

Reset Form

SACRAMENTO

Office of the City Clerk

Requires Council Approval:  N  Y

Council Meeting Date: 05/08/2018

Labor/Union

Other Party Signature Needed

Recording Requested

General Information

Contract Type: NA

PO Type: NA

\$ Not to Exceed: 00

Other Party: City of Sacramento

Project Name: Section 125 Cafeteria Plan

Project Number:

Bid Transaction #: Reso 2018-0163

Attachment #:

Original Doc #:

Certified Copies of Document:

Deed:

Tax ID # (if applicable):

Preferences:

LBE  SBE  DBE  MWBE

Department Information

Department: Human Resources

Project Manager: Samantha Wallace

Contract Services: Katherine Robbins

Phone Number: (916) 808-1562

Comment:

Division: Safety-Risk

Supervisor: Shelley Banks Robinson

HR Manager: Samantha Wallace

Org Number: 08001021

Review and Signature Routing

Department

Project Manager:

HR Manager:

Contract Services:

Accounting:

Division Manager:

Signature or Initial

Date

*[Signature]* 5/23/18

*[Signature]* 5/23/18

City Attorney

City Attorney:

Signature or Initial

Date

*[Signature]* 5/24/18

Name and Phone Ext:

Send Interoffice Mail

Notify for Pick Up Katherine 1562

Authorization

HR Director:

Signature or Initial

Date

*[Signature]* 5-24-18

City Manager: Y  N

Contract Cover/Routing Form: Must Accompany ALL Contracts; however, it is not part of the contract

For City Clerk Processing

Finalized:

Initial:

*me*

Date:

6-5-18

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Date:

*6/5/2018*

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(City Clerk Stamp Here)



2018-0756

With: City of Sacramento  
Title: Saction 125 Cafeteria Plan

RECEIVED  
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CITY OF SACRAMENTO  
MAY 24 2018

**RESOLUTION NO. 2018-0163**

Adopted by the Sacramento City Council

May 8, 2018

**Resolution Restating the Cafeteria Plan Document of the City of Sacramento**

**BACKGROUND**

- A. The City offers employees benefits on a pre-tax basis.
- B. An employer's benefit plan that offers benefits on a pre-tax basis is referred to as a "Section 125 Plan" or "Cafeteria Plan."
- C. Section 125 of the Internal Revenue Code requires an employer who offers pre-tax benefits to have an approved written Cafeteria Plan document that describes all benefits and establishes rules for eligibility and elections.
- D. The City needs to restate its Cafeteria Plan document to reflect current pre-tax benefit options.

**BASED ON THE FACTS SET FORTH IN THE BACKGROUND, THE CITY COUNCIL RESOLVES AS FOLLOWS:**

Section 1. The City of Sacramento Cafeteria Plan attached as Exhibit A is adopted.

Section 2. The City Manager or the City Manager's designee is authorized to execute the Cafeteria Plan document.

**Table of Contents:**

Exhibit A – Cafeteria Plan



**2018-0756**

With: City of Sacramento  
Title: Section 125 Cafeteria Plan

Adopted by the City of Sacramento City Council on May 8, 2018, by the following vote:


Ayes: Members Ashby, Carr, Guerra, Hansen, Harris, Jennings, Schenirer, Warren and Mayor Steinberg

Noes: None

Abstain: None

Absent: None

Attest:

 e-Signed by Mindy Cuppy  
on 2018-05-18 16:36:31 GMT

City Clerk

May 18, 2018

*The presence of an electronic signature certifies that the foregoing is a true and correct copy as approved by the Sacramento City Council.*

**CITY OF SACRAMENTO  
CAFETERIA PLAN**

**CITY OF SACRAMENTO  
CAFETERIA PLAN**

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**CITY OF SACRAMENTO**  
**CAFETERIA PLAN**

City Of Sacramento (Employer) hereby adopts the City Of Sacramento Cafeteria Plan (Plan) on the date set forth on the signature page hereof, for the exclusive benefit of its eligible employees and their families.

**RECITALS**

Whereas:

- A. The Employer has provided various employee welfare benefits to its eligible employees pursuant to the provisions of the Internal Revenue Code of 1986, as amended (Code).
- B. The Employer previously adopted a cafeteria plan under Code section 125 in order to allow its eligible employees to pay for their share of the costs for such benefits on a pre-tax basis.
- C. The Employer has determined that it is appropriate to amend and restate the Plan.

**OPERATIVE PROVISIONS**

Now, therefore, the Employer hereby amends and restates the Plan upon the following terms and conditions:

**ARTICLE 1. GENERAL**

1.01. **Plan Name.**

The name of this Plan is the "City Of Sacramento Cafeteria Plan."

1.02. **Effective Date.**

Except as otherwise indicated, the effective date of this amended and restated Plan is January 1, 2018.

1.03. **Exclusive Benefit.**

It is the intention of the Employer that the Plan is created and maintained for the exclusive benefit of the Employer's eligible Employees and their Beneficiaries.

1.04 Income Tax Status.

- A. This Plan is intended to qualify as a "cafeteria plan" within the meaning of Code section 125(d). It is the intention of the Employer that the benefits provided under this Plan shall be eligible for exclusion from the gross incomes of the Employees and their Beneficiaries to the extent permitted by the Code.
- B. There is no assurance that the intended tax benefits under this Plan will be available. None of the Employers, nor the Administrator, nor its designated representative makes any commitment or guarantee that any amounts elected or paid for the benefit of a Participant will be excludable from the Participant's gross income for federal or State income tax purposes, or that any other federal or State tax treatment will apply to, or be available to, any Participant. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and State income tax purposes, and to notify the Participant's Employer if the Participant has reason to believe that any such payment is not so excludable. Each Participant, by accepting a benefit under this Plan, agrees to be liable for any taxes, tax penalties and interest that may be imposed by the Internal Revenue Service, or any other governmental agency, with respect to these benefits.

1.05. Administrator And Named Fiduciary.

The person(s), individual(s) or committee appointed by the Employer shall be the Administrator of the Plan. The Administrator may engage the services of one or more third parties to assist the Administrator with the administration of the Plan.

1.06. Defined Terms.

All initially capitalized terms (other than headings) are defined terms and will be defined in the General Definitions article or in the applicable Contract(s). If a particular word or phrase is not defined in the General Definitions article or in an applicable Contract, then such words and phrases shall have the meaning customarily given them by the Administrator, the insurer or other service provider under the Contract. In the case of a conflict between the provisions of the General Definitions article and definitions in a Contract, the General Definitions article of the Plan shall control unless otherwise specified. The definitions in the General Definitions article shall be interpreted as consistent with the applicable Contract to the extent possible.

## ARTICLE 2. GENERAL DEFINITIONS

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

### 2.01. Administrator.

"Administrator" means the person(s), individual(s) or committee appointed by the Employer from time to time with authority and responsibility to manage and direct the operation and administration of the Plan. If the Employer does not appoint an Administrator, the Employer shall be the Administrator.

### 2.02. Beneficiary.

- A. "Beneficiary" means any one or more person(s) entitled under the provisions of this Plan, including the terms of a Contract, to receive benefits payable under any benefit plan included in this Plan in accordance with procedures established by the Employer, the Administrator, or the insurer or other service provider under the applicable Contract pursuant to the terms of the Plan or the Contract.
- B. "Beneficiary" shall include the lawful spouse of a Participant but shall not include, if excluded under a Contract, (i) an individual legally separated from the Participant under a decree of legal separation or (ii) an individual who is on active duty with the Armed Forces, for purposes of such Contract. Whether an individual is the lawful spouse of a Participant shall be determined based upon whether the individual and the Participant were lawfully married in the State where the marriage was entered into regardless of the married couple's place of domicile (unless, for purposes of determining who is a lawful spouse under a Contract, the Contract provides otherwise).
- C. "Beneficiary" shall include a Participant's domestic partner (i.e., one of two adults who is in a registered domestic partnership pursuant to section 297 of the California Family Code) for purposes of a Contract if required under the Contract.
- D. "Beneficiary" shall include a Participant's dependents as defined in Code section 152 (as modified by Code section 105(b) for purposes of benefits governed by Code section 105) or in a Contract; provided, however, that such an individual shall not be eligible for benefits under a Contract unless the Contract extends coverage to such an individual.

- E. "Beneficiary" also includes any child (as defined in Code section 152(f)(1)) of the Participant who has not attained age twenty-six (26); provided, however, that such a child shall not be eligible for benefits under a Contract unless the Contract extends coverage to such a child.

2.03. COBRA.

"COBRA" means the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as it may be amended from time to time, and the regulations issued thereunder.

2.04. Code.

"Code" means the Internal Revenue Code of 1986, as it may be amended from time to time.

2.05. Compensation.

"Compensation" means:

- A. For purposes of any Code section 505(b) nondiscrimination test which any benefit plan must pass in order to avoid adverse tax consequences for any Employee because such benefit is funded through a trust that is exempt from tax pursuant to Code section 501(c)(9), other than such a trust that is exempt from Code section 505(b) pursuant to Code section 505(a)(2) because the trust is part of a plan maintained pursuant to the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code section 7701(a)(46)) and the Employer under the plan was the subject of good faith bargaining, "Compensation" means the Employee's Code section 414(s) compensation from the Employer, which amount shall be limited each Plan Year, except for purposes of Code section 79, to the applicable dollar amount set forth in Code section 401(a)(17) as such amount may be adjusted by the Commissioner of Internal Revenue for increases in the cost of living in accordance with Code section 401(a)(17)(B) (e.g., two hundred seventy thousand dollars (\$270,000) for 2017).
- B. For all other purposes "Compensation" means the Employee's compensation or earnings as described or defined in any applicable benefit plan or Contract.

2.06. Compensation Reduction Benefits.

"Compensation Reduction Benefits" means those compensation reduction benefits available to the Participant under the Plan.

2.07. Contract.

"Contract" or "Contracts" means any insurance contract, HMO contract, health care service plan document or other service provider agreement, and any other document through which the Employer provides benefits for which an Employee's share of the costs are payable under this Plan as set forth on Exhibit A attached to this Plan, as such may be in effect from time to time.

2.08. Dependent.

"Dependent" means:

- A. With respect to the Irrevocability Of Elections section (other than its application with respect to the benefit provided under the Dependent Care Assistance Benefit article) and the benefit provided under the Medical Expense Reimbursement Benefit article, a "dependent," as defined in Code section 152 as modified by Code sections 105 and 106 and the Treasury regulations promulgated thereunder, and any child (as defined in Code section 152(f)(1)) of the Participant who as of the end of the Participant's taxable year has not attained age twenty-seven (27); or
- B. With respect to the Irrevocability Of Elections section (limited to its application with respect to the benefit provided under the Dependent Care Assistance Benefit article) and the benefit provided under the Dependent Care Assistance Benefit article, any individual who is a "qualifying individual," as defined in Code section 21(b)(1).

2.09. Elective Contributions.

"Elective Contributions" means the amount by which a Participant has elected to reduce his or her wages for a Plan Year, to use such amounts to purchase any of the benefits provided under this Plan on a pre-tax basis (or on an after-tax basis for federal tax purposes, State tax purposes, or both federal and State tax purposes, to the extent that the benefits cannot be purchased under the applicable tax law(s) on a pre-tax basis).

2.10. Employee.

"Employee" means an individual who is employed by the Employer as a common law employee of the Employer.

2.11. Employer.

"Employer" means the Employer adopting this Plan, any predecessor employer and any successor assuming the Plan.

2.12. ERISA.

"ERISA" means the Employee Retirement Income Security Act of 1974, as it may be amended from time to time.

2.13. Highly Compensated Employee.

A. Highly Compensated Employee In General.

"Highly Compensated Employee" means any Employee who for the preceding Plan Year, had total Code section 415 compensation from the Employer in excess of the applicable dollar amount set forth in Code section 414(q)(1)(b) as such amount may be adjusted by the Commissioner of Internal Revenue for increases in the cost of living in accordance with Code section 415(b) (e.g., one hundred twenty thousand dollars (\$120,000) for 2017).

B. Top-Paid Group Election.

1. If the Employer has made the top-paid group election under Code section 414(q)(1)(B)(ii), as indicated below, an Employee will be considered a Highly Compensated Employee based on the Employee's Code section 415 compensation only if the Employee was in the group of Employees, for the preceding Plan Year, consisting of the top twenty percent (20%) of all Employees when ranked on the basis of total Code section 415 compensation; excluding only for purposes of determining the number of Employees in the top twenty percent (20%) group, the following Employees:

a. Unless the Employer otherwise elects pursuant to Treasury regulations promulgated under Code section 414(q), Employees who either (i) have not completed six (6) months of service by the end of

the year including service from the immediately preceding year, (ii) normally work less than seventeen and one-half (17-1/2) hours per week, (iii) normally work during not more than six (6) months during any year, or (iv) have not attained age twenty-one (21) by the end of the year;

- b. Employees who are nonresident aliens described in Code section 414(q)(11); and
  - c. Employees who are covered under a collective bargaining agreement or agreements that the Secretary of Labor finds to be collective bargaining agreements between employee representatives and the Employer, which agreements satisfy Code section 7701(a)(46) and Temporary Treasury regulations section 301.7701-17T, but only if ninety percent (90%) or more of the Employees of the Employer are covered by such agreements and this Plan covers only Employees who are not so covered.
2. For purposes of determining Highly Compensated Employees under the Plan:
- a. If the Employer has made the top-paid group election for the Employer's Code section 401(a) qualified retirement plan(s), then the Employer will be treated as having made the top-paid group election under this Plan.
  - b. If the Employer has not made the top-paid group election for the Employer's Code section 401(a) qualified retirement plan(s), then the Employer will be treated as not having made the top-paid group election under this Plan.
  - c. If the Employer does not maintain any Code section 401(a) qualified retirement plan, then the Employer will be treated as having made the top-paid group election under this Plan.

2.14. Highly Compensated Individual.

- A. For purposes of any self-insured medical reimbursement plan, as defined in Code section 105(h), provided under this Plan, if any, "Highly Compensated Individual" means any individual who is:
1. One (1) of the five (5) highest paid officers of the Employer; or
  2. Among the highest paid twenty-five percent (25%) of all Employees (other than those who are not eligible to participate in the Plan).
- B. For all other purposes, "Highly Compensated Individual" means any individual who:
1. For the preceding Plan Year (or for the current Plan Year in the case of the first year of employment with the Employer) was an officer of the Employer;
  2. For the preceding Plan Year (or for the current Plan Year in the case of the first year of employment with the Employer) had compensation in excess of the amount set forth in the Highly Compensated Employee section, above, and, if the Employer made the top-paid group election as set forth in the Highly Compensated Employee section, above, was in the top-paid group as determined in the Highly Compensated Employee section, above; or
  3. Is a spouse or dependent of any of the preceding individuals.

2.15. Highly Compensated Participant.

"Highly Compensated Participant" means a Participant who is a Highly Compensated Individual.

2.16. HIPAA.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time, and the regulations issued thereunder.



2.17. Participant.

"Participant" means any Employee or former Employee who has met the Plan's eligibility requirements, commenced participation in the Plan, and is or may become eligible to receive a benefit under the Plan, or whose Beneficiaries may be eligible to receive any such benefit.

2.18. PHSA.

"PHSA" means the Public Health Service Act as it may be amended from time to time.

2.19. Plan.

"Plan" means the cafeteria plan as set forth herein and any amendments hereto.

2.20. Plan Year.

"Plan Year" means the twelve (12) consecutive month period ending on the last day of December each year.

2.21. Total Compensation.

"Total Compensation" means wages as defined in Code section 3401(a) and all other payments of compensation paid to an Employee by the Employer (in the course of or the Employer's trade or business) for which the Employer is required to furnish the Employee a written statement under Code sections 6041(d), 6051(a)(3) and 6052. "Total Compensation" is determined without regard to any rules under Code section 3401(a) that would otherwise limit the remuneration included in wages based on the nature or location of the employment or the services performed. However, "Total Compensation" shall not include amounts paid or reimbursed by the Employer for moving expenses incurred by the Employee to the extent that at the time of payment it is reasonable to believe that these amounts are deductible by the Employee under Code section 217. "Total Compensation" shall include elective deferrals as defined in Code section 402(g)(3) and any amount that is not includible in an Employee's gross income by reason of Code section 125, Code section 457, or Code section 132(f)(4).

