have overspent their accounts will not elect continued coverage). The plan cannot accept the additional contributions as such a practice would be a violation of the Uniform Coverage rule. If the Participant chooses to not extend his or her coverage, the Participant will cease to be a Participant in this Plan, as described in Section 3.02.

(a) **COBRA.** Health FSA COBRA continuation coverage will be available if the Employer normally employed 20 or more Employees on a typical business day during 50% or more of the preceding calendar year. The COBRA Administrator shall provide notice to the Participant of his or her right to continuation coverage and shall administer continuation coverage hereunder in accordance with applicable law and regulations.

Employers subject to COBRA must offer Health FSA COBRA coverage to qualified beneficiaries who lose their Health FSA coverage as the result of a qualifying event when the account is underspent (taking into account all claims submitted and deductions due before the date of the qualifying event). An Employer is not required to offer COBRA when accounts are overspent, but may choose to do so in a uniform manner.

The type of COBRA continuation obligation depends on whether the Health FSA is considered to be a qualifying Health FSA. There are three conditions that must be met for a Health FSA to be considered a qualifying Health FSA:

- **Condition 1:** The maximum benefit payable under the Health FSA to any Participant in the class for a year cannot exceed two times the Participant's salary reduction election under the Health FSA for the year (or, if greater, the amount of the Employee's Salary Reduction election for the Health FSA for the year, plus $500).

- **Condition 2:** Other group health plan coverage, not limited to benefits that are excepted benefits (e.g., limited-scope dental and vision coverage), must be made available for the year to the class of Participants by reason of their employment.

- **Condition 3:** The maximum annual COBRA premium chargeable for Health FSA COBRA coverage must equal or exceed the maximum annual Health FSA coverage amount.

If the Health FSA is a qualifying Health FSA, COBRA continuation coverage must be offered to all qualified beneficiaries but is subject to special limitations. This is called

Special Limited COBRA continuation. If the Special Limited COBRA continuation is elected for the Health FSA, it will be available only for the Plan Year in which the qualifying event occurs, with coverage for the Health FSA ceasing at the end of the Plan Year, and no ability to re-enroll with a new election for the next Plan Year. In the event the qualified beneficiary experiences a secondary qualifying event, the COBRA continuation period may not be extended.

If the Health FSA is not a qualifying Health FSA (i.e., does not meet the three conditions above), COBRA continuation coverage must be offered to all qualified beneficiaries for the maximum COBRA period which includes the rest of the Plan Year in which the qualifying event occurred, and, until the maximum COBRA period expires. Qualified beneficiaries may re-enroll for subsequent plan years during open enrollment with a new election. In addition, in the event the qualified beneficiary experiences a secondary qualifying event, the COBRA continuation period may be extended.

Regardless if the Health FSA is considered qualifying or not, if the Grace Period applies to the Health FSA, the Grace Period would also apply to Participants who are receiving coverage under the Health FSA at the end of the Plan Year. In addition, if the Carryover Provision applies to the Health FSA, the Carryover Provision would also apply to Participants who are receiving coverage under the Health FSA at the end of the Plan Year, although the Carryover Provision would not last beyond the end of the 18-month or other applicable maximum COBRA coverage period.

A Participant who elects Health FSA COBRA continuation coverage will generally pay for coverage with after-tax dollars by writing a check to his or her Employer each month. However, an agreement can be made with the Employer to make payments with pre-tax dollars to his or her Employer, generally on a monthly basis but only through the end of the Plan Year in which the qualifying event occurred.

(b) **Premium Completion Agreement.** This option will not be available unless specified in Section IV Component Options - Health FSA Component, *"Can I continue my Health FSA coverage after terminating employment?"* of the Summary Plan Description. In the event the Employee terminates employment or otherwise ceases to be an Eligible Employee, then the Employer can require the Employee to waive his or her COBRA rights with respect to the Health FSA as a condition to electing the voluntary Premium Completion Agreement to cover the Health FSA premium for the balance for the current Plan Year.

The Employer must discuss and give the Participant the option to make a pre-tax final paycheck Salary Reduction or self-pay on an after-tax basis any remaining Contributions for the Plan Year to his or her Health FSA Account. If the final paycheck does not cover the remaining contributions, an agreement can be made with the Employer to voluntarily pay the remaining funds with after-tax dollars for coverage through the end of the current Plan Year.

If the Grace Period applies to the Health FSA, the Grace Period would also apply to Participants who are receiving coverage under the Health FSA at the end of the Plan Year. In addition, if the Carryover Provision applies to the Health FSA, the Carryover Provision would also apply to Participants who are receiving coverage under the Health FSA at the end of the Plan Year, although the Carryover Provision would not last beyond the end of the coverage period that it rolled into. However, if a minimum Salary

Reduction election to the Health FSA Component for the next year is required in order to carryover unused amounts to the next Plan Year, the Carryover Provision is not permitted and Participants will forfeit their unused amounts after the 90-day runout period.

ARTICLE IV. Method and Timing of Elections

4.01 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits once the eligibility requirements have been satisfied, provided that Enrollment Materials are submitted to the Employer before the first day of the pay period in which participation will commence.

An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 11.03.

The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Group Sponsored Insurance Plan Documents.

4.02 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Employer shall provide a paper or electronic Enrollment Materials to each Employee who is eligible to participate in this Plan. The Enrollment Materials shall enable the Employee to elect to participate in the various components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Enrollment Materials must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year.

If an Eligible Employee fails to return the Enrollment Materials during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 11.03.

4.03 Reinstated Participants

For a Participant or Employee who terminates employment or becomes ineligible to participate and is later rehired by the Employer (or who returns to employment following an unpaid leave of absence) or later becomes eligible, reinstatement is determined by the length of time the Employee was terminated or ineligible as specified in Section III Participation in the Plan, of the Summary Plan Description.

Once an Employee becomes eligible, the Employer shall provide Enrollment Materials to the Employee. The Enrollment Materials must be completed and returned to the Employer on or before such date as the Employer shall specify, which date shall be no later than 30 days after the Participant has become eligible for the Plan. For an Employee hired after the Plan effective date, Salary Reduction will begin with the first day of the next period after eligibility requirements are met as provided in Section 4.01.

4.04 Enrollment Materials

(a) **Group Sponsored Insurance.** The Employee will be deemed to elect for each upcoming Plan Year whatever election is in effect in the current Plan Year, unless the Participant expressly changes his or her election by turning in completed Enrollment Materials prescribed by the Employer.

For example, if the Participant is enrolled in the Group Sponsored Insurance in the current year and wants to remain enrolled in the upcoming year, the Employee need not do anything, but if the Employee wants to stop participating in that Program, the Employee must affirmatively elect not to participate during the Open Enrollment Period for the upcoming Plan Year.

(b) **Under all the other Programs.** The Employee must make an affirmative election to participate every year by turning in completed Enrollment Materials prescribed by the Employer or the Employee will be deemed to have elected not to participate.

4.05 Failure of Eligible Employee to File Enrollment Materials

If an Eligible Employee fails to file Enrollment Materials within the time period described in Sections 4.01 and 4.02, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Section 11.03 or Section 11.04.

If an Employee who fails to file Enrollment Materials are eligible for Group Sponsored Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described under Section 11.03), timely Enrollment Materials to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

4.06 Electing with Carryover Provision

Under the Health FSA Component, when the Carryover Provision is permitted and unused amounts are carried forward, the Employee will be deemed as having elected for each upcoming Plan Year.