## ARTICLE 3. ELIGIBILITY AND PARTICIPATION

### 3.01. Eligible Employees; Excluded Employees.

Only Employees may participate in the Plan. All Employees of each Employer that has adopted this Plan, who are not otherwise excluded from participation in the Plan, are eligible to participate in the Plan after completion of the eligibility requirements set forth in the Eligibility Requirements section, below. This Plan excludes the following Employees (even if they might otherwise satisfy the eligibility criteria specified in the Plan):

- A. Each Employee whose employment is not governed by the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code section 7701(a)(46)) and the Employer except to the extent provided in the employment agreement between the Employee and the Employer regardless of how the employment agreement is memorialized (e.g., an individual employment agreement, the Employer's Employee handbook, or the Employer's policy and procedure manuals) and only to the extent such participation is not inconsistent with the requirements of the Code;
- B. Employees whose employment is governed by the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code section 7701(a)(46)) and the Employer under which employee welfare benefits were the subject of good faith bargaining, unless the collective bargaining agreement specifically requires participation in the Plan, but only to the extent provided for in the collective bargaining agreement and only to the extent such participation is not inconsistent with the requirements of the Code; and
- C. A worker whom the Employer did not treat as an Employee even if either (i) the individual might otherwise satisfy certain legal tests or criteria to be considered a common law employee of the Employer or (ii) the individual is subsequently determined to be a common law employee of the Employer by a local State or federal governmental entity or by a court of competent jurisdiction.

### 3.02. Eligibility Requirements.

#### A. Insured Benefits.

Each Employee who is eligible to participate in any of the insured benefit plans provided by the Employer under the Plan and who is

not otherwise excluded shall become a Participant in the Plan with respect to insured benefits based upon the eligibility rules as described in detail in the Contract(s).

B. Uninsured Benefits.

Each Employee who is eligible to participate in any of the uninsured benefit plans provided by the Employer under the Plan through a Contract, if any, and who is not otherwise excluded shall become a Participant in the Plan with respect to uninsured benefits based upon the eligibility rules as described in detail in the Contract(s).

C. Eligibility Requirements In General.

If a Contract does not contain its own eligibility and participation requirements or if any benefits under the Plan are not governed by a Contract, each Employee who is not otherwise excluded shall become a Participant in the Plan with respect to such benefit(s) upon the completion of the period of employment as set forth in either (i) the employment agreement between the Employee and the Employer with respect to each Employee whose employment is not governed by the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code section 7701(a)(46)) and the Employer or (ii) the terms of the collective bargaining agreement between Employee representatives (within the meaning of Code section 7701(a)(46)) and the Employer with respect to each Employee whose employment is governed by such collective bargaining agreement.

3.03. Commencement Of Participation.

Each Employee who is not otherwise excluded from participation in the Plan shall become a Participant in this Plan on the first day of the month coinciding with or following (i) the Employee's becoming an eligible Employee as set forth in the Eligibility Requirements section, above, and (ii) the Employee's proper completion and submittal of the applications and agreements required under the Application For Participation section, below, if any. Family members of eligible Employees may participate in the Plan only as set forth in the Plan or the applicable Contract(s).

3.04. Participation.

The Administrator, using employment dates certified by the Employer, shall determine which Employees are eligible to participate. The

Administrator shall notify each Employee of the Employee's eligibility and of any application or other requirements for participation. By becoming a Participant, the Employee agrees to be bound by all terms, conditions and covenants of this Plan as then in effect or as thereafter amended.

3.05. Application For Participation.

- A. To become a Participant, an eligible Employee shall (i) complete any application or agreements as may be required by the Employer, the Administrator, or the insurer or other service provider, (ii) specify his or her election of Compensation Reduction Benefits, and (iii) submit such properly completed applications and agreements to the Employer, the Administrator, or the insurer or other service provider, on or before the deadline as established by the Employer, the Administrator, or the insurer or other service provider.
- B. If an eligible Employee fails to submit such properly completed applications and agreements to the Employer, the Administrator, or the insurer or other service provider within such deadline, such eligible Employee shall participate in the Plan during that Plan Year in accordance with the default selections, if any, in effect for that Plan Year.
- C. During the open enrollment period of each Plan Year, in accordance with the rules established by the Administrator, each eligible Employee who is not a Participant in the Plan shall be given the opportunity to apply for participation in the Plan during the next Plan Year, all as provided in the Election Procedures and Failure To Elect sections, below.

3.06. Automatic Enrollment.

Notwithstanding the Plan's other enrollment provisions, in accordance with, but only to the extent required by, the Patient Protection and Affordable Care Act, any subsequent legislation, and the lawful guidance published thereunder, the Employer shall automatically enroll new full-time eligible Employees in one of the group health plans offered (subject to any waiting periods) and continue the enrollment of current Participants in a group health plan. The Employer or the Administrator shall also provide adequate notice to the Employees of such automatic enrollment and the opportunity for an Employee to opt out of any coverage in which the Employee was automatically enrolled.

3.07. Leaves Of Absence.

Except to the extent otherwise provided in a Contract or elsewhere in this Plan:

- A. An Employee who is granted a leave of absence by the Employer and who is otherwise eligible to participate in the Plan shall participate in the Plan in the same manner as an active eligible Employee if, and so long as, the Employer continues to pay compensation to such Employee.
- B. If the Employer does not continue to pay compensation to an Employee who is on a leave of absence, and the Employee does not continue paying to the Employer the amounts necessary to provide for the Compensation Reduction Benefits that the Employee had elected, then:
  - 1. The Employee shall continue to receive any insured benefit applicable to the Employee under the Plan until the end of the month for which the Employee's insurance premiums have been paid;
  - 2. The Employee shall continue to receive the medical expense reimbursement benefit under the Medical Expense Reimbursement Benefit article, below, if elected by the Employee, until the earlier of (i) the end of the month for which the Employee's cost for such benefit has been paid or (ii) such Employee's benefits under the Medical Expense Reimbursement Benefit article are exhausted; and
  - 3. The Employee shall continue to receive the dependent care assistance program benefit under the Dependent Care Assistance Benefit article, below, if elected by the Employee, until the earlier of (i) the end of the Plan Year in which such leave begins or (ii) such Employee's benefits under the Dependent Care Assistance Benefit article are exhausted.

3.08. Family Leaves.

If the requirements of the Family and Medical Leave Act of 1993, as amended (FMLA), or if the requirements of applicable State law (e.g., the California Family Rights Act), are applicable to the Employer, the Employer shall provide, with respect to those group health plans that are subject to the provisions of the FMLA or such State law, the notices

required under the FMLA or such State law, as applicable, and the Employer shall continue to provide coverage under those group health plans that are subject to the provisions of the FMLA or such State law, as applicable, for a Participant who is entitled to leave under the FMLA or such State law, as applicable, during such leave, all as required by and to the extent permitted under the FMLA or such State law, as applicable. In addition, an Employee who is on such leave and who desires to continue during such leave any life insurance, disability insurance, or other benefit under a plan that is subject to this Plan, for which he or she pays the premiums, may do so pursuant to the Employer's established policies and practices for continuing such benefits for other instances of leave without pay.

3.09. Military Leaves.

Each group health plan that is subject to this Plan shall provide that an Employee, who is absent from the Employee's position of employment by reason of service in the uniformed services, may elect to continue such coverage, as, and to the extent required by the Uniformed Services Employment And Reemployment Rights Act of 1994 (USERRA) as it may be amended by subsequent federal legislation. The maximum period of coverage of an Employee and the Employee's dependents under such an election shall be the lesser of (i) the period of twenty-four (24) months beginning on the date on which the Employee's absence begins or (ii) the day after the date on which the Employee fails to apply for or return to a position of employment as determined under section 4312(e) of USERRA. An Employee who elects to continue coverage under USERRA shall be required to pay not more than one hundred two percent (102%) of the full premium under the plan, determined in the same manner as the applicable premium under COBRA associated with such coverage for the Employer's other Employees; provided, however, that in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, the Employee shall not be required to pay more than the Employee share, if any, for such coverage. In the case of a person whose coverage under a health plan that is subject to this Plan was terminated by reason of service in the uniformed services, an exclusion or waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under USERRA if an exclusion or waiting period would not have been imposed had coverage of such person by such plan not been terminated as a result of such service; provided, however, that the preceding requirement shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

3.10. Eligibility Of Reemployed Employees.

Except to the extent otherwise provided in a Contract or elsewhere in the Plan, a Participant who terminates employment with the Employer and is then rehired by the Employer shall participate in the Plan in accordance with the provisions of the Eligible Employees; Excluded Employees, Eligibility Requirements, and Commencement Of Participation sections, above.

3.11. Eligibility Of Excluded Employees.

Except to the extent otherwise provided in a Contract or elsewhere in the Plan:

- A. If a Participant ceases to be a member of an eligible class of Employees, the Participant shall become ineligible to continue to participate in the Plan as an active Participant.
- B. If a Participant becomes ineligible to continue to participate because the Participant is no longer a member of an eligible class of Employees, such Employee shall participate immediately upon return to an eligible class of Employees.
- C. If an Employee who is not a member of the eligible class of Employees becomes a member of the eligible class, such Employee shall participate immediately if such Employee has met the eligibility requirements of the Eligibility Requirements section, above, and would have previously become a Participant had the Employee been in an eligible class [only after meeting the eligibility requirement set forth in the Eligibility Requirements section, above, after becoming a member of the eligible class].

3.12. Qualified Medical Child Support Orders.

Each group health plan benefit that is provided under this Plan, and that is also subject to the requirements of the Child Support Performance And Incentive Act of 1998 and any applicable subsequent federal or State legislation dealing with medical child support orders, shall provide benefits to each "alternate recipient" in accordance with the applicable requirements of any "qualified medical child support order" as those terms are defined in section 609(a) of ERISA as if ERISA applied to the Plan. The Administrator shall establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders and to administer the provision of benefits under such qualified orders.

3.13. Special Enrollment Periods.

A. HIPAA Special Enrollment Periods.

An Employee and the Employee's dependents shall be able to enroll in each group health plan benefit that is provided under this Plan during special enrollment periods to the extent required by the applicable requirements of HIPAA.

B. Children's Health Insurance Program Special Enrollment Periods.

An Employee who is eligible, but not enrolled, for coverage under the terms of a group health plan benefit that is provided under this Plan (or a dependent of such an Employee if the dependent is eligible, but not enrolled, for coverage under such terms) shall be able to enroll for coverage under the terms of the group health plan if either of the following conditions is met:

1. The Employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, coverage of the Employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage, and the Employee requests coverage under the group health plan not later than sixty (60) days after the date of termination of such coverage; or
2. The Employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the Employee requests coverage under the group health plan not later than sixty (60) days after the date the Employee or dependent is determined to be eligible for such assistance.

C. Health Care Reform Special Enrollment Periods.

An Employee and the Employee's eligible Beneficiaries shall be able to enroll in each group health plan benefit that is provided under this Plan during special enrollment periods to the extent required by the applicable requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as they may be amended from time to time, and the lawful guidance thereunder published by the



Treasury Department, the Internal Revenue Service, the Department of Labor, or the Department of Health and Human Services from time to time.

3.14. Termination Of Participation.

- A. Except as otherwise provided in this Plan, a Participant will automatically cease to be a Participant as a result of the occurrence of the earliest of the following events on (i) the last day of the month in which the event occurs if the event does not occur on the first day of the month or (ii) the first day of the month in which the event occurs if the event does occur on the first day of the month:
1. The death for the Participant;
  2. The termination of the Participant's employment with the Employer;
  3. The Participant's failure to continue to be an eligible Employee under the terms of the Plan and, if appropriate, all of the Contracts;
  4. The Employee ceases to be a Participant pursuant to the Leaves Of Absence section, above;
  5. The Participant's Employer ceases to be a sponsoring Employer of the Plan; or
  6. The termination of the Plan in accordance with the Amendments And Termination article.
- B. Termination of participation shall not affect the Participant's or the Participant's Beneficiary's right to claim benefits for expenses incurred prior to such termination. However, no additional expenses incurred after such termination shall be covered by the Plan. For purposes of this Plan, an expense shall be "incurred":
1. With respect to the payment of premiums for benefits provided under a Contract, when the premiums for the month of coverage are due; and
  2. With respect to benefits not provided under a Contract, when the services that give rise to the expense are rendered.

- C. The Administrator may rescind coverage under the Plan of any individual if the individual or someone on behalf of the individual either (i) performs an act, practice, or omission that constitutes fraud or (ii) makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits, under the Plan. The Administrator may (i) void coverage for the individual for the period of time coverage was in effect or (ii) terminate coverage as of a date to be determined at the Administrator's sole and absolute discretion. The rescission may have a retroactive date; provided, however, that a rescission may have a retroactive date with respect to a group health plan benefit that is provided under this Plan only if the Administrator provides at least thirty (30) days advance written notice to each individual who would be affected by such rescission. The Administrator will refund all Employee contributions paid for any coverage rescinded; provided, however, that the refund will be offset, in whole or in part, by any claims paid by the Plan that would not have been paid but for the fraud or intentional misrepresentation. In addition, the Administrator may exercise its rights under the Repayment Of Overpayment Of Benefits section, below.

3.15. Benefits Upon Termination Of Employment.

In the event a Participant terminates employment and thereby permanently discontinues contributions to the Plan, the former Participant shall receive any and all eligible benefits to which that former Participant is entitled subject to the provisions of the Plan.

3.16. Continuation Of Coverage (COBRA).

If the Employer is not subject to the federal law requirements regarding the continuation of health care coverage enacted by COBRA, no Participant or his or her qualified beneficiaries, as defined in COBRA, who are covered under a group health plan benefit that is provided under this Plan, shall be eligible to continue such coverage after the termination of participation set forth in the Termination Of Participation section, above. If, however, the Employer is subject to the federal law requirements regarding the continuation of health care coverage enacted by COBRA, then the Participant and his or her qualified beneficiaries, as defined in COBRA, who are covered under a group health plan benefit that is provided under this Plan, shall be eligible to continue such benefits (COBRA benefits) under the following conditions; provided, however, that if the COBRA provisions of any Contract are inconsistent with the following provisions, and such provisions of the Contract are not inconsistent with the then applicable requirements of

COBRA, such provisions of the Contract shall supersede the following provisions as applicable to that Contract.

A. Qualifying Events.

Upon the occurrence of any of the following qualifying events, a qualified beneficiary shall be allowed to continue group health plan benefits under this Plan to the extent that the qualified beneficiary was receiving such benefits under this Plan immediately prior to such qualifying event and the qualifying event would otherwise result in the termination of such coverage before the end of the maximum coverage period set forth below:

1. The death of the Employee;
2. The termination of the Employee for reasons other than gross misconduct, or a reduction in the Employee's hours;
3. The divorce or legal separation of the Employee from his or her spouse;
4. The Employee becoming entitled to Medicare;
5. A dependent child ceasing to be a dependent child; or
6. An Employee who is on a leave under FMLA not returning to employment with the Employer at the end of the FMLA leave, but only if (i) the covered person was receiving group health plan benefits under this Plan on the day before the first day of the FMLA leave and (ii) the Employer does not eliminate, on or before the last day of the Employee's FMLA leave, coverage under this Plan for the class of Employees to which the Employee would have belonged if the Employee had not taken the FMLA leave;

provided, however, that the only events that shall be treated as a qualifying event with respect to an Employee are the events set forth in paragraph 2 and paragraph 6, above.

B. Term Of Continuation Of Coverage.

The COBRA benefits shall terminate on the earliest of the following dates:

1. Eighteen (18) months following the date when coverage under the group health plan benefit that is provided under

the Plan would have been lost as a result of the qualifying event in the absence of an election to continue coverage as provided in this Continuation Of Coverage (COBRA) section, if the qualifying event referred to in the Qualifying Events subsection is termination of the Employee or a reduction in the Employee's hours; provided, however, that:

- a. This period may be extended during the period when an individual is disabled under title II or XVI of the Social Security Act, up to eleven (11) additional months, if:
  - (1) The individual is determined, under title II or XVI of the Social Security Act, to have been disabled at any time during the first sixty (60) days of COBRA continuation coverage;
  - (2) The individual notifies the Administrator of that fact before the end of the initial eighteen (18) month period; and
  - (3) The individual notifies the Administrator of the Social Security Administration's determination of disability within sixty (60) days of such determination;
- b. In the case of a qualified beneficiary other than the Employee, this period may be extended up to eighteen (18) additional months if another qualifying event referred to in the Qualifying Events subsection (other than the bankruptcy of the Participant's Employer) occurs during the initial eighteen (18) month period; and
- c. If the termination of the Employee or a reduction in the Employee's hours occurs less than eighteen (18) months after the Employee becoming entitled to Medicare, the period of COBRA benefits for qualified beneficiaries other than the Employee shall not terminate under this provision before the close of the thirty-six (36) month period beginning on the date the Employee became entitled to Medicare;

2. If the qualifying event is the bankruptcy of the Participant's Employer, the date of the death of the retiree or the retiree's surviving spouse, or, in the case of the dependents of a deceased retiree, thirty-six (36) months after the date when coverage under the group health plan benefit that is provided under the Plan would have been lost as a result of the qualifying event in the absence of an election to continue coverage as provided in this Continuation Of Coverage (COBRA) section;
3. In the case of a qualified beneficiary other than the Employee, thirty-six (36) months following the date when coverage under the group health plan benefit that is provided under the Plan would have been lost as a result of the qualifying event in the absence of an election to continue coverage as provided in this Continuation Of Coverage (COBRA) section for any of the other qualifying events enumerated in the Qualifying Events subsection;
4. The date on which the Employer ceases to provide any group health plan to any Employee;
5. The date on which coverage ceases for nonpayment of any premium or contribution required of the covered person; provided, however, that a grace period shall be provided for the payment of any such premium or contribution that is equal to:
  - a. Thirty (30) days after the due date for such amount or such longer period allowed under the Contract if the COBRA benefits are being provided under the Contract; or
  - b. In the event that an error is made in the amount paid and the amount paid is not significantly less than the correct amount (i.e., the shortfall is no greater than the lesser of (i) fifty dollars (\$50) or such other amount as published by the Internal Revenue Service or (ii) ten percent (10%) of the amount of the premium that is required to be paid), thirty (30) days after the Administrator notifies the individual of the error;
6. The date on which the person continuing coverage first becomes, after the date of the election, covered under any other group health plan, unless that plan has an exclusion

or limitation with regard to any preexisting condition of such person (other than such an exclusion or limitation which does not apply to or is satisfied by such person by reason of Code sections 9801 *et seq.*, in which case, the date on which such exclusion or limitation is no longer applicable);

7. As to individuals other than those who have COBRA benefits as a result of the Employer's bankruptcy, the date on which the individual first becomes, after the date of the election, entitled to benefits under Medicare;
8. As to individuals who are receiving extended COBRA benefits because of the determination of disability under title II or XVI of the Social Security Act of a qualified beneficiary, the first day of the month that begins more than thirty (30) days after the date of any final determination by the Social Security Administration that the individual who had been determined to have been disabled under title II or XVI of the Social Security Act is no longer disabled under title II or XVI of the Social Security Act; or
9. The date on which coverage is terminated for cause on the same basis as for a similarly situated nonCOBRA beneficiary (e.g., for filing a fraudulent claim).