4.07 Irrevocability of Elections

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

ARTICLE V. Components Offered and Method of Funding

5.01 Components Offered

When first eligible or during the Open Enrollment Period, Participants will be given the opportunity to elect one or more of the following components:

(a) Premium Payment Component, as described in Article VI;

(b) Health FSA Component, as described in Article VII. The election may be for one of the following:
- General-Purpose Health FSA Option;
- Limited-Scope Health FSA Option (Vision/Dental Care, excluding Preventive Care); or
- Limited-Purpose Health FSA Option (Vision/Dental/Preventive Care);

(c) DCAP Component, as described in Article VIII;

Refer to Section II Your Plan at a Glance, of the Summary Plan Description, to determine which of the components are available to elect.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.02 Participant and Employer Contributions

(a) **Participant Contributions.** Participants who elect the Group Sponsored Insurance described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing Enrollment Materials. Participants who elect Health FSA Component or DCAP Component must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing Enrollment Materials. Such Contributions shall be prorated for Participants who begin participating in the middle of a Plan Year unless Section II Your Plan at a Glance, of the Summary Plan Description specifies otherwise.

(b) **Employer Contributions.** An Employer may provide non-elective Contributions in the form of Employer Funding. To the extent specified in Section II Your Plan at a Glance, of the Summary Plan Description, the Employer is required or permitted to make non-elective Contributions, which shall be credited to the Accounts of some or all Participants in the amounts and manner specified in Section II Your Plan at a Glance, of the Summary Plan Description. Such Contributions shall be prorated for Participants who begin participating in the middle of a Plan Year unless Section II Your Plan at a Glance, of the Summary Plan Description specifies otherwise. If available, the Employer designates the Account(s) that are eligible to receive the funding. The Participant may elect to have the amount of the Employer Funding applied to the components indicated in Section II Your Plan at a Glance, of the Summary Plan Description.

When Employers contribute to a Health FSA Component or make matching Contributions on behalf of Participants, these Contributions generally do not count toward the annual Federal Limit for Health FSA. However, if an Employer's Plan offers a Cash-out option, which allows Participants to receive non-elective Contributions in cash

or as taxable benefit, then the Contributions will be treated as Salary Reductions and will count toward the Federal Limit when contributed to the Health FSA Component.

5.03 Using Salary Reductions to Make Contributions

(a) **Salary Reductions per Pay Period.** The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (elected under the Plan as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Employer (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant changes his or her election under the Health FSA Component or DCAP Component to the extent permitted under Section 11.03, the Salary Reductions per pay period will be, for the components affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 11.03, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Employer (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

(b) **Considered Employer Contributions for Certain Purposes.** Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the components elected under the Plan and, for the purposes of this Plan and the Code, are considered to be Employer Contributions.

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

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

5.04 Funding This Plan

The Plan shall be funded with amounts withheld from Salary or Wages and/or Employer Contributions as specified in Section IV Component Options, of the Summary Plan Description, as allocated pursuant to Enrollment Election from Participants. All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or PacificSource Administrators to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund

from which Benefits 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.

5.05 Maximum Contribution

The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions for Premium Payment Benefits, as specified in Section II Your Plan at a Glance, of the Summary Plan Description.

5.06 Electronic Payment Cards

If the Employer allows the Health FSA Component to be accessed by an Electronic Payment Card (e.g., debit card, credit card, or similar arrangement), Participants will be required to comply with substantiation procedures established by PSA in accordance with applicable IRS guidance regarding Electronic Payment Card programs. In addition, the following provisions shall apply:

(a) **Initial and Periodic Certification.** Each Participant must certify that he or she will only use the card to pay for Medical Care Expenses, will not use the card for expenses that have already been reimbursed, will not seek reimbursement under any other health plan for expenses paid for with the card, and will acquire and keep sufficient documentation (see subsection (d) below) for expenses paid with the card. The Participant must also agree to abide by any other terms and conditions of the card program as set forth herein and in any cardholder agreement issued in conjunction with the card, including but not limited to payment of any fees for participation in the card program and the Plan's right to recoup improper card payments by withholding amounts from Compensation and offsetting against other HRE Account, LSFSA Account or LFSA Account claims. The Participant must reaffirm these agreements during each subsequent Open Enrollment Period in order for the card to remain activated. In addition, these agreements are reaffirmed each time the Participant uses the card. Failure to abide by these agreements may result in deactivation of the card.

(b) **Issuance and Deactivation of Card.** Such Card shall be issued upon the Participant's commencement of participation and reissued (or remain active) for Coverage Periods during which the Participant remains a Participant in the Plan. A Participant's card will be deactivated when participation in the Health FSA Component ceases or at other times as set forth herein (e.g., for failure to comply with the Plan's substantiation and recoupment procedures). A Participant whose card has been deactivated must request reimbursement for Medical Care Expenses through other methods (e.g., by submitting paper claims).

(c) **Merchants; Card Use.** Card use is limited to eligible merchants as provided in applicable IRS guidance and as further identified by PSA. The card's debit balance (or credit limit, as applicable) must be limited to the amount of the Participant's available reimbursement as described in Section 7.04. Each time the card is swiped, the Participant certifies to the Plan that the expense for which payment under the Health FSA Component is being made is a Medical Care Expense that has not already been reimbursed from another source and that reimbursement for the expense will not be

sought from another source. Use of a card to pay for a service or product is not considered to be a claim for benefits under the Plan; a claim does not arise until a paper or electronic reimbursement request is submitted.

(d) **Substantiation of Expenses.** For each expense that is paid with the card, the Participant must obtain and retain a bill, invoice, or other statement from the merchant describing the service or product, the date of the service or sale, and the amount of the expense. The documentation must be retained until the close of the Plan Year following the Plan Year in which the card transaction occurred. If the Participant is asked to provide the documentation to PSA, he or she must do so within the period specified in the request. A Participant who is unable to provide adequate or timely substantiation upon request from PSA must repay the Plan for the unsubstantiated expense. In addition, the Participant's card may be deactivated. Without limiting the generality of the preceding sentence, the following rules apply:

- **Co-payment Match Substantiation Method.** To the extent permitted by IRS guidance, charges shall be considered substantiated if they satisfy the co-payment match substantiated method as provided in applicable IRS guidance. Under that method, a charge is considered substantiated without the need for submission of a receipt or further review if the Group Sponsored Insurance has co-payments in specific dollar amounts, and the dollar amount of the transaction at a medical provider (as identified by its merchant category code), or other merchant/service provider as otherwise allowed by IRS guidance, equals an exact multiple of not more than five times the dollar amount of the co-payment for the specific service (i.e., pharmacy benefit co-payment, co-payment for a physician's office visit, etc.) under the Group Sponsored Insurance covering the specific Participant. In addition, if a health plan has multiple co-payments for the same benefit (e.g., tiered co-payments for a pharmacy benefit), exact matches of multiples or combinations of the co-payments (but not more than the exact multiple of five times the maximum co-payment) will similarly be fully substantiated without the need for submission of a receipt or further review.

- **Recurring Expenses.** To the extent permitted by IRS guidance, charges shall be considered substantiated without the need for submission of a receipt or further review if they match expenses previously approved as to amount, provider, and time period (e.g., for a Participant who received treatment on a regular basis at the same provider for the same amount).

- **Real Time Substantiation.** To the extent permitted by IRS guidance, charges shall be considered substantiated without the need for submission of a receipt or further review if the merchant, service provider, or other independent third party (e.g., pharmacy benefit manager), at the time and at the point of sale, provides information to verify to PSA (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for an eligible expense.

- **Inventory Information Approval System.** Charges shall be considered substantiated without the need for submission of a receipt or further review if they are made through an inventory information approval system as set forth in applicable IRS guidance.

- **Direct Third-Party Substantiation.** Charges shall be considered substantiated without the need for submission of a receipt or further review by submission of information from an independent third party (such as an Explanation of Benefits from an insurance company) indicating the date of the service or product and the Participant's responsibility for payment (e.g., co-insurance payments and amounts below the plan's deductible).