C. Notice Requirements.

The following notices shall be given, in writing, by the parties indicated:

1. The Employer shall notify each covered Employee and spouse of their rights under this Continuation Of Coverage (COBRA) section at the time of commencement of coverage under the Plan (as set forth in Department of Labor regulations section 2590.606-1(b)).
2. The Employer must notify the Administrator of any of the following qualifying events:
  - a. Death of the Employee;
  - b. Termination of the Employee for reasons other than gross misconduct, or a reduction in the Employee's hours;
  - c. The Employee becoming entitled to Medicare; or

- d. The bankruptcy of the Employer (only as to retirees and their dependents or a deceased retiree's surviving spouse);

within thirty (30) days of the date when coverage under the group health plan benefit that is provided under the Plan would have been lost as a result of the qualifying event in the absence of an election to continue coverage as provided in this Continuation Of Coverage (COBRA) section.

3. The Employee or qualified beneficiary shall notify the Administrator within sixty (60) days of any of the following qualifying events:
  - a. Divorce or legal separation of the Employee from his or her spouse; or
  - b. A dependent child ceasing to be a dependent child.

The failure to satisfy this notice requirement shall result in the inability of any person to elect COBRA benefits as a result of the qualifying event.

4. The Employee or qualified beneficiary shall notify the Administrator within sixty (60) days of a determination of disability from the Social Security Administration in order to complete eligibility for extended COBRA benefits because of disability. The failure to satisfy this notice requirement shall result in the inability of any person to obtain extended COBRA benefits because of such disability.
5. The Administrator shall notify the Employee or qualified beneficiaries within fourteen (14) days of its receipt of any notice required under this Notice Requirements subsection. Notice to the Spouse shall serve as notice to all qualified beneficiaries. If the Administrator receives a notice required under this Notice Requirements subsection with respect to an individual and the Administrator determines that the individual is not entitled to COBRA benefits or to extended COBRA benefits, the Administrator shall notify the individual of the Administrator's determination within fourteen (14) days of its receipt of the notice.

6. The disabled individual who is receiving extended COBRA benefits shall notify the Administrator within thirty (30) days of the date of any final determination by the Social Security Administration that the individual is no longer disabled.
7. If a qualified beneficiary's COBRA benefits are going to terminate earlier than the end of the maximum period set forth in the Term Of Continuation Of Coverage subsection, above (e.g., eighteen (18) months following the termination of the Employee or a reduction in the Employee's hours), the Administrator shall notify the qualified beneficiary of such early termination as soon as practicable following the Administrator's determination that the qualified beneficiary's COBRA benefits are going to terminate early.

D. Election Period.

A covered Employee or qualified beneficiary must elect to continue benefits under the group health plan within a period of at least sixty (60) days:

1. Beginning no later than the date when coverage would otherwise terminate as a result of a qualifying event; and
2. Ending sixty (60) days following the later of the following events:
  - a. The date when coverage would otherwise terminate as a result of a qualifying event; or
  - b. The date of the fourteen (14) day notice from the Administrator as described in the Notice Requirements subsection, above.

Unless specified to the contrary, an election by the Employee or the Employee's spouse is effective for all qualified beneficiaries.

E. Required Contributions.

In order to continue coverage under the Plan pursuant to this Continuation Of Coverage (COBRA) section, the Employee or qualified dependent shall remit monthly an amount equal to one hundred two percent (102%) of the cost of providing benefits to similarly situated beneficiaries for whom no qualifying event has occurred, without regard to whether such costs are paid by the Employer or the Employee in the absence of a qualifying event;



provided, however, that "one hundred fifty percent (150%)" shall be substituted for "one hundred two percent (102%)" during the period of extended COBRA benefits for an individual who is receiving extended COBRA benefits because of the determination of disability under title II or XVI of the Social Security Act of a qualified beneficiary, but only if the disabled individual is a member of the individual's coverage group. All premium payments shall be payable monthly in advance, on or before the first day of the month for which the coverage is to be provided; provided, however, that no contributions shall be required before the day that is within forty-five (45) days of the date on which the election to continue coverage is submitted to the Administrator (and such initial premium shall, at a minimum, cover the period through the end of the month preceding the month in which the initial premium payment deadline falls).

F. Special COBRA Rule For Flexible Spending Arrangements.

1. COBRA benefits under a group health plan benefit that is provided through a flexible spending arrangement (FSA) shall be limited as set forth in this Special COBRA Rule For Flexible Spending Arrangements subsection if the FSA meets each of the following conditions:
  - a. The FSA's maximum benefit cannot exceed the greater of (i) two (2) times the Employee's salary reduction election, if any, or (ii) the Employee's salary reduction election, if any, plus five hundred dollars (\$500);
  - b. The individual must have other coverage available under a group health plan of the Employer that is not limited to "excepted" benefits under HIPAA (i.e., benefits under an arrangement under which benefits for medical care are secondary or incidental to other benefits such as disability insurance, liability insurance or workers' compensation); and
  - c. The maximum COBRA premium that the FSA can require for a year of continuation coverage equals or exceeds the maximum benefit available for the year.
2. If these conditions are met, then:
  - a. COBRA benefits shall be available for the remainder of the Plan Year during which the qualifying event

occurred only if the qualified beneficiary can become entitled to receive, during the remainder of that Plan Year, a benefit that exceeds the maximum premium that the FSA can require for the remainder of the Plan Year; and

- b. No COBRA benefits shall be available for the Plan Year following the Plan Year in which the qualifying event occurred.
3. For purposes of this Special COBRA Rule For Flexible Spending Arrangements subsection, a "FSA" means a flexible spending arrangement within the meaning of Code section 106(c)(2) (i.e., a benefit program that provides employees with coverage under which (i) specified incurred expenses may be reimbursed (subject to maximums and reasonable conditions) and (ii) the maximum reimbursement that is reasonably available to a Participant for such coverage is less than five hundred percent (500%) of the value of the coverage).

G. No Evidence Of Insurability.

No evidence of insurability or good health shall be required of any person for COBRA benefits.

H. COBRA Coverage For Domestic Partners.

Although a domestic partner of an Employee (and the domestic partner's dependents) may be covered under a group health plan benefit that is provided under the Plan, neither the domestic partner or the domestic partner's dependents are entitled to elect COBRA benefits under the preceding provisions unless the Contract under which such a domestic partner is covered provides for such an election. Even if the Contract under which such a domestic partner is covered does not provide for such an election, an Employee who (i) has a qualifying event that is termination of the Employee for reasons other than gross misconduct or a reduction in the Employee's hours and (ii) elects COBRA benefits may elect to continue benefits for the Employee's domestic partner (and the domestic partner's dependents) to the same extent that the Employee could elect such coverage if the Employee had not had a qualifying event.

I. Interpretation Of COBRA Benefits Requirements.

The applicability and operation of the requirements of this Continuation Of Coverage (COBRA) section shall be interpreted in a manner that is consistent with COBRA and the regulations promulgated thereunder by the federal agency or agencies that have jurisdiction of COBRA's provisions that apply to the Employer.

J. Single Group Health Plan.

Even though the group health plan benefits provided under the Plan are part of a single group health plan, the Employer hereby designates the group health plan benefits provided under the Plan as being provided under separate group health plans for purposes of the elections permitted under this Continuation Of Coverage (COBRA) section, all in accordance with Treasury regulations section 54.4980B-2 Q&A-6.

3.17. Continuation Of Coverage Under State Law.

A Participant and his or her qualified beneficiaries, who are covered under a group health plan benefit that is provided under this Plan through a Contract issued by a licensed insurance provider in any State that requires continuation of coverage beyond or in addition to the continuation of coverage under the Continuation Of Coverage (COBRA) section, above, shall be eligible to continue such insured group health benefits in accordance with such applicable State law(s) and such Contract(s).

#### ARTICLE 4. PLAN BENEFITS

4.01. Benefits In General.

- A. Benefits under this Plan for an eligible Employee who has commenced participation under the Plan shall consist of those Compensation Reduction Benefits that the Participant has elected pursuant to the provisions of the Election Of Available Benefits article, below, and for which the Participant has paid all required Employee contributions.
- B. Except as otherwise provided in this Plan or in a Contract, the periods of coverage for each Compensation Reduction Benefit shall be the Plan Year (or, for the first Plan Year when a new Compensation Reduction Benefit becomes effective, the period

from the effective date of the new Compensation Reduction Benefit to the end of that Plan Year).

- C. The Plan may pay or reimburse only those substantiated expenses for Compensation Reduction Benefits incurred on or after the later of (i) the effective date of the Plan (or, for a new Compensation Reduction Benefit added to the Plan after the Plan's effective date, the effective date of the new Compensation Reduction Benefit) or (ii) the date the Employee commences participation under the Plan. Notwithstanding this provision, a new Employee who makes a compensation reduction election within thirty (30) days of the new Employee's date of hire with the Employer may make an election effective as of the Employee's date of hire with the Employer; provided, however, that:
  - 1. Compensation reduction amounts used to pay for such an election must be from Compensation not yet currently available on the date of the election; and
  - 2. Any Employee who either (i) terminates employment with the Employer and is rehired by the Employer within thirty (30) days after terminating employment or (ii) returns to employment with the Employer following an unpaid leave of absence of less than thirty (30) days shall not be treated as a new Employee for purposes of this provision.

4.02. Insured And Self-Insured Benefits.

- A. The benefits provided under the Plan through Contracts shall be provided by such insurance companies, health care service plans or other service providers with which the Employer or the Administrator, on behalf of the Plan, contracts from time to time in order to provide such benefits under the Plan. The Employer shall have no obligation under this Plan, with respect to benefits provided under a Contract, beyond the payment of the Employer's share of the appropriate premium and the remittance of each eligible Employee's share of the premium to the appropriate third party to the extent that such premiums have been paid to the Employer by the Employee or withheld from the Employee's wages pursuant to the terms of this Plan. In the case of a conflict between the provisions of a Contract and this Plan, the provisions of the Contract shall control unless otherwise specified in this Plan.
- B. The benefits payable under this Plan other than through Contracts may be paid from a welfare benefit plan trust, which

may be, but shall not be required to be, tax exempt pursuant to either Code section 115 or Code section 501(c)(9).

- C. The benefits payable under this Plan other than through Contracts or through a welfare benefit plan trust shall be paid from the general assets of the Employer.

#### 4.03. Funding And Benefit Payments.

- A. Except to the extent required by the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code section 7701(a)(46)) and the Employer, the Employer shall determine, in its sole and absolute discretion, at any time and from time to time, the amount or percentage of the cost of the benefits provided under this Plan to be paid by the Employer and the amount or percentage of the cost of the benefits provided under this Plan to be paid by the Participants. The Employer shall announce such amounts or percentages at such times as are deemed necessary or appropriate by the Employer. Any and all changes to such amounts or percentages as announced by the Employer shall be effective as of the time(s) established by the Employer without regard to whether the Employer has adopted an amendment to the Plan.
- B. The benefits provided under a Contract shall be funded through, and benefits provided under, and in accordance with, the provisions of the Contracts. Such Contracts shall be purchased and maintained by the Employer or the Administrator, on behalf of the Plan. The Contracts may provide for the receipt of premium payments from the Employer, though premium payments may consist of contributions from the Employer and contributions from the Employees who are eligible under the provisions of the applicable Contract.
- C. The benefits provided under a Contract shall be paid by the insurance companies, health care service plans or other service providers in accordance with the provisions of the Contracts. The Employer shall not be responsible for the validity of any Contract or any policy issued by any provider of coverage, or for the failure on the part of any provider of coverage, other than the Employer, to make payments provided for under any such Contract, or for the action of any person that may delay or render void or unenforceable, in whole or in part, any such Contract.
- D. Any dividends, or retroactive rate or other refunds which may be or may become payable under the Contracts shall be the property

of, and shall be retained by, the Employer to the extent the dividends, or retroactive rate or other refunds do not exceed the aggregate contributions to the cost of the benefit under the Contract made by the Employer from its own funds. In the event such dividends, or retroactive rate or other refunds exceed the aggregate contributions to the cost of the benefit under the Contract made by the Employer from its own funds, such dividends shall be returned to the Plan and used to reduce Participant contributions toward the cost of the benefit provided under the specific Contract to which the dividend or retroactive rate or other refund is attributable.

4.04. Preexisting Condition Limitations.

- A. Each group health plan benefit that is provided under the Plan shall not impose preexisting condition restrictions or limitations on coverage that are contrary to or inconsistent with the applicable requirements of HIPAA. The Administrator shall provide certifications of coverage to Participants to the extent required by HIPAA.
- B. In accordance with, but only to the extent required by, the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, any subsequent legislation, and the lawful guidance published thereunder, no preexisting condition exclusion shall be applied by any group health plan that is provided under the Plan.

4.05. Newborns And Mothers.

Each group health plan benefit that is provided under this Plan shall comply with all applicable requirements of the Newborns' And Mothers' Health Protection Act of 1996.

4.06. Mental Health Parity.

- A. Each group health plan benefit provided under the Plan shall comply with all applicable requirements of the Mental Health Parity Act of 1996, as amended (MHPA), unless the Employer is a small employer as defined in MHPA or:
  - 1. For Plan Years beginning before the MHPA amendments effective date set forth below, if the application of MHPA's requirements results in a cost increase of at least one percent (1%); or

2. For Plan Years beginning on or after the MHPA amendments effective date set forth below, if the application of MHPA's requirements results in an actuarially certified cost increase in excess of the "applicable percentage," all as set forth in Code section 9812 and PHSA section 2705, as each may be amended from time to time, as applicable to this Plan.

B. The MHPA amendments effective date referenced above shall be Plan Years beginning after October 3, 2009; provided, however, that in the case of a group health plan benefit maintained pursuant to one or more collective bargaining agreements between Employee representatives and the Employer ratified before October 3, 2008, the MHPA amendments effective date shall apply to Plan Years beginning on or after the later of (i) the date on which the last of the collective bargaining agreements related to the Plan terminates (determined without regard to any extension thereof agreed to after October 3, 2008) or (ii) January 1, 2009.

4.07. Women's Health And Cancer Rights.

Each group health plan benefit that is provided under this Plan shall comply with the applicable requirements of the Women's Health And Cancer Rights Act Of 1998.

4.08. Student Health Insurance Act.

Each group health plan benefit that is provided under the Plan shall comply with the applicable requirements of the 2008 Student Health Insurance Act for "medically necessary leaves of absence" beginning during such Plan Years, all as set forth in PHSA section 2728, as it may be amended from time to time.

4.09. Over-The-Counter Drugs.

No reimbursement shall be made under the Plan for a medicine or drug unless the medicine or drug is a prescribed drug (determined without regard to whether it is available without a prescription) or insulin.

4.10. Maximum Lifetime Or Annual Limits.

In accordance with, but only to the extent required by, the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, any subsequent legislation, and the lawful

guidance published thereunder, no group health plan benefit that is provided under the Plan shall:

- A. Impose any lifetime limit on the dollar amount of benefits for any individual except with respect to:
  - 1. Specific covered benefits that are not essential health benefits, as defined in section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations, to the extent that such limits are otherwise permitted under applicable federal or State law; or
  - 2. The exclusion of all benefits for a condition.
- B. Impose any annual limit on the dollar amount of benefits for any individual except with respect to:
  - 1. A health flexible spending arrangement as defined in Code section 106(c)(2);
  - 2. Specific covered benefits that are not essential health benefits, as defined in section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations, to the extent that such limits are otherwise permitted under applicable federal or State law; or
  - 3. The exclusion of all benefits for a condition.