(e) **Correction of Improper Payments.** All charges on the Card shall be conditional pending substantiation. Improper payments may be recouped in accordance with applicable IRS guidance. Until the amount is repaid, PSA shall take further lawful action to ensure that further violations of the terms of the Card do not occur, up to, and including deactivating the card. Participants must repay the Plan for any improper payments that are made with their cards. If a charge is determined not to be an eligible expense, one or more of the following correction methods will be used to make the Plan whole:

- Repayment of the improper amount by the Participant;
- Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law; and
- Claims substitution or offset of future claims until the amount is repaid.

If the Plan is unable to recoup an improper payment, then the Employer will treat the payment as it would treat any other business indebtedness. If the debt is not collected and the Employer forgives the indebtedness, the payment should be reported as wages on Form W-2 for the year in which the indebtedness was forgiven. The reported amount is subject to withholding for income tax, FICA, and FUTA.

ARTICLE VI. Premium Payment Component

6.01 Benefits

Upon becoming eligible, a Participant may elect in writing on Enrollment Materials provided and filed with the Employer, can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Group Sponsored Insurance on a pre-tax Salary Reduction basis; or (b) elect no benefits under the Premium Payment Component and pay for his or her share of the Contributions, if any, for Group Sponsored Insurance with after-tax deductions outside of this Plan. The premium insurance benefits that may be offered under the Group Sponsored Insurance for premium-type benefits pursuant to an insurance policy issued by an insurance company, or a contract with a point of service organization are medical, dental, vision, or other qualified benefits under Section 125.

Notwithstanding any other provision in this Plan, the premium insurance benefits are subject to the terms and conditions of the respective insurance policy, and no changes can be made with respect to such premium insurance benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable insurance policy. Unless an exception applies (as described in Article XI), such election is irrevocable for the duration of the Period of Coverage to which it relates.

If a Participant does not elect upon initial enrollment to pay such premiums on a Salary Reduction pre-tax basis, he or she may later elect to do so by executing Enrollment Materials during the next Enrollment Period, effective as of the start of the next Plan Year. Once an election is made, a Participant may change that election only during the Enrollment Period, except as provided in Article XI.

If a Health Savings Account (HSA) is offered and the Employee elects to participate, eligible Participants may make contributions to the HSA on a pre-tax basis from which funds can be withdrawn to pay for eligible healthcare expenses. Refer to Section IV Component Options, of the Summary Plan Description, to determine if a HSA is offered.

6.02 Contributions for Cost of Coverage

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

6.03 Tax Compliance

Any insurance program covered in this section shall comply with the applicable sections of the Code to obtain the desired tax benefits. For example, a group-term life insurance program shall comply with Code §79, to the extent the Employer desires pre-tax treatment and pre-tax treatment is available.

6.04 Benefits Provided Under the Group Sponsored Insurance

Group Sponsored Insurance benefits will be provided by the insurance provider(s), not this Plan. The types and amounts of Group Sponsored Insurance, the requirements for participating in the each insurance plan, and the other terms and conditions of coverage and benefits of the insurance plan(s) are set forth in the insurance plan(s). All claims to receive benefits under the insurance plan(s) shall be subject to and governed by the terms and conditions of the insurance

plan(s) and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.05 Insurance Benefits; COBRA

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

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

6.06 Grace Period

No Grace Period applies to the Premium Payment Component of this Plan.

ARTICLE VII. Health FSA Component

7.01 Health FSA Benefits

Upon becoming eligible, and to the extent specified in Section III Participation in the Plan, of the Summary Plan Description, 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 under one of the Health FSA Component Options described in Section 7.03. A Participant may elect in writing on Enrollment Materials to reduce his or her Salary or Wages each pay day and to have the amount of the reduction contributed to one of the various Health FSA Accounts on such Participant's behalf. Such an election shall be filed with the Employer prior to the date the Participant is enrolled in the Plan. Unless an exception applies (as described in Article XI), such election is irrevocable for the duration of the Period of Coverage to which it relates.

If a Participant does not elect upon initial enrollment to establish one of the various Health FSA Accounts on a Salary Reduction pre-tax basis, he or she may later elect to do so by executing Enrollment Materials during the next Enrollment Period, effective as of the start of the next Plan Year. Once an election is made, a Participant may change that election only during the Enrollment Period, except as provided in Article XI.

7.02 Contributions for Cost of Coverage of Health FSA Benefits

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 7.04(b).

7.03 Eligible Medical Care Expenses

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force. In addition, an Employer may choose to allow reimbursement for Medical Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in the Participant's account for that Plan Year in accordance with Section 7.05 or for which Health FSA Benefits are otherwise available as a result of a carryover as provided in Section 7.06.

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

(b) **Medical Care Expenses.** Medical Care Expenses will vary depending on which Health FSA coverage option the Participant has elected. Notwithstanding any other provision of this Plan, an Eligible Employee shall not be eligible for the General-Purpose Health FSA Option unless he or she is also eligible for the Medical Insurance Plan.

Employees who are not eligible for the Medical Insurance Plan may only enroll in the Limited-Scope Health FSA Option (covering Vision and Dental Care, but excluding Preventive Care). In addition, when a Participant has unused amounts remaining in his or her HRE Account at the end of the preceding Plan Year that are available for carryover as provided in Section 7.06, if any, and is no longer eligible for the Medical Insurance Plan, those unused amounts can only be carried over to a LSFSA Account.

Employees who elect to participate in an HSA Benefit, or a Spouse participating in their Employer's HSA Benefit, may only enroll in the Limited-Purpose Health FSA Option (covering Vision, Dental and Preventive Care). In addition, when a Participant has unused amounts remaining in his or her HRE Account at the end of the preceding Plan Year that are available for carryover as provided in Section 7.06, if any, and elects to Participate in an HSA Benefit, those unused funds can only be carried over to a LFSA Account.

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

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

- medicines or drugs, unless the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin (for this purpose, the Employer shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug and whether the requirement of a prescription has been satisfied);

- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, cosmetic surgery means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease); or

- any other expense excluded under Appendix A or otherwise under the terms of this Plan.

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

(d) **Limited-Scope Health FSA Option (Vision and Dental).** For purposes of this Option, Medical Care Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care as defined in Code §213(d) and as further described under the General-Purpose Health FSA Option—provided, however, that such expenses are for vision care and dental care (as defined in Code §223(c)) only and excludes the coverage of preventive care.

(e) **Limited-Purpose Health FSA Option (Vision/Dental/Preventive Care).** For purposes of this Option, Medical Care Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care as defined in Code §213(d) and as further described under the General-Purpose Health FSA Option—provided, however, that such expenses are for vision care, dental care, or preventive care (as defined in Code §223(c)) only.

7.04 Maximum and Minimum Benefits for Health FSA Accounts

(a) **Maximum Reimbursement Available; Uniform Coverage.** The maximum dollar amount which a Participant may receive in any Plan Year for reimbursement of expenses (as defined below) shall be the amount credited to his or her HRE Account, LSFSA Account or LFSA Account and shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's HRE Account, LSFSA Account or LFSA Account pursuant to Section 7.07. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after participation in this Plan has terminated, unless the Participant has elected continued coverage as provided in Section 3.08. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective (or during a Grace Period, if applicable under Section 7.05), provided that the other requirements of this Article VII have been satisfied.

(b) **Maximum and Minimum Dollar Limits.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be subject to Section 7.04(c) and Section 7.07(c). The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $0 unless otherwise specified in Section IV Component Options – Health FSA Component, *"What are the benefits that I may elect under the Health FSA Component?"*, of the Summary Plan Description. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's HRE Account, LSFSA Account or LFSA Account.

(c) **Maximum and Minimum Election Changes.** For Plan Years beginning after 2015, the maximum and minimum dollar limit may be changed by the Employer and shall be communicated to Employees through the Enrollment Materials or another document, provided that the maximum dollar limit shall not exceed the maximum amount permitted under Code §125(i). If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 11.03, then there will be no proration unless otherwise specified in Section IV Component Options – Health FSA Component, *"What are the benefits that I may elect under the Health FSA Component?"*, of the Summary Plan Description. Notwithstanding the foregoing, the Employer may limit the elections of a Participant who is terminated and rehired during the same Plan Year to the extent necessary to comply with the requirements of Code §125(i).

(d) **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election under Article XI (other than under Section 11.03(c) for FMLA leave) that increases Contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the

election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the Contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total Contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the HRE Account, LSFSA Account or LFSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 11.03(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

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

7.05 Grace Period

Notwithstanding any contrary provision in this Plan and subject to the conditions of Section 7.04(b), the Grace Period, applicable as specified in Section II Your Plan at a Glance – Grace Period, of the Summary Plan Description, is an extension of time to use plan benefits before they become subject to the Use-It-or-Lose-It Rule. An individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her HRE Account, LSFSA Account or LFSA Account at the end of the Plan Year to which that Grace Period relates (Prior Plan Year Amounts) if he or she Is a Participant in the Plan with Health FSA Component that is in effect on the last day of that Plan Year.

(a) Prior Plan Year Amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, Prior Plan Year Health FSA Component amounts may not be used to reimburse Dependent Care Expenses.

(b) Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 7.09 will be reimbursed first from any available Prior Plan Year Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year. An individual's Prior Plan Year Amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Amounts.

(c) Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than the end of the Run-Out Period following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Amounts. Any Prior Plan Year Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.08.

7.06 Carryover Provision

Notwithstanding any other provision of this Plan to the contrary, the Carryover Provision, applicable as specified in Section II Your Plan at a Glance – Carryover Provision, of the Summary Plan Description, allows unused amounts remaining in a Participant's HRE Account, LSFSA Account or LFSA Account at the end of a Plan Year to be carried over and used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year, subject to the following conditions:

(a) When Carryover Provision is available, no more than the amount specified in Section II Your Plan at a Glance – Carryover Provision, of the Summary Plan Description of the Participant's unused Health FSA Component amount for a Plan Year may be carried over for use in the next Plan Year. Carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit under subsections (b) and (c) above.

(b) An Employee or other individual must be a Participant in the Health FSA Component as of the last day of a Plan Year and make a minimum salary reduction election to the Health FSA Component for the next Plan Year in order to carryover unused amounts to the next Plan Year for Medical Care Expenses incurred in the current or preceding Plan Year (as further provided herein). In the alternative, the Employer may allow a Participant who is otherwise eligible for the Carryover Provision but does not make a minimum salary reduction election for the next Plan Year to carryover unused amounts from the preceding Plan Year. Termination of employment and cessation of eligibility will result in a loss of carryover eligibility unless coverage is continued (see Section 3.08).

(c) A Participant who is not eligible for the Medical Insurance Plan may enroll in the Limited-Scope Health FSA Option for that Plan Year, and unused amounts remaining in the Participant's General-Purpose Health FSA Option at the end of the preceding Plan Year that are available for carryover, if any, will be carried over to the Limited-Scope Health FSA Option. However, the Participant may continue to submit claims for general-purpose Medical Care Expenses incurred during the preceding Plan Year until the end of the Run-Out Period of the following Plan Year, to be reimbursed from the Participant's available General-Purpose Health FSA Option amounts for the preceding Plan Year.

(d) A Participant who elects to participate in an HSA Benefit may enroll in the Limited-Purpose Health FSA Option for that Plan Year, and unused amounts remaining in the Participant's General-Purpose Health FSA Option at the end of the preceding Plan Year that are available for carryover, if any, will be carried over to the Limited-Purpose Health FSA Option. However, the Participant may continue to submit claims for general-purpose Medical Care Expenses incurred during the preceding Plan Year until the end of the Run-Out Period of the following Plan Year, to be reimbursed from the Participant's available General-Purpose Health FSA Option amounts for the preceding Plan Year. In addition, a Participant may elect to waive the carryover from the preceding Plan Year in accordance with procedures established by the Employer. A Participant who waives the carryover may continue to submit claims for Medical Care Expenses incurred during the preceding Plan Year until the end of the Run-Out Period of the following Plan Year, to be reimbursed from the Participant's available General-Purpose Health FSA Option amounts.

(e) Medical Care Expenses incurred during a Plan Year will be reimbursed first from a Participant's unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses and cannot exceed the maximum carryover amount.

(f) If unused Health FSA Component amounts remain for a Plan Year after all reimbursements have been made for that Plan Year in excess of the amount that can be carried over under this Section 7.06, the Participant will forfeit all rights with respect to those amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.08.

7.07 Establishment of Health FSA Accounts

The Employer will establish and maintain a HRE Account, LSFSA Account or LFSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of Contributions and determining forfeitures under Section 7.08.

(a) **Crediting of Accounts.** A Participant's HRE Account, LSFSA Account or LFSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with the Participant's Salary Reductions elected, as well as any Employer non-elective Contributions and/or carryovers (if applicable), to be allocated to such Account as specified in Section 7.04.

(b) **Debiting of Accounts.** A Participant's HRE Account, LSFSA Account or LFSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during the Period of Coverage, or for reimbursement of Medical Care Expenses incurred during any Grace Period (if applicable).

(c) **Available Amount Not Based on Credited Amount.** As described in Section 7.04, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage and increased by any carryovers, if applicable; it is not based on the amount credited to the HRE Account, LSFSA Account or LFSA Account at a particular point in time except as provided in Section 7.06. Thus, a Participant's HRE Account, LSFSA Account or LFSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.08 Forfeiture of Health FSA Accounts; Use-It-or-Lose-It Rule

(a) **Use-It-or-Lose-It Rule.** Except as otherwise provided in Section 7.05 and Section 7.06, if any balance remains in the Participant's HRE Account, LSFSA Account or LFSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the

Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) **Use of Forfeitures.** All forfeitures under this Plan shall be 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 may be retained by the Employer to use in the subsequent Plan Year (all such administrative costs shall be documented by the Employer); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Employer deems appropriate, consistent with applicable regulations. In addition, any HRE Account, LSFSA Account or LFSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) shall be forfeited and applied as described above.

7.09 Reimbursement Claims Procedure for Health FSA Accounts

After receipt by PSA of a reimbursement claim from a Participant, PSA will reimburse the Participant for the Participant's Medical Care Expenses, or PSA will notify the Participant that his or her claim has been denied. A Participant has through the end of the Run-Out Period following the earliest of (a) the last day of the Plan Year when a Grace Period is not offered, (b) the last day of the Grace Period following the Plan Year when a Grace Period is offered, (c) the date on which the Participant terminates employment, or (d) the date on which the Participant ceases to be eligible to participate in the Plan, to obtain reimbursement for expenses incurred through the earliest of those dates.

(a) **Claims Substantiation.** A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to PSA in such form as PSA may prescribe, by no later than the end of the Run-Out Period following the close of the Plan Year in which the Medical Care Expense was incurred setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- a Participant must provide bills, invoices, or other written statements from an independent third party verifying the Medical Care Expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed under any other Health FSA; and
- other such details about the expenses that may be requested by PSA in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Participant).

If the Health FSA Account is accessible by an Electronic Payment Card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by PSA in accordance with Section 5.06 and applicable IRS guidance regarding Electronic Payment Card programs.

PSA will issue a reimbursement to the Participant from the Participant's HRE Account, LSFSA Account or LFSA Account for Medical Care Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with this Section 7.09. Medical Care Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses that were incurred before the Effective Date or before the date of the Participant's participation in the Health FSA Component will not be reimbursed.