4.11. Health Care Reform Legislation.

In accordance with, but only to the extent required by, the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, any subsequent legislation, and the lawful guidance published thereunder, the following provisions shall apply to any group health plan; provided, however, that, if a group health plan or any "benefit package" under this Plan is a "grandfathered health plan," as such terms are defined in such legislation and guidance, then the following provisions shall not apply to any such group health plan or benefit package:

- A. Effective for Plan Years beginning on or after September 23, 2010, preventative health services shall be provided on a no-cost sharing basis in accordance with PHSA section 2713.



- B. Effective for the later of (i) Plan Years beginning on or after September 23, 2010 or (ii) such date as is established by such legislation and guidance, a fully insured group health plan shall not discriminate in favor of highly compensated individuals as proscribed by PHSA section 2716.
- C. Effective for Plan Years beginning on or after September 23, 2010, a group health plan shall comply with the patient protection requirements of PHSA section 2719A.
- D. Effective for Plan Years beginning on or after January 1, 2014, a group health plan shall not establish rules for eligibility of any individual to enroll under the terms of the group health plan based on any of the factors set forth in PHSA section 2705.
- E. Effective for Plan Years beginning on or after January 1, 2014, a group health plan shall not discriminate with respect to participation under the group health plan against any health care provider who is acting within the scope of that provider's license or certification under applicable State law contrary to PHSA section 2706.
- F. Effective for Plan Years beginning on or after January 1, 2014, any annual cost-sharing imposed under a group health plan shall not exceed the limitations provided for under paragraph (1) of section 1302(c) of the Patient Protection and Affordable Care Act and applicable regulations contrary to PHSA section 2707.
- G. Effective for Plan Years beginning on or after January 1, 2014, a group health plan that provides coverage to a "qualified individual" as defined in PHSA section 2709, then the group health plan may not (i) deny the individual participation a clinical trial, (ii) deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial, or (iii) discriminate against the individual on the basis of the individual's participation in such trial contrary to PHSA section 2709.

4.12. Nondiscrimination.

- A. Except as otherwise provided in this section, to the extent required by the provisions of either (i) the Code and the Treasury regulations promulgated thereunder or (ii) the PHSA and the regulations promulgated thereunder, each class of benefits provided by the Plan shall be provided under a classification of Employees that is set forth in the Plan and that is not

discriminatory in favor of Employees who are Highly Compensated Individuals, and, in the case of each class of benefits, such benefits shall not discriminate in favor of Employees who are Highly Compensated Individuals.

- B. In the case of Plan benefits funded through a Code section 501(c)(9) trust, unless the Code, or the Treasury regulations promulgated thereunder provide to the contrary, a life insurance, disability, severance pay or supplemental unemployment compensation benefit shall not be considered to so discriminate merely because the benefits available bear a uniform relationship to the total Compensation, or the basic or regular rate of Compensation, of Employees covered by the Plan.
- C. Notwithstanding any other provisions of this Plan, this Plan shall not discriminate as to eligibility in favor of Highly Compensated Individuals, nor as to contributions or benefits in favor of Highly Compensated Participants. If the Administrator determines before or during any Plan Year that the Plan may fail to satisfy for such Plan Year any of the foregoing nondiscrimination requirements, or any other such requirements, imposed by the Code or any limitation on benefits provided to Highly Compensated Participants, the Administrator shall take such action as the Administrator deems appropriate, in its sole and absolute discretion, to assure compliance with such requirement or limitation.

#### 4.13. Distributions To Incapacitated Participants.

Whenever, in the Administrator's opinion, a person who is entitled to receive any payment of benefits under the Plan is unable to manage his or her personal financial affairs by reason of minority, death, illness or infirmity, mental incapacity or incompetency of any kind, the Administrator may in its discretion:

- A. Make payments to the persons or institutions that are providing for the care and maintenance of the Participant or Beneficiary and continue to make such payments to them until a duly appointed legal representative makes a claim for the payment;
- B. Apply the payment for the benefit of such Participant or Beneficiary in such manner as the Administrator considers advisable;
- C. Make payments to the legally appointed guardian of such person;

- D. Make payments as directed by a court of competent jurisdiction;  
or
- E. Deposit any amount due to a minor to his credit in any savings or commercial bank of the Administrator's choice.

Any payment made pursuant to the terms of this Distribution To Incapacitated Participants section shall be a complete discharge of any liability of the Plan, the Employer, the Administrator, the Administrator's designated representative, or any other person for the making of such payment under the provisions of the Plan.

4.14. Repayment Of Overpayment Of Benefits.

- A. By accepting payment of benefits under the Plan, the Participant or Beneficiary receiving the payment agrees that, in the event of overpayment, the Participant or Beneficiary will promptly repay the amount of overpayment, without interest, upon notice by the Administrator; provided that, if the Participant or Beneficiary has not repaid the overpayment within thirty (30) days after notice, the Administrator may deduct all or any portion of the overpayment that is not timely repaid from any amount that would otherwise then be payable, or that may become payable, to the Participant or Beneficiary under the Plan.
- B. In the event that the Plan makes a payment to a Participant, Beneficiary or third party that is in excess of the amount otherwise due under the Plan, the Plan shall have an equitable lien on the excess portion of such payment, which shall be regarded by the Plan as a distinct and separate fund held by such Participant, Beneficiary or third party subject to such lien. Such lien shall continue in effect to any account of such Participant, Beneficiary or third party to which all or any portion of such payment is transferred, and as to any tangible or intangible asset acquired by such Participant, Beneficiary or third party using all or any portion of such payment.

ARTICLE 5. ELECTION OF AVAILABLE BENEFITS

5.01. Election Of Compensation Reduction Benefits.

Each Participant shall agree to reduce his or her Compensation by such amounts as are necessary to provide for those Compensation Reduction Benefits which the Participant has elected pursuant to the provisions of this Election Of Available Benefits article. These amounts shall then be

utilized by the Participant's Employer to provide such elected benefits on the Employee's behalf.

5.02. Election Amounts.

Except as provided in the Nondiscrimination section, above, the amount of a Participant's Elective Contributions applicable to the benefits provided under a Contract shall equal the Participant's share of the cost for such Plan benefits as the Participant is permitted to elect pursuant to the provisions of this Plan and the amount of a Participant's Elective Contributions applicable to the benefits not provided under a Contract shall equal the amounts selected by the Participant subject to the additional limitations contained in the articles governing such other benefits.

5.03. Maximum Compensation Reduction.

The maximum amount of the Participant's Elective Contributions under the Plan for any Participant for any Plan Year shall be the costs, from time to time, of the most expensive Plan benefits available to the Participant as Compensation Reduction Benefits under the Plan; provided, however, that, unless otherwise specified in the Plan:

- A. The maximum amount that a Participant may allocate for unreimbursed medical expenses under the Medical Expense Reimbursement Benefit article shall be such amount as shall be determined by the Administrator from time to time and communicated to eligible Employees; provided, however, that, effective as of January 1, 2013, in accordance with, but only to the extent required by, the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, any subsequent legislation, and the lawful guidance published thereunder, a Participant may not elect to have salary reduction contributions to a health flexible spending arrangement under the Plan in excess of two thousand five hundred dollars (\$2,500), as adjusted by the Commissioner of Internal Revenue for increases in the cost of living in accordance with Code section 125(i)(2), prorated for any Plan Year of less than twelve (12) months.
- B. The maximum amount that a Participant may allocate for dependent care assistance shall be the amount set forth in the Limitations On Benefits article of the Dependent Care Assistance Benefit article or such amount as shall be determined by the Administrator from time to time and communicated to eligible Employees.

5.04. Employer Credits And Opt-Out Payments.

Except to the extent required by the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code section 7701(a)(46)) and the Employer:

- A. The Employer may, but shall not be obligated to, provide, in its sole and absolute discretion, credits that are available to the Employer's eligible Employees to apply towards the purchase of benefits provided under the Plan. In the event that the Employer provides such credits, the Participants may either use the credits for the purchase of benefits provided under this Plan or receive such credits, or a portion thereof, in cash as additional compensation in such amounts and at such times as the Employer shall determine in its sole and absolute discretion. The Employer shall announce (i) any such credits that are available, (ii) the benefits provided under the Plan for which such credits may be used, (iii) the extent to which such credits may be used, and (iv) the disposition of any unused credits, with the election information that is provided to the Employees each year.
- B. The Employer may, but shall not be obligated to, provide, in its sole and absolute discretion, opt-out payments that permit the Employer's eligible Employees to decline coverage under one or more of the benefits provided under this Plan, including waiving coverage in which the Participant would otherwise be enrolled, and to receive such opt-out payments in cash as additional compensation in such amounts and at such times as the Employer shall determine in its sole and absolute discretion. The Employer shall announce any such opt-out payments that are available with the election information that is provided to the Employees each year.
- C. The Employer may also decide, in its sole and absolute discretion, (i) whether the Employer credits described in subsection A, above, should be provided in such a way so as to qualify as an employer contribution to a cafeteria plan (commonly known as a "health flex contribution") that is described in Treasury regulations section 1.5000A-3(e)(3)(ii)(E) and Treasury regulations section 1.36B-2(c)(3)(v)(A)(6), and (ii) whether the Employer opt-out payments described in subsection B, above, should be provided in such a way so as to qualify as "eligible opt-out payments" that are described in proposed Treasury regulations section 1.36B-2((c)(3)(v)(A)(7)(ii) or the final version of such regulation.

5.05. Election Procedures.

- A. The Administrator shall provide one or more election forms and compensation reduction agreements, using such medium or media as the Employer or the Administrator determines (e.g., printed, online, or both), to each Participant and to each other Employee who is expected to become a Participant. Each Participant and each other Employee who is expected to become a Participant shall specify his or her Elective Contributions to be used for Plan Benefits and the compensation reduction applicable to each Plan Benefit so selected pursuant to this Plan. Such elections shall be made by each newly hired eligible Employee within the time deadlines established by the Administrator each year.
- B. The Employer or the Administrator shall determine which Employees are eligible to participate in this Plan and shall notify each such Employee of the Employee's eligibility to participate in the Plan in sufficient time to enable such Employee to elect benefits under the Plan on or before the date on which he or she becomes a Participant in the Plan.
- C. To become a Participant, an eligible Employee shall, to the extent necessary or appropriate under the applicable Contracts, (i) complete any application or agreements as may be required by the Employer, the Administrator, the insurer or other service provider, (ii) specify his or her election of salary reduction benefits, and (iii) submit such properly completed applications and agreements to the Employer, the Administrator, the insurer or other service provider, on or before the deadline established by the Employer, the Administrator, the insurer or other service provider. By completing such applications and agreements, the eligible Employee shall be deemed for all purposes to have agreed to participate in and to conform to the requirements of this Plan and the applicable Contracts then in effect or as thereafter amended. If an eligible Employee fails to submit such properly completed applications and agreements to the Employer, the Administrator, the insurer or other service provider within such deadline, such eligible Employee shall participate in the Cafeteria Plan during that Plan Year in accordance with the default selections in effect for that Plan Year as designated by the Employer. During the open enrollment period of each Plan Year, in accordance with the rules established by the Administrator, each eligible Employee shall be given the opportunity to apply for participation in the Cafeteria Plan during the next Plan Year, all as provided in the Election Of Available Benefits section, below.

5.06. Failure To Elect.

An Employee failing to submit a properly completed election form to the Employer or the Administrator on or before the specified due date for any Plan Year shall be deemed to have elected to receive his or her full Compensation in the manner and at such intervals as the Employer may determine in the administration of normal payroll activity, and shall not participate in the Plan during such Plan Year, except to the extent necessary for the payment of the benefits under the Health Care Plan Benefit article, below, with respect to the lowest cost, traditional health maintenance organization (HMO) coverage.

5.07. Irrevocability Of Elections.

Elections made under the Plan shall be irrevocable by the Participant during the Plan Year, subject to the following:

A. HIPAA Enrollment Rights.

A Participant may revoke a benefit election under the Plan for group health coverage for the balance of a Plan Year and file a new election that corresponds with the following special enrollment rights, all as provided in Code section 9801(f):

1. If the Participant is eligible but not enrolled for such coverage (or a dependent of such a Participant if the dependent is eligible, but not enrolled, for coverage), the Participant (or the dependent) shall be permitted to enroll for such coverage if each of the following conditions is met:
  - a. The Participant (or the dependent) was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Participant (or the dependent);
  - b. The Participant stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor (or the health insurance issuer offering health insurance coverage in connection with the plan) required such a statement at such time and provided the Participant with notice of such requirement and the consequences of such requirement at such time;

- c. The Participant's (or the dependent's) other group health plan coverage or health insurance coverage described above was either:
    - (1) Under a COBRA continuation provision and the coverage under such provision has been exhausted; or
    - (2) Not under a COBRA continuation provision and either (a) the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or (b) employer contributions towards such coverage were terminated; and
  - d. Under the terms of the plan, the Participant requests such enrollment not later than thirty (30) days after the date of the exhaustion or termination of coverage described above.
2. If (i) a group health plan makes coverage available with respect to a dependent of a Participant, (ii) the Participant is a participant in the group health plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and (iii) a person becomes such a dependent of the Participant through marriage, birth, adoption or placement for adoption, then the group health plan shall provide for a special enrollment period during which the person (or, if not otherwise enrolled, the Participant) may be enrolled under the group health plan as a dependent of the Participant, and in the case of the birth or adoption of a child, the spouse of the Participant may be enrolled as a dependent of the Participant if such spouse is otherwise eligible for coverage. The special enrollment period shall be a period of not less than thirty (30) days and shall begin on the later of:
- a. The date when dependent coverage is made available; or



- b. The date of the marriage, birth, adoption or placement for adoption (as the case may be).
3. If a Participant seeks coverage of a dependent during the first thirty (30) days of such a special enrollment period, the coverage of the dependent shall become effective as follows:
- a. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
  - b. In the case of a dependent's birth, as of the date of such birth; or
  - c. In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.
4. If the Participant is eligible but not enrolled for such coverage (or a dependent of such a Participant if the dependent is eligible, but not enrolled, for coverage), the Participant (or the dependent) shall be permitted to enroll for such coverage if either of the following conditions is met:
- a. The Participant or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, coverage of the Participant or dependent under such a plan is terminated as a result of loss of eligibility for such coverage, and the Participant requests coverage under the group health plan not later than sixty (60) days after the date of termination of such coverage; or
  - b. The Participant or dependent becomes eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the Participant requests coverage under the group health plan not later than sixty (60) days after the date the Participant or dependent is determined to be eligible for such assistance.

B. Change In Status.

Subject to the requirements of the Consistency Rules subsection, below, a Participant may revoke a benefit election under the Plan for the balance of a Plan Year and file a new election if a change in status occurs. A change in status for this purpose includes:

1. Events that change an Employee's legal marital status, including marriage, death of a spouse, divorce, legal separation, or annulment;
2. Events that change an Employee's number of dependents (as defined in Code section 152 as modified by Code sections 105 and 106 and the Treasury regulations promulgated thereunder), including birth, death, adoption, placement for adoption (as defined in the Treasury regulations promulgated under Code section 9801);
3. Any of the following events that change the employment status of the Employee, spouse, or Dependent:
  - a. A termination or commencement of employment;
  - b. A strike or lockout;
  - c. A commencement of or return from an unpaid leave of absence; or
  - d. If the eligibility conditions of this Plan or any cafeteria plan or other employee benefit plan of the Employee, spouse, or Dependent depend on the employment status of that individual, a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan;
4. Events that cause a Dependent to satisfy or cease to satisfy the eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance;
5. A change in the place of residence of the Employee, spouse or Dependent;

6. For purposes of any adoption assistance provided through this Plan, the commencement or termination of an adoption proceeding; and
7. A child (as defined in Code section 152(f)(1)) of the Participant who as of the end of the Participant's taxable year has not attained age twenty-seven (27) becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

C. Consistency Rules.

An Employee's revocation of a benefit election under the Plan for the balance of the Plan Year and a new election under the Change In Status subsection, above, is permitted if and only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan (including with respect to accident or health plan or group-term life insurance plan, for example, a change in status that results in an increase or decrease in the number of an employee's family members or dependents who may benefit from coverage under the plan).

D. Judgment, Decree Or Order.

In the event of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order, that requires accident or health coverage for an Employee's child or for a foster child who is a Dependent of the Employee, then:

1. The Employee's compensation reduction shall increase as appropriate to provide accident or health coverage for the child; and
2. A Participant may revoke a benefit election under the Plan for accident or health coverage in order to cancel accident or health coverage for the child if the order requires the spouse, former spouse, or other individual to provide coverage for the child.