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

7.10 Reimbursements from Health FSA Accounts after Termination of Participation

As designated in Section III Participation in the Plan, of the Summary Plan Description, a Participant's participation in the Health FSA Component will end on the day on which he or she terminates employment or otherwise ceases to be an Eligible Employee, whichever occurs first.

In the alternative (as described in Section 3.08), an Employee electing to participate in the HRE Account, LSFSA Account or LFSA Account may agree to maintain his or her HRE Account, LSFSA Account or LFSA Account and make the elected Contributions for the entire Plan Year, regardless of whether the Employee remains employed or continues to be an Eligible Employee for the entire Plan Year.

7.11 Coordination of Benefits with Other Coverage

The HRE Account, LSFSA Account or LFSA Account is 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 Component shall not be considered to be a group health plan for coordination of benefits purposes, and the HRE Account, LSFSA Account or LFSA Account shall not be taken into account when determining benefits payable under any other plan that is not administered by PSA.

7.12 Health FSA Component Provisions

(a) Medicaid. Benefits under the Health FSA Component shall be provided in compliance with Section 609(b) of ERISA.

(b) Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Benefits under the Health FSA Component shall be provided in compliance with and as mandated by the provisions of USERRA applicable to health plans.

(c) Claims Procedures for Health FSA Component. Claims procedures for claims under the Health FSA Component shall be as set forth in the Summary Plan Description for the Plan.

(d) Qualified Medical Child Support Order. The Plan shall provide benefits under the Health FSA Component in accordance with any QMCSO received by the Plan with respect to any Participant or beneficiary who is eligible to receive benefits from the Health FSA Component. A Qualified Medical Child Support Order is a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or beneficiary is eligible under the Health FSA Component, and which clearly specifies the following:

(1) The name and last known mailing address of the Participant and the name and mailing address of each Alternate Recipient covered by the Order, except that, to the extent provided in the Order, the name and mailing address of an official of a state or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient.

(2) A reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined.

(3) The period to which the Order applies.

An Alternate Recipient is any child of a Participant who is recognized under the Medical Child Support Order as having a right to enrollment under the Health FSA Component with respect to the Participant.

Notwithstanding any other Health FSA Component provision, the following procedures shall apply when any Medical Child Support Order is received by the Health FSA Component with respect to a Participant:

(1) The Employer shall promptly notify the Participant, and each Alternate Recipient of the receipt of such Order and the Plan's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders. The Employer shall permit each Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

(2) The Employer shall promptly, after receipt of the Order, determine whether the Order is a Qualified Medical Child Support Order, as defined in Section 609(a)(2)(A) of ERISA. The Employer shall promptly notify the Participant and each Alternate Recipient of its decision.

(3) An Alternate Recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the Plan.

(4) Any payment for benefits made by the Health FSA Component pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

If each Alternate Recipient and the Participant (or their attorneys) stipulates in a manner acceptable to the Employer that an Order is a Qualified Medical Child Support Order and the notice of the Employer's determination states that the Order so qualifies, any further determination, notice, claims, and review procedures with respect to the Employer's determination that the Order so qualifies shall cease to apply.

ARTICLE VIII. DCAP Component

8.01 DCAP Benefits

Upon becoming eligible, and to the extent specified in Section III Participation in the Plan, of the Summary Plan Description, a Participant may elect in writing on Enrollment Materials to reduce his or her Salary or Wages each pay day and to have the amount of the reduction contributed to a DCE Account on such Participant's behalf. Such an election shall be filed with the Employer prior to the date the Participant is enrolled in the Plan. Unless an exception applies (as described in Article XI), such election is irrevocable for the duration of the Period of Coverage to which it relates.

If a Participant does not elect upon initial enrollment to establish a DCE Account on a Salary Reduction pre-tax basis, he or she may later elect to do so by executing Enrollment Materials during the next Enrollment Period, effective as of the start of the next Plan Year. Once an election is made, a Participant may change that election only during the Enrollment Period, except as provided in Article XI.

8.02 Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, such election may not elect to reduce the Participant's Salary or Wages by more than $5,000 per Plan Year ($2,500 in the case of married individuals filing separate returns).

8.03 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force. In addition, an Employer may choose to allow reimbursement for Dependent Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in a Participant's DCE Account for that Plan Year in accordance with Section 8.05.

(a) **Incurred.** A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.

(b) **Dependent Care Expenses.** Dependent Care Expenses are expenses incurred by a Participant which (a) are incurred to enable the Participant to be gainfully employed for any period during which the Participant has one or more dependents, (b) are paid or payable to a Dependent Care Service Provider, and (c) are incurred for the care of a dependent of the Participant or for related household services that include the care of the dependent. Dependent Care Expenses shall not include expenses incurred for services outside the Participant's household for the care of a dependent unless such dependent is (a) under the age of 13 and with respect to whom the taxpayer is entitled to a deduction under Code §151(c) or regularly spends at least eight hours each day in the Participant's household, (b) 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 (c) a Participant's Spouse who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year.

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

If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP Component imposes maximum benefit limitations), the DCAP Component can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

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

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

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

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

8.04 Maximum and Minimum Benefits for DCE Account

(a) **Maximum Reimbursement Available.** The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCE Account pursuant to Section 8.07. No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the

Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements). Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective (or during a Grace Period, if applicable under Section 8.05), provided that the other requirements of this Article VIII have been satisfied.

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

- the Participant's Earned Income for the calendar year;

- the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse will be deemed to have Earned Income of at least $250 ($500 if the Participant has two or more Qualifying Individuals) for each month in which the Spouse is either (1) physically or mentally incapable of self-care (provided that the Spouse must have the same principal place of abode as the Participant for more than one-half of such year), or (2) a Student); or

- either $5,000 or $2,500 for the calendar year, as applicable:

  (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; or

  - the Participant is single or is the head of the household for federal income tax purposes; or

  (2) $2,500 for the calendar year if the Participant is married and files a separate federal income tax return under circumstances other than those described above.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any

Period of Coverage shall be $0 unless otherwise specified in Section IV Component Options – DCAP Component *"What are the benefits that I may elect under the DCAP Component?"*, of the Summary Plan Description.

(c) **Maximum and Minimum Election Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Employer and shall be communicated to Employees through the Enrollment Materials or another document. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 11.03, then there will be no proration unless otherwise specified in Section IV Component Options – DCAP Component *"What are the benefits that I may elect under the DCAP Component?"*, of the Summary Plan Description.

(d) **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election under Article XI 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 Section 8.04(a) and Section 8.04(b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the Contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total Contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCE Account, reduced by (3) reimbursements during the Period of Coverage.

8.05 Grace Period

Notwithstanding any contrary provision in this Plan and subject to the conditions of Section 8.04(b), the Grace Period, applicable as specified in Section II Your Plan at a Glance – Grace Period, of the Summary Plan Description, is an extension of time to use plan benefits before they become subject to the Use-It-or-Lose-It Rule. An individual may be reimbursed for Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her DCE Account at the end of the Plan Year to which that Grace Period relates (Prior Plan Year Amounts) if he or she Is a Participant in the Plan with DCAP Component coverage that is in effect on the last day of that Plan Year.

(a) Prior Plan Year Amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, Prior Plan Year DCE Amounts may not be used to reimburse Medical Care Expenses.

(b) Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 8.09 will be reimbursed first from any available Prior Plan Year Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year. An individual's Prior Plan Year Amounts will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Amounts.

(c) Claims for reimbursement of Dependent Care Expenses incurred during a Grace Period must be submitted no later than the end of the Run-Out Period following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Amounts. Any Prior Plan Year Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The

Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 8.08.

8.06 Carryover Provision

The Carryover Provision is not permitted and therefore unused balances are subject to the Use-It-or-Lose-It Rule discussed in Section 8.08.