E. Entitlement To Medicare/Medicaid.

If an Employee, spouse or Dependent who is enrolled in the Employer's accident or health plan becomes entitled to coverage

under Medicare or Medicaid, other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines, the Participant may revoke a benefit election under the Plan in order to cancel or reduce coverage of that Employee, spouse or Dependent under the accident or health plan. In addition, if an Employee, spouse or Dependent who has been entitled to coverage under Medicare or Medicaid, other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines, loses such coverage, the Participant may make a benefit election under the Plan in order to commence or increase coverage of that Employee, spouse or Dependent under the accident or health plan.

F. Change In Costs.

If the cost of a benefit provided under this Plan, other than under the Medical Expense Reimbursement Benefit article, increases or decreases during the Plan Year and the Participant is required to make corresponding changes in their payments, the Employer will automatically adjust the amount that the Participant would otherwise receive in cash under the Plan in accordance with such change. However, if the cost charged to an Employee for a benefit package option offered under the Plan significantly increases or decreases, as determined by the Employer or the Administrator, in its sole and absolute discretion (but only if permitted under the Treasury regulations promulgated under Code section 125), the Participant may make a corresponding change in election under the Plan. However, the preceding provisions of this Change In Costs subsection shall apply to the benefit provided under the Dependent Care Assistance Benefit article of this Plan only if the cost change is imposed by a dependent care provider who is not a relative of the Participant (as described in Code sections 152(d)(2)(A) through (G), incorporating the rules of Code sections 152(f)(4) and (1)(B)).

G. Coverage Changes.

1. If an Employee, spouse or Dependent has a significant curtailment of coverage that is not a loss of coverage described below, a Participant who had been receiving such coverage may revoke a benefit election for that coverage and, in lieu thereof, elect to receive coverage under another benefit package option offered under the Plan providing similar coverage, but only if there is an overall reduction in coverage so as to constitute reduced coverage generally.
2. If an Employee, spouse or Dependent has a significant curtailment of coverage that is a loss of coverage described below, a Participant who had been receiving such coverage may either (i) revoke a benefit election for that coverage and, in lieu thereof, elect to receive coverage under another benefit package option offered under the Plan providing similar coverage, or (ii) drop coverage if no similar benefit package option is available under the Plan. For these purposes, a loss of coverage means:
  - a. A complete loss of coverage under the benefit package option or other coverage option;
  - b. A substantial decrease in the medical care providers available under the option; or
  - c. A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Employee, spouse or Dependent is in a course of treatment at the time of such reduction.
3. If a new benefit package option or other coverage option is added to the Plan, or if coverage under an existing benefit package option or other coverage option is significantly improved, a Participant may revoke a benefit election and, in lieu thereof, elect to receive coverage under the new or improved benefit package option offered under the Plan.

H. Other Coverage Changes.

A Participant may revoke a benefit election under the Plan for the balance of a Plan Year and file a new election if both the revocation and the new election are on account of, and correspond with, a change made under another employer plan if

(i) the other plan permits participants to make an election change that would be permitted under the Treasury regulations promulgated under Code section 125 and (ii) this Plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the other plan.

I. Loss Of Other Group Health Coverage.

A Participant may make a benefit election under the Plan to add group health coverage for the Participant, spouse or Dependent, if the Participant, spouse or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including, without limitation, (i) a State children's health insurance program under title XXI of the Social Security Act, (ii) a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization, (iii) a State health benefits risk pool, or (iv) a foreign government group health plan.

J. FMLA Leave.

A Participant may revoke a benefit election under the Plan for accident or health plan coverage for the balance of the Plan Year and file a new election if the Participant takes a FMLA leave subject to the following:

1. If the FMLA leave is unpaid leave and the Participant continues accident or health plan coverage while on FMLA leave, the Participant shall be responsible for paying the Participant's share of the premiums that the Participant was paying while working. These amounts may be paid under the following methods at the election of the Participant:
  - a. Prior to the commencement of the FMLA leave period, the Participant may either:
    - (1) If the FMLA leave does not extend beyond the end of the then current Plan Year, prepay the amounts due, on a pre-tax basis, for the FMLA leave period; or
    - (2) If the FMLA leave does extend beyond the end of the then current Plan Year, prepay the amounts due, on a pre-tax basis, for the balance of the Plan Year and either (i) prepay

the amounts due, on an after-tax basis, for the balance of the FMLA period or (ii) pay the amounts due during the FMLA leave period, on an after-tax basis, on the same schedule as payments would be made if the Participant were not on leave;

- b. The Participant may pay the amounts due during the FMLA leave period, on an after-tax basis, on the same schedule as payments would be made if the Participant were not on leave.
2. If the FMLA leave is paid leave and the Participant continues accident or health plan coverage while on FMLA leave, the Participant's share of the premiums must be paid by the method normally used during any paid leave (i.e., compensation reduction).
3. If the Participant's accident or health plan coverage terminated while the Participant was on FMLA leave, the Participant may elect to be reinstated, on the same terms as prior to taking FMLA leave, pursuant to the Administrator's FMLA procedures.
4. If the Participant had elected coverage under the Medical Expense Reimbursement Benefit article, below, and such coverage terminated while the Participant was on FMLA leave, and the Participant returns from the FMLA leave during the same Plan Year, the Participant has the right, upon return from the FMLA leave, to either:
  - a. Resume coverage for the balance of the Plan Year at the level in effect for such Plan Year before the FMLA leave and make up the unpaid portion of the Participant's share of the premiums for such coverage over the balance of the Plan Year; or
  - b. Resume coverage for the balance of the Plan Year at a level that is reduced and resume the payment of the Participant's share of the premiums for such coverage at the level in effect before the FMLA leave, in which case the coverage shall be prorated for the period for which no premiums were paid.

In either case, the coverage level under the Medical Expense Reimbursement Benefit article, below, for the

balance of the Plan Year shall be reduced for prior reimbursements with respect to such Plan Year.

K. Children's Health Insurance Program Disenrollment Rights.

To the extent permitted by Code section 125, the Treasury regulations promulgated thereunder, and the lawful guidance published by the Internal Revenue Service thereunder, a Participant, who is a parent of a targeted low-income child receiving a premium assistance subsidy, may revoke a benefit election under the Plan in order to disenroll such child from group health plan coverage that qualifies as "qualified employer-sponsored coverage" effective as of the first day of any month for which the child is eligible for assistance under the relevant State's child health plan, all in accordance with and to the extent permitted by (i) section 301 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and (ii) the relevant State's process under CHIPRA.

L. Effective Date Of Changes.

Except as specifically set forth above, any new election under this section shall be effective as follows:

1. If the election is received by the Administrator before the deadline established by the Employer, the Administrator, or the insurer or other service provider, which period shall not exceed thirty (30) days after the date of the event that permits the Participant to elect such a change, any new election under this section shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the Employer and the Administrator are notified, in writing, of such change by the Participant in the case of a family status change or by the third-party provider in the case of other changes.
2. If the election is received by the Administrator after the deadline established by the Employer, the Administrator, or the insurer or other service provider, which period shall not exceed thirty (30) days after the date of the event that permits the Participant to elect such a change, any new election under this section shall be effective the first day of the next Plan Year (unless the Participant changes the Participant's election for the next Plan Year as otherwise permitted by this Plan).



M. Termination Of Employment

If a Participant terminates employment with the Employer, such Participant's compensation reduction elections shall be revoked unless the Participant recommences employment with the Employer within thirty (30) days after termination of employment. If the Participant recommences employment with the Employer within thirty (30) days after termination of employment, the Participant's prior elections shall be automatically reinstated, but the Participant may not make any new elections unless such new elections would be permitted under any of the other provisions of this Plan. If the Participant recommences employment with the Employer more than thirty (30) days after termination of employment, the Participant shall be treated as a new Employee at that time.

N. Health Care Reform.

In accordance with Code section 105(b), as amended by the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, any subsequent legislation, and the lawful guidance published by the Internal Revenue Service thereunder and under Code section 125 (e.g., Internal Revenue Service Notice 2010-38), the preceding provisions shall be applied with respect to any child of the Participant who as of the end of the taxable year has not attained age twenty-seven (27).

5.08. Effective Periods For Elections.

Except as otherwise provided in the Plan:

- A. Each Participant must make his or her elections by the earlier of (i) the date when taxable benefits are currently available or (ii) the first day of the Plan Year; provided, however, that an Employee may, within thirty (30) days after the Employee's date of hire by the Employer, make elections under the Plan with respect to compensation not yet currently available on the date of the election and such an election may be effective as early as the Employee's date of hire by the Employer.
- B. Participants may not carry over any compensation reduction amounts that were not utilized by the Employer to provide benefits or any available benefits from one Plan Year to a subsequent Plan Year. Participants may not use any compensation reduction amounts that were not utilized by the

Employer to provide benefits from one Plan Year to purchase any available benefits that will be provided in a subsequent Plan Year. Any compensation reduction amounts during a Plan Year that are not utilized to provide benefits for such Plan Year shall be applied toward the costs of administering this Plan or any of the benefits provided under this Plan. Notwithstanding the preceding provisions, however, in accordance with the Treasury regulations promulgated under Code section 125, whether in proposed or final form:

1. Compensation reduction amounts from the last month of one Plan Year may be applied to pay accident and health insurance premiums for insurance during the first month of the immediately following Plan Year, if done on a uniform and consistent basis with respect to all Participants (based on the usual payroll interval for each group of Participants); and
2. Compensation reduction amounts from one Plan Year under either the Medical Expense Reimbursement article or the Dependent Care Assistance Benefit article that were not utilized by the Employer to provide benefits under such article may be utilized to pay claims incurred during the grace period, if any, provided under such article during the immediately following Plan Year.

- C. The Employer may designate a minimum period of time for which an Employee's election must remain in effect with regard to the Employee's participation in any insured benefit under the Plan, subject to the Irrevocability Of Elections section, above, and the default selections, if any, in effect under the Plan.

5.09. Sufficiency Of Each Participant's Compensation.

Each Participant's Compensation must be sufficient to provide for those Compensation Reduction Benefits that the Participant has elected pursuant to the provisions of this Election Of Available Benefits article at the time when the Participant's compensation reduction elections were made. If a Participant's compensation reduction elections satisfied the preceding requirement at the time when the Participant's compensation reduction elections were made, but the Participant's Compensation subsequently becomes insufficient to provide for those Compensation Reduction Benefits that the Participant has elected, then the Employer may, in the Employer's sole and absolute discretion, make arrangements with the Participant (i) to continue to provide benefits under this Plan as if the Participant's Compensation were sufficient to provide for those

Compensation Reduction Benefits that the Participant has elected and (ii) to the extent that the Employer advances the Participant's share of the costs for such benefits, to recoup the advanced amounts from the Participant on either a pre-tax basis (e.g., by increasing the Participant's future compensation reduction election amounts) or an after-tax basis.

## ARTICLE 6. HEALTH CARE PLAN BENEFIT

### 6.01. Purpose Of Health Care Plan Benefit.

The benefit available under this article provides payments by the Participant's Employer of the Participant's share of the cost of the health care benefits (including accident coverage) maintained by the Employer and offered through this Plan to the extent elected by the Participant or to the extent deemed to have been elected by the Participant under the Failure To Elect section, above.

### 6.02. Health Care Plan Benefit Limitations.

For purposes of this Plan, the cost of a health care plan shall mean the Participant's share of the cost for any medical, dental or vision benefits provided under a Contract. Such costs shall include those costs incurred with respect to the Participant, a spouse of a Participant, and any dependent children of a Participant, who is covered by such Contract(s). There shall be no reimbursement under this article to the extent there is other reimbursement to the Participant. There shall be no payment under this article for premiums for coverage under a medical plan maintained by another employer of either the Participant, the spouse of the Participant or any dependent child of the Participant. In no event will the amount of the Employer's payment under this article exceed the amount allocable by the Participant for the benefit provided under this article under the Election Of Available Benefits article, above.

### 6.03. Health Care Plan Benefit Payments.

The Participant's Employer will pay the health care plan costs due on behalf of the Participant directly to the provider of the health care plan or the appropriate billing entity. In such event, the Employer shall be relieved of all further responsibility with respect to any such costs and the provision of benefits under this article.

### 6.04. Intent Of Health Care Plan Benefit.

The benefit provided under this article is intended to comply with the provisions of Code sections 105 and 106 and, therefore, will be deemed

to be automatically amended to comply with all legislative changes to, and valid regulations promulgated under, these Code sections, as of the effective date of such legislation or regulations.

6.05. Domestic Partner Health Care Plan Benefits.

If the medical, dental or vision benefits provided under a Contract or Contracts provides for benefits of a domestic partner of an Employee, a Participant who is eligible for such coverage for the Participant's domestic partner or the domestic partner's dependents, and who has been enrolled for such coverage under the Contract(s), may elect to pay the Participant's share of the cost for such coverage under this Plan. Notwithstanding the foregoing and any other provision of this Plan, the amounts deducted from the Participant's Compensation under this Domestic Partner Health Care Plan Benefits section shall be treated as included in the Participant's gross income and not as a qualified benefit under Code section 125.

ARTICLE 7. MEDICAL EXPENSE REIMBURSEMENT BENEFIT

7.01. Purpose Of Medical Expense Reimbursement Benefit.

The benefit available under this article provides payments by the Participant's Employer to reimburse the Participant for medical expenses other than those expenses reimbursed pursuant to the Health Care Plan Benefit article and those expenses reimbursed through insurance or otherwise.

7.02. Medical Expense Reimbursements.

A. Reimbursements In General.

Except as provided in the Medical Expense Reimbursement Benefit Limitations section, the Participant's Employer shall reimburse the Participant for all expenses incurred by such Participant for medical care (as defined in Code section 213(d)) of such Participant and of such Participant's spouse and Dependents, that are incurred during a Plan Year, during the period of the Participant's participation in this Plan while an election is in effect by the Participant under this Medical Expense Reimbursement Benefit article.

B. Health Savings Account Eligible Individuals.

If a Participant is covered by the Employer's high deductible health plan (as defined in Code section 223(c)(2)) and is, so far

as the Employer is aware, is otherwise a health savings account eligible individual (as defined in Code section 223(c)(1)), the expenses that are covered under this article shall be limited to dental and vision expenses.

C. Qualified Reservist Distributions.

Notwithstanding the other provisions of this article, the Administrator may, in its sole and absolute discretion, permit "qualified reservists distributions," as defined in Code section 125(h)(1), of all or a portion of a Participant's medical expense reimbursement benefit provided under this article in accordance with the following provisions:

1. A Participant who has unused amounts allocated for the medical expense reimbursement benefit for a Plan Year may elect, by the last day of the Plan Year (or the last day of the grace period for the Plan Year, if applicable), to have the Employer make a qualified reservist distribution, as defined in Code section 125(h), to the Participant from the Participant's account under this article.
2. A Participant may make such an election only if the Participant has been, by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code), ordered or called to active duty for a period in excess of one hundred seventy-nine (179) days or for an indefinite period.
3. The Administrator shall make the qualified reservist distribution directly to the Participant within a reasonable time, but not more than sixty (60) days after the request for the qualified reservist distribution has been made.
4. The qualified reservist distribution shall equal the balance of the Participant's account as of the date of the distribution after the payment of substantiated claims for covered expenses submitted with respect to the Participant's account before the Participant requested the qualified reservist distribution.
5. The Administrator shall make no reimbursements from the Participant's account on behalf of the Participant for the Plan Year after the qualified reservist distribution.

6. No more than one (1) distribution shall be made under the above provisions with respect to the Participant for a Plan Year.
7. A qualified reservist distribution may not be made with respect to a Plan Year ending before the order or call to active duty.

7.03. Medical Expense Reimbursement Benefit Limitations.

- A. The maximum amount of the medical expense reimbursements that any Participant may receive for a Plan Year shall be the amount allocated by the Participant for the medical expense reimbursement benefit for the Plan Year under the Election Of Available Benefits article.
- B. The reimbursement or payment of the benefits under this article shall be made by the Participant's Employer only in the event and to the extent that such reimbursement or payment is:
  1. Not provided for under any insurance policy, whether the premium on such policy is paid by the Participant's Employer or the individual Participant; and
  2. Not provided for or reimbursable under any other plan or policy.
- C. No reimbursements shall be made under this article for any health insurance premiums.
- D. No reimbursements shall be made under this article for a medicine or drug unless the medicine or drug is a prescribed drug (determined without regard to whether it is available without a prescription) or insulin.
- E. The benefits provided under this article shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or as to benefits.
- F. Amounts not used for medical expenses incurred by the end of the Plan Year shall be forfeited and shall not be carried over from one Plan Year to the next Plan Year; provided, however, that medical expenses for orthodontia services to be provided in the future shall be deemed to have been incurred when the Participant makes the advance payment for such services but only if the advance payment is required by the dentist.