8.07 Establishment of DCE Account

The Employer will establish and maintain a DCE Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of Contributions and determining forfeitures under Section 8.08.

(a) **Crediting of Accounts**. A Participant's DCE Account will be credited periodically during each Period of Coverage with the Participant's Salary Reductions elected, as well as any Employer non-elective Contributions (if applicable), to be allocated to such Account as specified in Section 8.04.

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

(c) **Available Amount Is Based on Credited Amount**. As described in Section 8.04, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCE Account, less any prior reimbursements for Dependent Care Expenses incurred during the Plan Year (or during the Grace Period, if applicable)—i.e., it is based on the amount credited to the DCE Account at a particular point in time. Thus, a Participant's DCE Account may not have a negative balance.

8.08 Forfeiture of DCE Accounts; Use-It-or-Lose-It Rule

(a) **Use-It-or-Lose-It Rule.** Except as otherwise provided in Section 8.05, if any balance remains in the Participant's DCE Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) **Use of Forfeitures.** All forfeitures under this Plan shall be 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 the DCAP Component during the Plan Year or may be retained by the Employer to be used in the subsequent Plan Year (all such administrative costs shall be documented by the Employer); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted

or uniform fashion the Employer deems appropriate, consistent with applicable regulations. In addition, any DCE Account benefit payments that are unclaimed (e.g., uncashed benefit checks) shall be forfeited and applied as described above.

8.09 Reimbursement Claims Procedure for DCE Account

After receipt by PSA of a reimbursement claim from a Participant, PSA will reimburse the Participant for the Participant's Dependent Care Expenses or PSA will notify the Participant that his or her claim has been denied.

(a) **Claims Substantiation.** A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to PSA in such form as PSA may prescribe, by no later than the end of the Run-Out Period following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- the name of the person, organization, or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
- a Participant must provide a written statement from an independent third party verifying the Dependent Care Expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed under any other DCAP Component; and
- other such details about the expenses that may be requested by PSA in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant); and

PSA will issue a reimbursement to the Participant from the Participant's DCE Account for Dependent Care Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with this Section 8.09. Dependent Care Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses that were incurred before the Effective Date or before the date of the Participant's participation in the DCAP Component will not be reimbursed.

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

8.10 Reimbursements from DCE Account after Termination of Participation

A Participant's participation in the DCAP Component will end on the day on which he or she terminates employment or ceases to be an Eligible Employee, whichever occurs first during a

Plan Year, and no further Salary Reductions shall be made. A Participant who terminates employment or ceases to be an Eligible Employee during a Plan Year shall be entitled to reimbursement of Dependent Care Expenses from his or her DCE Account for expenses incurred through the end of that Plan Year. A Participant has through the end of the Run-Out Period following the end of the Plan Year to obtain reimbursement for Dependent Care Expenses incurred during the preceding Plan Year except as otherwise provided in Section 8.05. Any amounts still credited to the Participant's DCE Account after the Run-Out Period expires shall be forfeited and remain the assets of the Employer.

8.11 Report to DCAP Participants

On or before January 31 of each year, the Employer will report to Participants of the DCAP Component prior calendar year Salary Reductions. The Salary Reductions will be shown on the Participants W-2 form; in turn, the Employee should file a Form 2441 with his or her 1040 tax return to justify that the amounts reported on the W-2 are non-taxable.

ARTICLE IX. HIPAA Provisions for Health FSA

9.01 General

As a HIPAA Health Plan, the Health FSA Component shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

9.02 Definitions

For purposes of this Article, the following definitions shall apply:

(a) **"Breach"** shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan determines there is a low probability that the PHI has been compromised. A Breach does not include: (1) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement, and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) **"Breach Notification Rule"** means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(c) **"Electronic Protected Health Information"** or **"Electronic PHI"** means PHI that is transmitted by or maintained in electronic media.

(d) **"Health Care Operations"** is as defined under 45 CFR §160.501.

(e) **"HIPAA Health Plan,"** as defined under 45 CFR §160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR §160.103.

(f) **"Payment"** is as defined under 45 CFR §160.501, and means activities undertaken by a HIPAA Health Plan to obtain Contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(g) **"Privacy Policy"** means the Employer HIPAA Privacy Policy.

(h) **"Privacy Rule"** means the regulations issued under HIPAA set forth in subpart E of 45 CFR Part 164.

(i) **"Protected Health Information"** or **"PHI"** means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care to a

Participant, Spouse, or Dependent, or payment for such health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant, Spouse, or Dependent; and (3) is received or created by or on behalf of the Health FSA Component. PHI includes information of persons living or deceased.

(j) **"Responsible Employee"** means an Employee (including a contract, temporary, or leased Employee) of the Health FSA Component or of the Employer whose duties (1) require that the Employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the Employee will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 10.03. A Responsible Employee shall also include any other Employee (other than a designated Responsible Employee) who creates or receives PHI on behalf of a Health FSA Component, even though the Employee's duties do not (or are not expected to) include creating or receiving PHI. Responsible Employees are within the Employer's HIPAA firewall when they perform Health FSA Component functions.

(k) **"Security Incident,"** as defined under 45 CFR §164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(l) **"Security Rule"** means the regulations issued under HIPAA set forth in subpart C of 45 CFR Part 164.

9.03 Adequate Separation Between Plan and Employer

Only Responsible Employees of the Employer shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Health FSA Component. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health FSA Component administration functions that the Employer performs on behalf of the Health FSA Component pursuant to Section 10.04. The Employer shall allow the following persons access to Protected Health Information (PHI):

(a) Employer Employees who perform the following functions on behalf of the Health FSA Component are Responsible Employees: (1) claims determination and processing functions; (2) vendor relations functions; (3) benefits education and information functions; (4) administration activities; (5) legal department activities; (6) compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions.

(b) In addition to those individuals described in subsection (a), the Health FSA HIPAA privacy officer and security official, and Employer Employees to whom the Health FSA HIPAA privacy officer and security official have delegated are Responsible Employees.

The Employer shall have access to PHI from the Plan only as permitted under this Article or as otherwise required or permitted by HIPAA. The Responsible Employees (or classes of Employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that any of these specified Employees does not comply with the provisions of this section, that Employee shall 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.

9.04 Permitted Uses and Disclosures

Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the Health FSA Component, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health FSA's own Payment and Health Care Operations functions;

(b) uses and disclosures for another HIPAA Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;

(d) disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;

(e) disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g);

(f) disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;

(g) uses and disclosures to comply with workers' compensation laws;

(h) uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;

(i) disclosures to the Secretary of Health and Human Services to demonstrate the Health FSA Component's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;

(j) uses and disclosures for other governmental purposes, such as for national security purposes;

(k) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(l) uses and disclosures to identify a decedent or cause of death, or for tissue-donation purposes;

(m) uses and disclosures required by other applicable laws; and

(n) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508.

9.05 Prohibited Uses and Disclosures

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.

(a) **Genetic Information.** Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term underwriting purposes includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

(b) **Employment-Related Actions.** Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

(c) **Other Benefits.** Use or disclosure of Protected Health Information in connection with any other benefit or Employee benefit plan of the Employer, except as expressly permitted in Section 10.04, shall not be a permitted use or disclosure.

9.06 Certification Requirement

The Health FSA Component shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Health FSA Component agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Health FSA Component any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 10.04, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health FSA Component, available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA Component with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

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

(j) to take reasonable steps to ensure that there is adequate separation between the Health FSA Component and the Employer's activities in its role as Health FSA sponsor and Employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

9.07 Mitigation

In the event of noncompliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer Employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

9.08 Breach Notification

Following the discovery of a Breach of unsecured PHI, the Employer and/or PSA will promptly report any Breach or impermissible or improper use or disclosure of PHI not authorized by the HIPAA of which the Employer and/or PSA becomes aware. Unsecured PHI means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

ARTICLE X. Irrevocability of Elections; Exceptions

10.01 Irrevocability of Elections

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

(a) participation in this Plan;

(b) Salary Reduction amounts; or

(c) election of particular Benefit Package Options (including the various Health FSA Component options).