- G. Notwithstanding the preceding provisions, this Plan provides a grace period as follows:
1. A grace period that extends to the fifteenth day of the third month after the end of a Plan Year (i.e., two and one-half (2-1/2) months after the end of the Plan Year) is available to each Participant who:
    - a. Is covered by the Plan on the last day of the Plan Year to which the grace period applies (Prior Plan Year), including a Participant whose coverage under the Plan is extended to the last day of such Prior Plan Year through COBRA continuation coverage if applicable to this Plan under the Continuation Of Coverage (COBRA) section, above; and
    - b. Has unused amounts allocated under the Plan for the Prior Plan Year as of the last day of such Prior Plan Year.
  2. Medical expenses that are incurred during the grace period shall be treated as incurred during the Prior Plan Year to the extent designated by the Participant on the Participant's claim for reimbursement. If the Participant makes no such designation, the Participant will be deemed to have made such a designation.
  3. Notwithstanding the preceding provision, to the extent that medical expenses incurred by a Participant during a grace period for a Prior Plan Year exceed the Participant's unused amounts allocated under the Plan for the Prior Plan Year, as of the last day of such Prior Plan Year, those excess medical expenses shall be treated as incurred during the then current Plan Year and shall not be treated as incurred during the Prior Plan Year.
  4. If medical expenses incurred during the grace period for a Prior Plan Year, that are treated as incurred during the Prior Plan Year, otherwise qualify for reimbursement under the Plan, they shall be reimbursed from the unused amounts allocated under the Plan for the Prior Plan Year.
  5. All claims for reimbursement shall be paid in the order in which they are approved by the Administrator. Once a claim has been paid, it will not be reprocessed or otherwise

recharacterized so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year.

6. To the extent that a Participant's unused amounts allocated under the Plan for a Prior Plan Year, as of the last day of such Prior Plan Year, exceed the medical expenses that are incurred by the Participant during the grace period for the Prior Plan Year and that qualify for reimbursement under the Plan, that remaining unused amount may not be carried forward to any subsequent period.
7. Unused amounts allocated under the Plan for a Prior Plan Year may not be cashed-out or converted to any other taxable or nontaxable benefit other than the benefit under the Plan.
8. The grace period for a Prior Plan Year shall remain in effect for a Participant for the entire two and one-half (2-1/2) months after the end of such Prior Plan Year even though the Participant may terminate employment on or before the last day of the grace period.
9. The grace period for Prior Plan Year does not extend the deadline for filing claims for such Prior Plan Year.

7.04. Medical Expense Reimbursement Benefit Claims.

The Participant may incur medical expenses and then submit proof of such expenses to the Participant's Employer or the Administrator. The Participant must actually pay an expense prior to being reimbursed for it; provided, however, that the Administrator may pay the reimbursements directly to the appropriate third party payee in lieu of requiring that the Participant must actually pay an expense and then making reimbursement to the Participant. The Participant shall provide such information and verification at such times and in such manner as required by the Participant's Employer or the Administrator.

7.05. Medical Expense Reimbursement Benefit Payments.

Upon making reimbursement for a Participant's medical expenses, the Participant's Employer shall be relieved of all further responsibility with respect to any such medical expenses and the provision of benefits under this article.



7.06. Intent Of Medical Expense Reimbursement Benefit.

The benefit provided under this article is intended to comply with the provisions of Code sections 105 and 106 and, therefore, will be deemed to be automatically amended to comply with all legislative changes to, and valid regulations promulgated under, these Code sections, as of the effective date of such legislation or regulations.

ARTICLE 8. DEPENDENT CARE ASSISTANCE BENEFIT

8.01. Purpose Of Dependent Care Assistance Benefit.

The benefit available under this article provides payments by the Participant's Employer to reimburse the Participant for dependent care assistance.

8.02. Dependent Care Assistance Benefit Definitions.

For purposes of this Dependent Care Assistance Benefit article, the following definitions shall apply:

A. Dependent.

"Dependent" means any individual who is a "qualifying individual," as defined in Code section 21(b)(1).

B. Earned Income.

"Earned Income" means all income derived from wages, salaries, tips, and other employee compensation, but only if such amounts are includible in gross income for the taxable year, plus the amount of net earnings from self-employment for the taxable year within the meaning of Code section 1402(a), determined with regard to the deduction allowed the self-employed individual for self-employment taxes by Code section 164(f); provided, however, that such term does not include (i) any amounts received under the Plan or any other dependent care assistance program under Code section 129, (ii) any amounts received as a pension or annuity, or (iii) other amounts excluded from the definition of "earned income" under Code section 32(c)(2)(B).

C. Eligible Employment Related Expenses.

"Eligible Employment Related Expenses" means all Employment Related Expenses incurred by a Participant that are paid to a person who is not:

1. With respect to whom, for the taxable year, a deduction under Code section 151(c) is allowable either to the Participant or the Participant's spouse; or
2. A child of the Participant within the meaning of Code section 152(f)(1) under the age of nineteen (19).

D. Employment Related Expenses.

"Employment Related Expenses" means expenses incurred for services performed to enable a Participant or the Participant's spouse to be gainfully employed and that are related to the care of a Qualifying Individual or Individuals which satisfy either paragraph 1 or 2, below, and which also satisfy the requirements of paragraph 3, below:

1. In the household of the Participant for the care of a Qualifying Individual; or
2. Outside the household of the Participant for:
  - a. The care of a Qualifying Individual who is a qualifying child of the Participant (as defined in Code section 152(a)(1)) who is under the age of thirteen (13); or
  - b. The care of any other Qualifying Individual who regularly spends at least eight (8) hours each day in the Participant's household.
3. Expenses shall not be considered "Employment Related Expenses" unless they meet each of the requirements of this paragraph. Such expenses must be expenses:
  - a. Which are considered employment-related expenses defined in Code section 21(b)(2);
  - b. Which are incurred by the Employee during a period of time during which he or she was a Participant under this Plan and had elected to participate in the

benefit provided under this Dependent Care Assistance Benefit article (regardless of when the Participant was actually billed or paid for the expense) and which are provided after the effective date of such election; and

- c. With respect to which the Participant has provided adequate substantiation.

E. Qualifying Individual.

"Qualifying Individual" means:

1. A Dependent of a Participant who is under the age of thirteen (13) and with respect to whom the Participant is entitled to a deduction under Code section 151(c);
2. A Dependent of a Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half (1/2) of the taxable year; or
3. The spouse of a Participant, if the spouse is physically or mentally incapable of taking care of himself or herself and who has the same principal place of abode as the Participant for more than one-half (1/2) of the taxable year.

F. Student.

"Student" means an individual who, during each of five (5) calendar months during the calendar year, is a full-time student at an educational organization that normally maintains a regular faculty and curriculum, and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.

8.03. Dependent Care Reimbursements.

- A. Except as provided in the Dependent Care Assistance Benefit Limitations section, the Participant's Employer shall reimburse the Participant for Eligible Employment Related Expenses incurred by such Participant, that are incurred during a Plan Year, during the period of the Participant's participation in this Plan while an election is in effect by the Participant under this Dependent Care Assistance Benefit article; provided, however, that if the Participant terminates employment during the Plan Year, the

Participant's Employer shall reimburse the Participant for Eligible Employment Related Expenses incurred by such Participant that are incurred by the Participant during such Plan Year after the Participant's termination of employment.

- B. Amounts not used for dependent care expenses incurred by the end of the Plan Year shall be forfeited and shall not be carried over from one Plan Year to the next Plan Year.

8.04. Dependent Care Assistance Benefit Limitations.

- A. A Participant may not receive benefits during any calendar year, from this Plan or any other dependent care assistance program under Code section 129, in excess of:
  - 1. In the case of a Participant who is not married at the close of such year, the Earned Income of the Participant for such year; or
  - 2. In the case of a Participant who is married at the close of such year, the lesser of:
    - a. The Earned Income of the Participant for such year; or
    - b. The Earned Income of the Participant's spouse for such year.
- B. For purposes of the preceding subsection, a spouse of a Participant who is not employed during any month in which the Participant incurs Eligible Employer Related Expenses and which spouse is either incapacitated or a Student shall be deemed to have Earned Income for such month of:
  - 1. Two hundred fifty dollars (\$250), if there is one (1) Qualifying Individual for whom the Participant incurs Eligible Employment Related Expenses; or
  - 2. Five hundred dollars (\$500), if there is more than one (1) Qualifying Individual for whom the Participant incurs Eligible Employment Related Expenses.
- C. In no event may a Participant and a Participant's spouse receive benefits for Eligible Employment Related Expenses during any calendar year, from this Plan or any other dependent care assistance program under Code section 129, in excess of five

thousand dollars (\$5,000); provided, however, that if the Participant is a married individual filing a separate federal income tax return for such calendar year, said amount shall be reduced to two thousand five hundred dollars (\$2,500).

- D. In no event shall any benefit be payable with respect to qualifying services by a facility that provides care for more than six (6) individuals (other than individuals who reside at the facility) unless the facility complies with all applicable State and local laws and regulations, including being licensed as a day care facility.
- E. The benefits provided during the Plan Year to Employees who are Highly Compensated Employees under this article shall be limited so that the Average Benefits provided during the Plan Year to Employees who are not Highly Compensated Employees shall be at least fifty-five percent (55%) of the Average Benefits provided during the Plan Year to Employees who are Highly Compensated Employees.
  - 1. "Average Benefits" means, with respect to Highly Compensated Employees, an amount equal to the aggregate benefits provided to the Highly Compensated Employees under this article divided by the number of Highly Compensated Employees, whether or not covered under this article.
    - a. The Average Benefits for Employees who are not Highly Compensated Employees shall be determined in the same manner as the Average Benefits for Highly Compensated Employees.
    - b. For purposes of this section, in the case of benefits provided through a compensation reduction agreement, the Employer may disregard any Employees whose total compensation during the Plan Year is less than twenty-five thousand dollars (\$25,000).
  - 2. In the event that it appears to the Administrator, at any time during the Plan Year, that the limitation set forth in this section may be violated, the Administrator may, in its sole and absolute discretion, and upon notice to the Participant, withhold the payments of benefits, or any portion thereof, to Participants who are Highly Compensated Employees, until such time as the Administrator determines that such amounts may be paid to the Highly Compensated

Employees without violating the limitation set forth in this section.

3. The Administrator shall limit benefits otherwise payable to Highly Compensated Employees in order to satisfy the requirements of this section by reducing the benefits otherwise payable to one or more Highly Compensated Employees in the manner determined by the Administrator in its sole and absolute discretion.

F. The maximum amount of the dependent care assistance reimbursement that any Participant may receive for a Plan Year shall be the amount allocated by the Participant for the dependent care assistance benefit under the Election Of Available Benefits article, above.

G. The Employer shall not be required to pay any dependent care assistance reimbursement amounts in excess of that portion of the amount by which the Participant's compensation has been reduced pursuant to the election described in this section and not previously paid out on behalf of the Participant under this article during the Plan Year.

8.05. Dependent Care Assistance Benefit Claims.

The Participant may incur dependent care assistance expenses and then submit proof of such expenses to the Participant's Employer or the Administrator. The Participant must actually pay an expense prior to being reimbursed for it. The services giving rise to the expense must actually be rendered prior to the Participant being reimbursed for it. The Participant shall provide such information and verification at such times and in such manner as required by the Participant's Employer or the Administrator, including, but not necessarily limited to, the following information:

A. The Dependent or Dependents for whom the services have been performed;

B. The nature of the services performed for the Participant;

C. The relationship, if any, of the person who performed the services to the Participant;

D. If the services were performed by a child of the Employee, such child's date of birth;

- E. A statement as to where the services were performed;
- F. If any of the services were performed outside the household of the Participant, a statement as to whether the Dependent for whom such services were performed regularly spends at least eight (8) hours each day in the Participant's household;
- G. If any of the services were performed outside the household of the Participant, a statement as to:
  - 1. Whether the facility complies with all applicable laws and regulations of the State of California;
  - 2. Whether the facility provides care for more than six (6) individuals (other than individuals who reside at the facility); and
  - 3. The amount of fee paid to the facility; and
- H. If the Participant is married, a statement of the Participant's spouse's salary or wages if the spouse is employed; or, if the Participant's spouse is not employed, a statement that the spouse is incapacitated or is a full-time Student and the months during the year when the spouse will attend the educational organization.

8.06. Dependent Care Assistance Benefit Payments.

Upon making reimbursement for a Participant's dependent care assistance expenses, the Participant's Employer shall be relieved of all further responsibility with respect to any such dependent care assistance expenses and the provision of benefits under this article.

8.07. Intent Of Dependent Care Assistance Benefit.

The benefit provided under this article is intended to comply with the provisions of Code section 129 with respect to dependent care assistance and, therefore, will be deemed to be automatically amended to comply with all legislative changes to, and valid regulations promulgated under, this Code section, as of the effective date of such legislation or regulations.

## ARTICLE 9. HEALTH SAVINGS ACCOUNT BENEFIT

### 9.01. Purpose Of Health Savings Account Benefit.

The benefit available under this article provides payments by the Employer to the Participant's Health Savings Account to the extent elected by the Participant.

### 9.02. Health Savings Account Benefit Special Definitions.

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

#### A. Eligible Individual.

1. "Eligible Individual" means with respect to any month, any Employee if:
  - a. The Employee is covered under a High Deductible Health Plan that is maintained by the Employer as of the first day of such month; and
  - b. The Employee is not, while covered under a High Deductible Health Plan, covered under any health plan that is not a under a High Deductible Health Plan and that provides coverage for any benefit that is covered under the under a High Deductible Health Plan. For this purpose, coverage under either a limited-purpose health flexible spending arrangement benefit under the Plan, if any, or a post-deductible health flexible spending arrangement benefit under the Plan, if any, shall not be considered to be such coverage.
2. The preceding provisions shall be applied without regard to:
  - a. Coverage for any benefit provided by insurance:
    - (1) If substantially all of the coverage provided under such insurance relates to (i) liabilities incurred under workers' compensation laws, (ii) tort liabilities, (iii) liabilities relating to ownership or use of property, or (iv) such other similar liabilities as the Secretary of the Treasury may specify by regulations;



- (2) For a specified disease or illness; or
- (3) Paying a fixed amount per day (or other period) of hospitalization;

and

- b. Coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

B. Health Savings Account.

"Health Savings Account" means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the requirements set forth in Code section 223(d).

C. High Deductible Health Plan.

"High Deductible Health Plan" means a health plan that:

1. Has an annual deductible that is not less than one thousand dollars (\$1,000) for self-only coverage and two thousand dollars (\$2,000) for family coverage, as such amounts may be adjusted by the Commissioner of Internal Revenue for increases in the cost of living in accordance with Code section 223(g);
2. Under which the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed five thousand dollars (\$5,000) for self-only coverage and ten thousand dollars (\$10,000) for family coverage, as such amounts may be adjusted by the Commissioner of Internal Revenue for increases in the cost of living in accordance with Code section 223(g); and
3. Under which substantially all of the coverage is not:
  - a. Coverage for any benefit provided by Permitted Insurance; or

- b. Coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

D. Health Savings Account.

"Health Savings Account" means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the requirements set forth in Code section 223(d).

To the extent that the terms defined above are defined in Code section 223 or any other related Code section, the above definitions shall be subject to and interpreted in a manner consistent with such Code sections, the Treasury regulations promulgated thereunder, and the lawful guidance published by the Internal Revenue Service regarding such terms.

9.03. Health Savings Account Benefit Eligibility.

- A. Those Participants who are eligible to participate under this article shall be determined on a monthly basis and shall be the Employees who (i) are Eligible Individuals for such month and (ii) have elected this benefit under the election procedures specified in this Plan for such month.
- B. If the Employer elects to provide Employer contributions to the Health Savings Account of one or more Participants for a month, without regard to whether they have elected this benefit under the election procedures specified in this Plan for such month, such Participants shall be eligible to participate under this article for such month if they are Eligible Individuals for such month; provided, however, that no Participant shall receive the Employer contribution to the Participant's Health Savings Account for a month unless the Participant is an Employee on the last day of such month.

9.04. Health Savings Account Payments.

Subject to the limitations contained in the Health Savings Account Benefit Limitations paragraph, below, and the other provisions of this Plan, the Employer shall make a monthly payment to the Health Savings Account of an eligible Participant according to the following provisions:

- A. The payments shall be limited to the months when the Participant is covered by this Plan and an Eligible Individual.
- B. Such amounts shall be paid to a Participant's Health Savings Account for a month only after the Participant has provided proof that is satisfactory to the Employer, the Administrator or the Claims Administrator, in their sole and absolute discretion, that the Participant is an Eligible Individual for such month and that the account to which the payment is to be made is a Health Savings Account.

9.05. Health Savings Account Benefit Limitations.

The maximum amount of the Health Savings Account payment that any Participant may receive for a month shall be determined as follows:

- A. In the case of an Eligible Individual who has self-only coverage under a High Deductible Health Plan as of the first day of such month, the limit shall be one-twelfth (1/12th) of two thousand two hundred fifty dollars (\$2,250), as such amount may be adjusted by the Commissioner of Internal Revenue for increases in the cost of living in accordance with Code section 223(g).
- B. In the case of an Eligible Individual who has family coverage under a High Deductible Health Plan as of the first day of such month, the limit shall be one-twelfth (1/12th) of four thousand five hundred dollars (\$4,500), as such amount may be adjusted by the Commissioner of Internal Revenue for increases in the cost of living in accordance with Code section 223(g).
- C. For purposes of the preceding provisions, for any taxable year, an individual who is an Eligible Individual during the last month of such taxable year shall be treated (i) as having been an Eligible Individual during each of the months in such taxable year and (ii) as having been enrolled, during each of the months such individual is treated as an Eligible Individual solely by reason of clause (i), in the same High Deductible Health Plan in which the individual was enrolled for the last month of such taxable year. If, however, an individual who is governed by the preceding sentence fails to remain an Eligible Individual for all of the following year (unless the individual ceases to be an Eligible Individual by reason of death or becoming disabled), then (i) the individual's gross income for that following year will be increased by the aggregate amount of the contributions to the Health Savings Account that could not have been made during the previous year except for the special rule in the preceding

sentence and (ii) the individual's federal income taxes for that following year will be increased by ten percent (10%) of the amount of this additional gross income, all to the extent required by Code section 223(b)(8)(B).

- D. In the case of an Eligible Individual who would attain age fifty-five (55) by the end of a calendar year, the preceding limitations shall be increased by an additional one thousand dollars (\$1,000).
- E. For purposes of the limitations above, in the case of married individuals, if either spouse has family coverage, then:
  - 1. Both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible); and
  - 2. The limitation in subparagraph B, without regard to subparagraph C, shall be reduced by the aggregate amount paid to Archer MSAs (i.e., a trust created or organized in the United States as a medical savings account exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the requirements set forth in Code section 220(d)) of such spouses for the calendar year and, after such reduction, shall be divided equally between them unless they agree on a different division.
- F. The limitation that would otherwise apply under this paragraph to a Participant for any calendar year shall be reduced to zero (0) in the case of a Participant with respect to whom a deduction under Code section 151 is allowable to another taxpayer for the calendar year.
- G. The limitation that would otherwise apply under this paragraph to the Participant for any calendar year shall be reduced to zero (0) for the first month such Participant is entitled to benefits under title XVIII of the Social Security Act (i.e., Medicare) and for each month thereafter.
- H. Qualified HSA distributions, as defined in Code section 106(e), shall not be taken into account in applying the above limitations.

9.06. Health Savings Account Benefit Special Elections.

In addition to the election changes that are permitted under the Irrevocability Of Elections section of the Plan:

- A. A Participant who elected the benefit under this article may (i) stop the election at any time if the Participant ceases to be an Eligible Individual, (ii) reduce the election at any time in order to stay within the limitations set forth above, or (iii) increase the election at any time so long as the change does not cause the limitations set forth above to be exceeded, so long as the change is effectively prospectively; and
- B. A Participant who has not elected the benefit under this article may make an election at any time if the Participant becomes an Eligible Individual so long as the change is effectively prospectively.

9.07. Intent Of Health Savings Account Benefit.

The benefit provided under this article is intended to comply with the provisions of Code sections 106(d), 125(d)(2)(D) and 223 with respect to health savings accounts, and, therefore, will be deemed to be automatically amended to comply with all legislative changes to, and valid regulations promulgated under, these Code sections, as of the effective date of such legislation or regulations.

## ARTICLE 10. PLAN ADMINISTRATION

10.01. Employment Records.

The Employer shall maintain sufficient employment records to determine benefits under this Plan for each Employee. The Employer shall make such records available to the Administrator, in a timely manner, and the Employer shall be responsible for the accuracy of such information, upon which the Administrator is entitled to rely.

10.02. Reports And Disclosure.

The Administrator shall prepare, file and distribute, in a timely manner, all reports and information to be disclosed to Participants as may be required by the Code or applicable State law. The Administrator shall prepare such reports from records kept by it and information furnished by the Employer.

10.03. Retention Of Records.

The Employer shall maintain records with respect to this Plan and the benefits offered through this Plan in accordance with the Employer's record retention schedule(s) or as otherwise required by the Code or applicable State law.

10.04. Powers And Responsibilities.

- A. The Employer shall be empowered to appoint and remove the Administrator, from time to time, as it deems necessary for the proper administration of the Plan and to assure that the Plan is being operated for the exclusive benefit of the Participants and their Beneficiaries in accordance with the terms of the Plan, the Code and applicable State law.
- B. The Employer shall periodically review the performance of any fiduciary or other person to whom duties have been delegated or allocated by it under the provisions of this Plan, or pursuant to procedures established hereunder. This requirement may be satisfied by formal periodic review by the Employer or by a qualified person specifically designated by the Employer, through day-to-day conduct and evaluation, or through other appropriate means.

10.05. Designation Of Administrative Authority.

- A. The Employer shall be the Administrator. However, the Employer may appoint another person or persons to serve as the Administrator. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify such appointee's acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer, or may be removed by the Employer with or without cause by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified.
- B. The Employer, upon the resignation or removal of an Administrator, shall promptly designate in writing a successor to this position. If the Employer does not appoint a successor Administrator, the Employer will function as the Administrator.

10.06. Allocation And Delegation Of Responsibilities.

If more than one person is appointed as the Administrator, the responsibilities of each appointed person may be specified by the Employer and accepted in writing by each Administrator. In the event that the Employer makes no such delegation, the Administrators may allocate the responsibilities among themselves, in which event the Administrators shall notify the Employer in writing of such action and specify the responsibilities of each Administrator. Except where there has been an allocation and delegation of administrative authority pursuant to this section, if there shall be more than one Administrator, they shall act by a majority of their number, but may authorize one or more of them to sign all papers on their behalf. The Administrators may act with or without a meeting being called or held and shall keep minutes of all meetings held and a record of all actions taken by written consent. No Administrator may participate in any decision that involves solely the Administrator's interest as a Participant in the Plan.

10.07. Powers And Duties Of The Administrator.

The primary responsibility of the Administrator is to administer the Plan for the exclusive benefit of the Participants and their Beneficiaries, subject to the specific terms of the Plan and in compliance with applicable State law. The Administrator shall administer the Plan in accordance with its terms and shall have the power and discretion to interpret and construe the terms of the Plan, to decide any disputes and resolve any ambiguities which may arise relative to the rights of the Employees, past and present, and their Beneficiaries, under the terms of the Plan, and to determine all questions arising in connection with the administration, interpretation and application of the Plan. Any such determination by the Administrator shall be conclusive and binding upon all persons. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan; provided, however, that any such procedure, discretionary act, interpretation or construction shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to be deemed a cafeteria plan under the terms of Code section 125, and shall comply with the terms of applicable State law and all regulations issued pursuant thereto. The Administrator shall have all powers necessary or appropriate to accomplish its duties under this Plan.

10.08. Administrative Functions.

The Administrator shall:

- A. Determine Participant eligibility;
- B. Except to the extent that an insurer or other service provider has the power to do so under a Contract, determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan, inform the Employer, and any party to a Contract, as appropriate, of the amount of such benefits, and provide a full and fair review to any claim for benefits which has been denied in whole or in part;
- C. Designate other person(s) to carry out any duty or power which would otherwise be a fiduciary responsibility of the Administrator under the terms of the Plan including but not limited to delegating certain claims administration duties to a claims administrator, provided that any such delegation or allocation of responsibilities shall be set out in a written instrument executed by the Administrator and the designated party and, provided further, that the fiduciary responsibilities of the Administrator with respect to each Contract shall be deemed to have been delegated and allocated to the insurer or other service provider that is a party to the Contract;
- D. Process claims and appeals from claims denied;
- E. Make recommendations to the Employer concerning any phase of Plan management or administration; and
- F. Develop and maintain qualified medical child support order procedures as required by applicable State law.

10.09. Appointment And Responsibility Of Representatives.

- A. With the consent of the Employer or its designee, the Administrator shall have the right and the power to appoint one or more representatives, accountants, counsel, specialists, and other advisory and clerical persons as it deems necessary or desirable to assist the Administrator in the administration of the Plan. All usual and reasonable expenses of such representatives, accountants, counsel, specialists, and other advisory and clerical persons may be paid in whole by the Plan, in whole by the Employer (if the Employer agrees to do so in advance), or in part



by the Plan and in part by the Employer (if the Employer agrees to do so in advance).

- B. The Administrator may designate any person as its agent for any purpose. The designated representative of the Administrator shall be responsible only for those specific powers, duties, responsibilities and obligations specifically given to it by the Administrator. The Administrator, the Employer and any person to whom the Administrator may delegate any duty or power in connection with the Plan's administration may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant (including employees who are actuaries or accountants), legal counsel, or other specialist, and they shall be fully protected whenever they take action based in good faith in reliance thereon. All actions taken in good faith reliance on advice from the advisors are conclusive upon all persons. Any benefits not paid by the Plan shall not be the responsibility of the designated representatives.

10.10. Appointment Of Fiduciaries And Agents.

The Employer or its designee shall have the right to hire and fire any fiduciary or agent, including the Administrator, or any agent designated pursuant to the Appointment And Responsibility Of Representatives section, above.

10.11. Compensation Of Administrator.

The Administrator(s) shall receive no compensation from the Plan for acting as such, but the Plan shall reimburse the Administrator(s) for all necessary and proper expenses incurred in carrying out its duties under the Plan.

10.12. Use Of Electronic Media.

In accordance with Treasury regulations and applicable State law and the regulations and guidance provided thereunder, the Administrator may use telephonic or electronic media to satisfy the notice requirements under this Plan and to make appropriate administrative pronouncements including, but not limited to, notices, elections and disclosures with respect to summary plan descriptions, summaries of material modifications, summary annual reports, participant disclosures, and qualified medical child support orders.

10.13. HIPAA Privacy, Security And Transaction Standards.

Inasmuch as (i) certain members of the Employer's workforce may have access to protected health information (PHI) and electronic PHI, as defined in HIPAA and its implementing regulations (HIPAA Rules), for administrative functions of the Plan, and (ii) HIPAA and its implementing regulations require that the group health plan be amended to incorporate certain provisions and that the group health plan sponsor agree to such provisions in order for a group health plan's sponsor to have access to PHI from the group health plan, the Employer and the Plan shall comply with the applicable privacy, security and administration regulations promulgated under HIPAA, as they may be in effect from time to time. In addition, the following provisions shall govern the use and disclosure of PHI by the Plan to the Employer by a group health plan benefit provided under the Plan (to the extent required by and not inconsistent with such regulations):

A. Hybrid Entity Designations.

In view of the fact that the Plan may be a hybrid entity as defined in the HIPAA Rules:

1. The Employer designates that the health care components of the Plan are the group health plan benefits provided under the Plan, if any, whether fully insured, self-insured, or a combination, and the administration functions of the Plan that relate to such benefits.
2. The Employer designates that the other components of the Plan are not health care components of the Plan.
3. The other components of the Plan that are not health care components shall be treated as if they were a separate legal entity from the health care components of the Plan for purposes of the following provisions.

B. Permitted Disclosure Of Enrollment/Disenrollment Information.

The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

C. Permitted Uses And Disclosure Of Summary Health Information.

The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose summary health information, as defined in the HIPAA Rules, to the Employer, provided the Employer requests the summary health information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan.

D. Uses And Disclosure For Plan Administrative Purposes.

Unless otherwise permitted by law, and subject to the conditions of disclosure described in the Conditions Of Disclosure For Plan Administration Purposes subsection, below, and obtaining written certification pursuant to the Certification Of The Employer subsection, below, the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI to the Employer; provided, however, that the Employer may use or disclose such PHI for Plan administration purposes only.

1. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring.
2. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with section 164.504(f) of the HIPAA Rules.

E. Conditions Of Disclosure For Plan Administration Purposes.

The Employer agrees that, with respect to any PHI (other than enrollment/disenrollment information and summary health information, that are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan), the Employer shall:

1. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make available PHI to comply with HIPAA's right to access in accordance with section 164.524 of the HIPAA Rules;
6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the HIPAA Rules;
7. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the HIPAA Rules;
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
9. If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall") required by section 164.504(f)(2)(iii) of the HIPAA Rules is satisfied.

F. Conditions Of Disclosure Of Electronic PHI To The Employer.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment or disenrollment information, summary health information, and information disclosed pursuant to a signed authorization that complies with section 164.508 of the HIPAA Rules, that are not subject to these restrictions) on behalf of the Plan, the Employer shall:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI;
2. Ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall") required by section 164.504(f)(2)(iii) of the HIPAA Rules is supported by reasonable and appropriate security measures;
3. Ensure that any agents (including subcontractors) to whom the Employer provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information; and
4. Report to the Plan any electronic PHI security incident of which it becomes aware.

G. Adequate Separation Between The Plan And The Employer.

The Employer shall allow only those employees of the Employer who are responsible for the Plan's administration functions to have access to the PHI. No other employees of the Employer shall have access to PHI. These employees shall have access to and use PHI only 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 do not comply with the provisions of this provision, such employee(s) shall be subject to disciplinary action by the Employer for noncompliance pursuant to the Employer's employee discipline and termination of employment procedures. The Employer shall ensure that the preceding provisions are supported by reasonable and appropriate security measures to the extent that such employees have access to electronic PHI.

H. Certification Of The Employer.

The Plan (or a health insurance issuer or HMO with respect to the Plan) shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions required by section 164.504(f)(2)(ii) of the HIPAA Rules and that the Employer agrees to the conditions of disclosure set forth in the Conditions Of Disclosure For Plan Administration Purposes subsection, above.

I. Genetic Information.

The Plan shall comply with the requirements of the Genetic Information Nondiscrimination Act Of 2008 (GINA) to the extent required by the provisions of GINA and the regulations thereunder, effective as of May 21, 2009, or such later date as may be provided under the regulations under GINA.

ARTICLE 11. CLAIMS PROCEDURES

11.01. Request For Information.

Any Participant or Beneficiary may request such information concerning the Participant's or Beneficiary's rights or benefits under this Plan as is required to be disclosed under applicable State law. The Administrator shall respond, in writing, within a reasonable time, not to exceed thirty (30) days, unless the failure to respond results from matters reasonably beyond the Administrator's control.

11.02. Claims For Benefits.

In order to receive benefits under this Plan, the Participant must submit satisfactory proof of entitlement to such a benefit as set forth in this Claims Procedures article. All claims must be substantiated by information from a third-party that is independent of the Employee, the Employee's spouse and the Employee's Dependents. The independent third party must provide information describing the service or product, the date of the service or sale, and the amount.

11.03. Filing Claims.

A. In the event that a Participant or Beneficiary has a claim for any benefit under any insured benefit under this Plan, then the Participant or Beneficiary shall file the claim with the insurer or other provider of the benefit in accordance with the applicable Contract. In the event that a Participant or Beneficiary has a

claim for any other benefit under this Plan, then the Participant shall file a claim with the Administrator on forms provided for such purpose. Upon request, the Administrator shall provide a Participant, Beneficiary or the Participant's or Beneficiary's designated representative with any and all necessary forms.

- B. Any Participant, Beneficiary, or duly authorized representative of a Participant or Beneficiary (Claimant) may file a claim for benefits to which such Claimant believes he or she is entitled. Claims must be made in writing and delivered to the Administrator or to the appropriate insurer or service provider in accordance with the applicable claims procedure under the Contract or this Claims Procedures article, as appropriate. Claimants shall provide the Administrator or the appropriate insurer or service provider with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.
- C. Unless otherwise announced by the Administrator, a claim for benefits must be filed within the time period provided in the Contract under which the benefit is provided. Claims for benefits incurred during a Plan Year, that are not governed by a Contract, must be made no later than ninety (90) days following the end of the Plan Year when the benefit was incurred. A claim for benefits for a grace period for a Prior Plan Year must be made no later than ninety (90) days following the end of the grace period. Notwithstanding the preceding claims deadlines, if a Participant ceases to be a Participant (e.g., upon termination of employment), claims for benefits incurred prior to cessation of participation must be made no later than ninety (90) days following such cessation of participation. Any delinquent claims will not be paid.

#### 11.04. Initial Determination Of Claim.

Claims for specific benefit payments or reimbursements that are governed by a Contract shall be adjudicated under the terms of the Contract under which such benefit payment or reimbursement is provided. For claims for specific benefit payments or reimbursements that are not governed by a Contract, the follow procedures shall apply:

- A. The Administrator shall have full discretion to grant or deny a claim in whole or in part.
- B. The Administrator will notify the Claimant, in writing, of the granting or denying, in whole or in part, of such claim, within thirty

(30) days after receipt of such claim; provided, however, that if the Administrator determines that an extension of time for processing the claim is necessary due to matters beyond the control of the Administrator, this period may be extended no more than fifteen (15) days from the end of the initial thirty (30) day period.