10.02 Procedure for Making New Election If Exception to Irrevocability Applies

(a) **Timeframe for Making New Election.** A Participant (or an Eligible Employee who, when first eligible under Section 3.01 or during the Open Enrollment Period under Section 4.02, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 11.03 (or within 60 days of the occurrence of an event described in Section 11.03(e)(3) or (4)), as applicable, but only if the election under the new enrollment materials are made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing Student status) that results in a beneficiary becoming ineligible for coverage under the Group Sponsored Insurance shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) **Effective Date of New Election.** Elections made pursuant to this Section 11.02 shall 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 Section 11.03(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change request was filed, but, as determined by the Employer, election changes may become effective later to the extent that any replacement coverage commences later).

(c) **Effect of New Election Upon Amount of Benefits.** For the effect of a changed election upon the maximum and minimum benefits under the Health FSA Component and DCAP Component, see Section 7.04, Section 8.04, and Section 9.04 respectively.

10.03 Events Permitting Exception to Irrevocability Rule for All Components

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

(a) **Open Enrollment Period (Applies to all Components of this Plan).** A Participant may change an election during the Open Enrollment Period in accordance with Section 4.02.

(b) **Termination of Employment (Applies to all Components of this Plan).** A Participant's election will terminate under the Plan upon termination of employment in accordance with Section 3.02 and Section 3.03, as applicable.

(c) **Leaves of Absence (Applies to all Components of this Plan).** A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.04 and upon non-FMLA leave in accordance with Section 3.05.

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

As specified in Section V Administrative Provisions – Election Changes, of the Summary Plan Description, election changes may or may not be made to the Health FSA coverage during a Period of Coverage due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such a change 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 Employer, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) **Loss of Spouse or Dependent Eligibility; 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 or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a Participant under this Plan in accordance with Section 3.02), then the Participant may increase his or her election to pay for such coverage.

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

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

(e) **HIPAA Special Enrollment Rights (Applies Only to Premium Payment Component for the Medical Insurance Plan).** If a Participant or his or her 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 (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such 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;

(2) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption;

(3) the Participant’s or Dependent’s coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

(4) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment

attributable to the 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 Section 11.03(e)(1), 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 an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) **Certain Judgments, Decrees, and Orders (Applies to Premium Payment Component, Health FSA Component, but Not to DCAP Component).** 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 for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan, and such coverage is actually provided.

(g) **Medicare and Medicaid (Applies to Premium Payment Component, Health FSA Component as Limited Below, but Not to DCAP Component).** If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or, as specified in Section V Administrative Provisions – Election Changes, of the Summary Plan Description, may or may not change the Participant's coverage. Notwithstanding the foregoing, such a change will not become effective to the extent that it would reduce future Contributions to the Health FSA Component 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, as specified in Section V Administrative Provisions – Election Changes, of the Summary Plan Description, may or may not change the Participant's coverage.

(h) **Change in Cost (Applies to Premium Payment Component and DCAP Component as Limited Below, but Not to Health FSA Component).** For purposes of this Section 11.03(h), similar coverage means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of

this definition, (1) a Health FSA is not similar coverage with respect to an accident or health plan that is not a Health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another Employer, such as a Spouse's or Dependent's Employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) **Increase or Decrease for Insignificant Cost Changes.** Participants are required to increase their elective Contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective Contributions to reflect insignificant decreases in their required contribution. The Employer, 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 Employer, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected Employees' elective Contributions on a prospective basis.

(2) **Significant Cost Increases.** If the Employer determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective Contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA Component); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Employer, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) **Significant Cost Decreases.** If the Employer determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Employer may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective Contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA Component) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.01 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 Employer, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) **Limitation on Change in Cost Provisions for DCAP Component.** The above Change in Cost provisions (Sections 11.03(h)(1) through 11.03(h)(3)) apply to the DCAP Component only if the cost change is imposed by a dependent care provider who is not a relative of the Employee. For this purpose, a relative is an

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

(i) Change in Coverage (Applies to Premium Payment Component and DCAP Component, but Not to Health FSA Component).

The definition of similar coverage under Section 11.03(h) applies also to this Section 11.03(i).

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

(a) **Significant Curtailment Without Loss of Coverage.** If the Employer 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 under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA Component). 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.

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

(c) **Definition of Loss of Coverage.** For purposes of this Section 11.03(i)(1), a Loss of Coverage means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation).

In addition, the Employer, 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 for the Medical Insurance Plan or in an HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(d) **DCAP Coverage Changes.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

(2) **Addition or Significant Improvement of a Benefit Package Option.** If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Employer may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.01 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 Employer, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

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

(4) **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an Employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's Employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its Participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the Plan Year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her Employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Employer, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other Employer plan, in accordance with prevailing IRS guidance.

(j) **Reduction of Hours (Applies Only to Premium Payment Component for the Medical Insurance Plan).** A Participant who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Medical Insurance Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the Medical Insurance Plan coverage is revoked.

(k) **Exchange Enrollment (Applies Only to Premium Payment Component for the Medical Insurance Plan).** A Participant who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual Open Enrollment Period may prospectively revoke his or her election for Medical Insurance Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Medical Insurance Plan coverage.

A Participant entitled to change an election as described in this Section 11.03 must do so in accordance with the procedures described in Section 11.02.

10.04 Election Modifications Required by the Employer

The Employer 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 Employer determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that Contributions need to be reduced for a class of Participants, the Employer 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.

ARTICLE XI. Appeals Procedure

11.01 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement or benefit under this Plan is wholly or partially denied, such claim shall be administered in accordance with the procedure set forth below and in the Summary Plan Description of this Plan. The Appeals Committee, separate and distinct from the individual(s) that adjudicate the claims, shall act on behalf of the Employer with respect to appeals. An external review process shall be provided as legally required and as further set forth below.

If PSA denies a claim, in whole or in part, the Employee will be notified in writing within 30 days of the date PSA receives the claim. The 30-day period may be extended for an additional 15 days for matters beyond PSA's control, such as situations where a claim is incomplete. PSA will provide written notice of any extension, describing the reasons for the extension and the date by which he or she can expect a decision. Where a claim is incomplete, the extension notice will describe the information still needed by PSA and allow 45 days from receipt of the notice to provide the additional information. If this happens, it will have the effect of suspending any decision on the claim until the specified information is provided.

If PSA denies a claim, the Employee will receive a notice that includes the following elements:

- The specific reason or reasons for the denial;
- The specific Plan provision or provisions that support the denial;
- A description of any items or information the Employee would need to validate the claim and an explanation of why the added material is necessary; and
- A description of the steps to appeal the denial, including the Employee's right to submit written comments, his or her right to review (upon request and at no charge) relevant documents and other information, and the Employee's right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of the claim.

11.02 Appeals

The Employee may appeal a claim denial by submitting a Request for Review (or other written appeal request) to PSA within 180 days of the date of notice of the claim denial. If the Employee 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 written appeal should state the reasons that he or she feels the claim should not have been denied, and should include any additional items or information that he or she feels supports the claim. The appeal process will provide the Employee with the opportunity to ask additional questions and make written comments, and he or she may review (upon request and at no charge) documents and other information relevant to the appeal. Requests should be submitted to PacificSource Administrators, Attn: Request for Review, PO Box 2797, Portland, OR 97208.

To the extent a dispute arises under the terms of one of the insurance plans, such as a group medical or dental insurance plan offered by the Employer, the ability to appeal decisions under the insurance plan will be outlined in the Summary Plan Description or similar explanatory booklet available from the insurer.

11.03 Decision on Review

PSA will review the Employee's appeal in a reasonable time, but within 60 days after receiving the request. PSA may, in its discretion, hold a hearing on the denied claim. If PSA consults with a medical expert to help analyze the appeal, the expert will be different from, and not subordinate to, any expert that was consulted in connection with the initial claim denial. If upon review a decision is reached to affirm the original denial of the claim, the Employee will receive a notice of that determination, which will include the following elements:

(a) The specific reason or reasons for the decision on review;

(b) The specific Plan provision or provisions that motivated the decision;

(c) A statement of the Employee's right to review (upon request and at no charge) relevant documents and other information;

(d) If internal rules, guidelines, protocols, or other similar criteria (collectively referred to as internal guidelines) are relied on in making the decision on review, a description of the specific internal guidelines, or a statement that such internal guidelines were relied on, and a copy of the internal guidelines will be provided free of charge to the Employee upon request; and

(e) A statement of the Employee's right to bring suit under ERISA Section 502(a) (where applicable).

ARTICLE XII. Recordkeeping and Administration

12.01 Plan Administrator (The Employer)

The administration of this Plan shall be under the supervision of the Employer. It is the principal duty of the Employer 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.

12.02 Powers of the Plan Administrator

The Employer will have full power to administer the Plan in all of its details, subject to applicable requirements of law. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Employer with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Employer shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the materials to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Employer determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Employer shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Employer determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Employer deems necessary or appropriate to comply with governmental laws and regulations to the maintenance of records, notifications to Participants, filing with the Internal Revenue Service and U.S. Department of Labor, and all other such requirements applicable to the Plan;

(g) to appoint or employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

12.03 Reliance on Participant, Tables, etc.

The Employer may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Employer 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 Employer.

12.04 Delegation

The Employer shall have the right to delegate a Third Party Administrator ("TPA") to carry out any and/or all of its responsibilities for control and management of the operation and administration of the Plan. The Employer has designated PacificSource Administrators ("PSA") to act as the Third Party Administrator. PSA may resign at any time or may be removed or replaced by the Employer at any time. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

12.05 Indemnification of the Third Party Administrator and Plan Administrator

PSA shall be indemnified by the Employer against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim relating thereto.

12.06 Fiduciary Liability

The Employer is the named fiduciary for the Plan for purposes of ERISA Section 402(a). To the extent permitted by law, the Employer shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

12.07 Bonding

The Employer shall be bonded to the extent required by ERISA.

12.08 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) 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 shall not be assets of the Plan but shall 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.

12.09 Notification to Employees

The Employer shall provide reasonable notification to Employees of the availability and terms of the Plan in time for Participants to make an election on a timely basis. The Employer will make available to each Participant such of its records under the Plan as pertain to such Participant, for examination at reasonable times during normal business hours.

12.10 Exclusive Benefit and Uniformity

It shall be a principal duty of the Employer 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. In operating and administering the Plan, the Employer shall apply all rules of procedure and decisions uniformly and consistently, in a nondiscriminatory manner, so that all persons similarly situated will receive substantially the same treatment.

12.11 Third Party Administrator Reliance on Others

PSA may rely upon any direction, information or action of a Participant under the Plan, and is not required under the Plan to inquire into the propriety of any such direction, information or action. PSA shall be responsible only for the proper exercise of the powers, duties; responsibilities and obligations granted it under the Plan and shall not be responsible for any act or failure to act of the Employer or any Employee of the Employer. When adjudicating a claim, PSA shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.

12.12 Required Information to be Furnished

Each Participant and beneficiary will furnish to the Employer such information as the Employer considers necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Participant or beneficiary of such true, full and complete information as the Employer may request. Any communication, statement or notice to a Participant and beneficiary addressed to the last post office address filed with the Employer, or if no such address was filed with the Employer, then to the last post office address of the Participant or beneficiary as shown on the Employer's records, will be binding on the Participant or beneficiary for all purposes of this Plan and neither the Employer or PSA shall be obliged to search for or ascertain the whereabouts of any Participant or beneficiary.

12.13 Inability to Locate Payee

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

12.14 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 Employer or PSA shall, to the extent that it deems

administratively possible and otherwise permissible under Code §125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Employer may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XIII. General Provisions

13.01 Expenses

All reasonable expenses incurred in administering the Plan shall be paid by the Employer or the Participant, and any expenses not paid by the Employer or the Participant shall not be the responsibility of PSA.

13.02 No Contract of Employment

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

13.03 Amendment and Termination

The Employer has established the Plan with the intention and expectation that it will be continued, but the Employer will have no obligation to maintain the Plan, and the Employer may terminate all or any part of this Plan at any time hereafter without liability. Upon termination of the Plan, all elections and reductions in compensation relating to the Plan shall terminate, and reimbursements shall be made as if all Employees had terminated employment. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business.

13.04 Governing Law

This Plan shall be construed, administered, and enforced in accordance with the law of the State where the Employer is headquartered, to the extent not superseded by the Code, ERISA, or any other federal law.

13.05 Compliance With Code, ERISA, and Other Applicable Laws

It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all regulations issued thereunder. ERISA applies to the Group Sponsored Insurance, the Health FSA Component but not to the DCAP Component. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

Church or governmental organizations (such as a city or school district) are not subject to ERISA.

13.06 No Guarantee of Tax Consequences

The Employer makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for

federal, state, and local income tax purposes and to notify the Employer if the Participant has any reason to believe that such payment is not so excludable.

If a Participant receives a reimbursement and it is later determined that the payment was made in error (e.g., reimbursement for an expense that is later paid by an insurance plan), the Participant will be required to refund the improper payment to the Plan. If the refund is not received for the improper payment, the Plan reserves the right to offset future reimbursement equal to the improper payment or, if that is not feasible, to withhold such funds from his or her pay. If all other attempts to recoup the improper payment are unsuccessful, the Employer may treat the overpayment as a bad debt, which may have income tax consequences to the Participant.

13.07 Indemnification of Employer

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

13.08 Non-Assignability of Rights

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

13.09 Limitation of Rights

Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Employee or other person any legal or equitable right against PSA or the Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Employee be modified or in any way be affected hereby.

13.10 Headings

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

13.11 Plan Provisions Controlling

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

13.12 Severability

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

13.13 Use of Forfeitures

All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements 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 Plan during the Plan Year or may be used by the Employer to be used in the subsequent Plan Year (all such administrative costs shall be documented by the Employer); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Employer deems appropriate, consistent with applicable regulations.

13.14 Substantiation

Every expense incurred by an Employee under a qualified benefit during the Plan Year (and Grace Period) is subject to the substantiation rules in accordance with Section 125.

* * *

This document is executed on this _____ day of _____, _____.

Multnomah County

By: _____

Title: _____

Appendix A

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

The Multnomah County Plan Document contains the general rules governing what expenses are reimbursable. This Appendix A, as referenced in the Plan Document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA Component—that is, expenses that are *not reimbursable*, even if they meet the definition of medical care under Code §213(d) and may otherwise be reimbursable under the regulations governing Health FSAs.

Terms and conditions of coverage and benefits under the LSFSA Option and LFSA Option (including eligible expenses and exclusions) will be described in Section 7.03(d) and Section 7.03(e) of the Plan Document.

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

- Premiums for other health coverage, including but not limited to premiums for any other plan (whether or not sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. Cosmetic surgery means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, 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 due to the rules in Prop. Treas. Reg. §1.125-5(k)(4) or other applicable law or regulations.