- C. If an extension of time is necessary, the Claimant must be given a written notice to this effect prior to the expiration of the initial thirty (30) day period and the notice must indicate the special circumstances requiring the extension and the date by which a decision will be made. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice shall specifically describe the required information and the Claimant shall submit the specified information no later than forty-five (45) days from receipt of the notice by the Claimant.
- D. If a claim is denied in whole or in part, the Administrator's notice denying such claim shall set forth, in a manner calculated to be understood by the Claimant, the following:
  - 1. The specific reason or reasons for the denial;
  - 2. Specific reference to pertinent Plan or Contract provisions on which the denial is based;
  - 3. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material information is necessary; and
  - 4. An explanation of the Plan's claim review procedures.
- E. If notice of the granting or denying of a claim is not furnished in accordance with the preceding provisions, the claim shall be deemed denied and the Claimant shall be permitted to exercise the Claimant's right to review pursuant to the Claims Appeals section, below.

#### 11.05. Claims Appeals.

If a claim for benefits under a Contract is fully or partially denied, the insurer's or service provider's appeals procedures shall be followed. If, however, a claim is made under this Plan other than under a Contract, then the following appeal procedures shall apply:



- A. If a Claimant wishes to appeal a denial of a claim, the Claimant or the Claimant's duly authorized representative:
  - 1. May request a review upon written application to the Administrator;
  - 2. May submit written comments, documents, records, and other information relating to the claim; and
  - 3. May obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
  
- B. The written request for review must be received by the Administrator within one hundred eighty (180) days after the Claimant receives notice that the Claimant's claim for Plan benefits has been denied.
  
- C. The decision on the review shall be made by the Administrator, who may, in its discretion, hold a hearing on the denied claim; provided, however, that the following requirements shall apply:
  - 1. The review of the denied claim shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the review nor the subordinate of such individual;
  - 2. If the adverse benefit determination that is the subject of the review was based in whole or in part on a medical judgment, the appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who shall not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the review, nor the subordinate of such individual; and
  - 3. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination shall be identified without regard to whether the advice was relied upon in making the benefit determination.

- D. The Administrator shall make its decision promptly, and not later than sixty (60) days after the Administrator's receipt of the request for a review, unless the Administrator determines that special circumstances require an extension of time for processing the claim. If the Administrator determines that an extension of time for processing is required, this period may be extended no more than sixty (60) days from the end of the initial sixty (60) day period, in which case the Administrator shall give the Claimant a written notice to this effect prior to the expiration of the initial sixty (60) day period and the notice shall indicate the special circumstances requiring the extension of time and the date by which a decision will be made on review.
  
- E. The decision on review must be written in a manner calculated to be understood by the Claimant. In the case of an adverse benefit determination, the notification to the Claimant shall set forth, in a manner calculated to be understood by the Claimant, the following:
  - 1. The specific reason or reasons for the denial;
  - 2. Specific reference to pertinent Plan provisions on which the denial is based;
  - 3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
  
- F. If the decision on review is not furnished to the Claimant within the time required in this section, the claim shall be deemed denied on review and the Claimant shall be permitted to exercise the Claimant's right to legal remedy pursuant to the remaining sections of this Claims Procedures article.

11.06. Internal And External Review.

In addition to the claims appeal provisions set forth above, each group health plan benefit that is provided under the Plan shall be subject to both internal and external claim review processes to the extent required by section 2719 of the PHSA, pursuant to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as such laws may be amended from time to time, and pursuant to the lawful guidance thereunder published by the Treasury Department, the Internal Revenue Service, or the Department of Health and Human Services from time to time; provided, however, that, if a

group health plan or any "benefit package" under a group health plan is a "grandfathered health plan," as such terms are defined in such legislation and guidance, then this provision shall not apply to any such group health plan or benefit package.

11.07. Legal Actions.

- A. A Claimant must submit a written claim and exhaust the preceding claims procedures before legal recourse of any type is sought. Except as explicitly permitted by statute, the Administrator, any appropriate insurer or other service provider specified in any Contract and the Employer are the only necessary parties to any action or proceeding that involves the Plan or a Contract, or the administration of the Plan or a Contract. No Participants or their Beneficiaries or any person having or claiming to have an interest under the Plan is entitled to notice of process. Any final judgment that is not appealable for any reason (including the passage of time) and that is entered in an action or proceeding involving the Plan or a Contract is binding and conclusive on the parties to this Plan or a Contract and all persons having or claiming to have any interest under the Plan or a Contract.
- B. Judicial review of a Claimant's denied claim shall be limited to a determination of whether there was an abuse of discretion. A Claimant may commence no legal action more than three (3) years after the final decision denying the claim.

11.08. Administration Pending Resolution Of Disputes.

If a dispute arises with respect to any matter under this Plan, the Administrator may refrain, or direct the appropriate insurer or other service provider specified in any Contract, from taking any other or further action in connection with the matter involved in the controversy until the dispute has been resolved under the Plan or the appropriate Contract. If a dispute arises as to the proper amount or recipient of any payment of benefits, the Administrator, in the Administrator's sole discretion, may withhold or cause to be withheld, such payment until the dispute has been settled by the parties concerned, or the Administrator or the appropriate insurer or other service provider specified in any Contract may deposit such funds or property with the court in an interpleader action brought under the law of the State having jurisdiction.

11.09. Time.

The filing of claims or receipt of notices of rulings and any event starting a time period shall be deemed to commence with personal delivery

signed for by the Claimant or by affidavit of personal service, or the date of actual receipt of certified mail or date returned if delivery is refused or a Claimant has moved without giving the Administrator a forwarding address.

11.10. Uncashed Reimbursements.

If, according to the records of the Plan, the Plan has made a reimbursement of an expense under the Medical Expense Reimbursement Benefit article, the Dependent Care Assistance Benefit article, or both, and the reimbursement has not been cashed or deposited by the last day of the Plan Year following the Plan Year when the Plan made such reimbursement, the Participant shall forfeit the right to such reimbursement and any future reimbursement with respect to the same expense(s).

ARTICLE 12. AMENDMENTS AND TERMINATION

12.01. Amendments.

- A. The Employer reserves the right to amend this Plan and any Contract at any time without the consent of the Administrator, any fiduciary, or any Participant or Beneficiary; provided, however, that, except in accordance with the provisions of the Plan including any appropriate Contract, or as otherwise specifically permitted by law, no such amendment shall affect any right to claim reimbursement of benefits incurred prior to such amendment. The Employer may make any amendment that it determines to be necessary or desirable, with or without retroactive effect, to comply with the law.
- B. Any such Plan or Contract amendment shall be made by means of a written instrument identified as an amendment of the Plan or the Contract effective as of a specified date. For an amendment adding a new Compensation Reduction Benefit to the Plan, the Plan will pay or reimburse only those expenses for benefits incurred under the new Compensation Reduction Benefit after the later of (i) the amendment's adoption date or (ii) the effective date of the amendment.
- C. Notwithstanding any other provision of the Plan or a Contract to the contrary, if there is a scrivener's error in properly transcribing the provisions of this Plan or a Contract, it shall not be a violation of the Plan or Contract terms to operate the Plan in accordance with its proper provisions, rather than in accordance with the terms of the Plan or the Contract, pending correction of the Plan

or the Contract through amendment. In addition, any provisions of the Plan or a Contract improperly added as a result of scrivener's error shall be considered null and void as of the date such error occurred.

- D. In accordance with, but only to the extent required by, the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act of 2010, any subsequent legislation, and the lawful guidance published thereunder, if any amendment to a group health plan constitutes a material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of ERISA) that is not reflected in the most recently provided summary of benefits and coverage, the Administrator shall provide notice of such modification to enrollees not later than sixty (60) days prior to the date on which such modification will become effective.

#### 12.02. Plan Termination.

The Employer expects to continue the Plan indefinitely, but reserves the right to terminate the Plan in part or in whole at any time by appropriate action; provided, however, that such termination shall not affect any right to claim reimbursement of benefits incurred prior to such termination. In the event of the dissolution, merger, consolidation or reorganization of an Employer, the Plan shall terminate unless the Plan is continued by a successor to the Employer. Upon the termination of the Plan, the rights of all Participants affected thereby shall become payable as the Administrator may direct, including, but not limited to a continuation of the Plan in order to pay balances in accordance with elected benefits, or a distribution of the unused portion of the Participant's compensation reduction amounts subject to the Plan. The termination of the Plan shall not affect any affected Participant's right to claim reimbursement of benefits incurred prior to such termination.

#### 12.03. Enactment Of Legislation.

If the federal government, any State or other jurisdiction enacts a law that prohibits the continuance of the Plan or any Contract, or the Code or applicable State law or other existing laws are interpreted so as to prohibit the continuance of the Plan or any Contract, the Plan or the affected plan or Contract shall terminate automatically coincident with the effective date of such law or interpretation.

## ARTICLE 13. MISCELLANEOUS

### 13.01. No Assignment Of Benefits.

- A. Subject to the exceptions provided below and as otherwise specifically permitted by law, no assets or benefits under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan. The prohibition against assignments includes, but is not limited to, a prohibition of any assignment to any provider of medical services or supplies. Any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy shall be void. Nor shall any such benefits in any manner be liable for, or subject to, the debts, contracts, liabilities, or torts of any person entitled to such benefits.
- B. Although benefits shall not be subject to alienation, a covered person may direct, in writing, that benefits payable to such covered person be paid instead to an institution in which the covered person is or was hospitalized, to a provider of medical services or supplies furnished or to be furnished to the covered person, or to a person or entity that has provided or paid for, or agreed to provide or pay for, a service or supply covered by the Plan. Any such direction to pay a third party is not an assignment of any right under this Plan or of any legal or equitable right to institute a court proceeding. Any payment by the Plan to such a third party does not make the payee an assignee. Notwithstanding the foregoing, the Plan reserves the right to make payment directly to the covered person and to refuse to honor such direction and assignment. No payment by the Plan pursuant to such direction shall be considered recognition by the Plan of a duty or obligation to pay a provider of medical services or supplies except to the extent the Plan actually chooses to do so.
- C. The prohibitions contained in this No Assignment Of Benefits section shall not apply to the extent a Participant or Beneficiary is indebted to the Plan, for any reason, under any provision of this Plan. At the time a distribution is to be made to or for a Participant's or Beneficiary's benefit, such proportion of the amount distributed as shall equal such indebtedness shall be

retained by the Plan to apply against or discharge such indebtedness. Prior to such application, however, the Administrator must give written notice to the Participant or Beneficiary that such indebtedness is to be so paid in whole or part from the Participant's benefit. If the Participant or Beneficiary does not agree that the indebtedness is a valid claim against the Participant's benefit, the Participant or Beneficiary shall be entitled to a review of the validity of the claim in accordance with procedures provided in the Claims Procedures article.

13.02. Limitation Of Rights; Employment Relationship.

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any Employee, or as a right of any Employee to be continued in the employment of the Employer, or as creating or modifying the terms of an Employee's employment, or as a limitation on the right of the Employer to discharge any Employee, with or without cause. Unless the law or this Plan explicitly provides otherwise, rights under any other employee benefit plan maintained by the Employer (for example, benefits upon an Employee's death, retirement, or other termination) do not create any rights under this Plan to benefits or continued participation. The fact that an individual is eligible to receive benefits under this Plan does not create any rights under any other employee benefit plan maintained by any Employer, unless that plan or the law explicitly provides otherwise.

13.03. Limitation Of Rights Of Participants And Others.

Neither the establishment of the Plan, nor any modifications thereof, nor the creation of any fund or account, nor the payment of any benefits, shall be construed as giving to any Participant or any other person any legal or equitable right against the Employer, the Administrator, or its designated representative, except as expressly provided herein or as provided by law.

13.04. Release From Liability.

Any payment to any Participant, or to the Participant's legal representative or Beneficiary, in accordance with the provisions of the Plan, shall to the extent thereof be in full satisfaction of all claims hereunder against the Plan, the Employer, the Administrator, any Plan fiduciary, and the insurer or other service provider specified in any Contract, any of whom may require such Participant, legal representative or Beneficiary, as a condition precedent to such payment, to execute a receipt and release therefor in such form as shall be determined by the Employer, the Administrator, any Plan fiduciary, or the

insurer or other service provider specified in any Contract, as the case may be.

13.05. Indemnity.

The Employer hereby agrees to indemnify and hold harmless each present and future Administrator and its employees, and all duly authorized agents, against all liabilities, costs and expenses, including, without limitation, attorneys' fees reasonably incurred by, or imposed upon, such person in connection with, or arising out of, any claims, demands, suits, actions or proceedings in which such indemnified party may be involved, except in the case of the willful misconduct of any such indemnified party. Expenses shall include the cost of reasonable settlement made with the view to curtailment of costs of litigation. The foregoing right of indemnification shall not be exclusive of other rights to which such indemnified party may be entitled as a matter of law.

13.06. Expenses.

Upon written instructions from the Administrator, the Plan shall pay the expenses necessary to carry out the administration of this Plan that are not paid by the Employer.

13.07. Insurers Not A Party.

No insurer or service provider under a Contract shall be considered a party to this Plan, nor to any future amendment to this Plan. The rights and obligations of any insurer or service provider are those specified in the Contract and no provisions of any portion of this Plan shall be deemed to alter or change the terms of such Contract.

13.08. State Insurance Laws.

This Plan is designed to be consistent with State insurance laws, to the extent that they are not preempted by any applicable federal law.

13.09. Construction.

No provision of this Plan shall be construed to conflict with any Treasury Department, Internal Revenue Service or Department of Health and Human Services regulation, ruling, release or proposed regulation or other order which affects, or could affect, the terms of this Plan. If any provision is susceptible of more than one interpretation, such interpretation shall be given thereto as is consistent with the Plan being in conformity with Code section 125 and the Plan being administered in conformity with other federal or State laws that apply to the Plan.



13.10. Headings.

The headings and subheadings of this Plan have been inserted for convenience of reference and are to be ignored in any construction of the provisions hereof.

13.11. Uniformity.

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner.

13.12. Gender And Number.

Any reference in the masculine gender herein shall be deemed to also include the feminine gender, unless expressly provided otherwise. Wherever appropriate, any reference in this document in the singular shall include the plural and any reference in the plural shall include the singular.

13.13. Controlling Law.

Unless otherwise provided in this Plan, the Plan shall be construed and enforced according to the laws of the United States of America to the extent applicable, otherwise by the laws of California including California's choice-of-law rules, except to the extent those laws would require application of a State other than California.

13.14. Severability.

In the event that any provisions of this document shall be held illegal or invalid for any reason by operation of law or a court of competent jurisdiction, said illegality or invalidity shall not affect the remaining legal and valid provisions of this document. This document shall continue as if said illegal or invalid provisions had not been included herein either initially, or beyond the date it is first held to be illegal or invalid; provided the basic purposes hereof can be effected through the remaining valid and legal provisions.

13.15. Waiver.

Failure to insist upon strict compliance with any provision of this Plan shall not be deemed to be a waiver of such provision or any other provision; waiver of breach of any provision of this Plan shall not be deemed to be a waiver of any other provision or subsequent breach of such provision. No term, condition, or provision of the Plan shall be

deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and such waiver shall operate only as to the specific term, condition, or provision waived.

13.16. Entire Document.


This document and any exhibits, appendices or supplements hereto shall constitute the entire document and shall govern the rights, liabilities and obligations of the parties under the Plan, except as it may be modified by a duly authorized and adopted amendment. No statements contained in any other writing or communication, including, but not limited to, a summary plan description or a summary of material modifications, shall constitute the terms of the Plan.

Executed this 8th day of May, 2018.

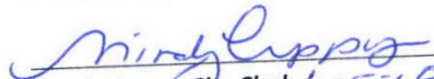
City Of Sacramento

By:

Title:

  
\_\_\_\_\_  
SUPERVISOR DEPUTY CA

**Attest By/Date:**

  
\_\_\_\_\_  
Mindy Cuppy, City Clerk 6-5-18

## EXHIBIT A

### **BENEFITS AVAILABLE TO EMPLOYEES PARTICIPATING IN THE CITY OF SACRAMENTO CAFETERIA PLAN**

The following benefits are available to the Employees participating in the City Of Sacramento Cafeteria Plan:

1. Major medical benefits under the Health Care Plan Benefit article provided through a Contract with Kaiser Permanente, Western Health Advantage, and Sutter Health Plus (or their successors);
2. Dental benefits under the Health Care Plan Benefit article provided through a Contract with Delta Dental (or its successor);
3. Vision benefits under the Health Care Plan Benefit article provided through a Contract with Vision Service Plan (or its successor);
4. Employee assistance program benefits under the Health Care Plan Benefit article provided through a Contract with Managed Health Network (or its successor);
5. Health flexible spending account benefits under the Medical Expense Reimbursement Benefit article as administered by Employee Benefit Specialists (or its successor);
6. Day care flexible spending account benefits under the Dependent Care Assistance Benefit article as administered by Employee Benefit Specialists (or its successor); and
7. Health savings account benefit under the Health Savings Account Benefit article provided through a Contract with Bank Of America (or its successor).