SUMMARY DESCRIPTION
for the
CAFETERIA PLAN, and ACCOUNT PLANS

The Employer named below sponsors this Plan:
City of Madison
215 Martin Luther King Jr., Blvd.
Madison, WI 53703
The Employer accepts service of legal process.

Federal Tax ID: 39-6005507

This is a Non-ERISA Summary Description.

Plan Name: The City of Madison **Cafeteria Plan and Account Plans**

Group Name, if applicable: N/A

Plan Effective Date: 01/01/2027

Plan Year: 01/01 to 12/31

Account Plans included in this Plan: Dependent Care FSA, Healthcare FSA

Run Out - Number of Days: 90 days

Carryover Maximum: N/A

Grace Period: 2 months, 15 days

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'You' and 'Your' refer to an Employee who has enrolled in at least one Qualified Benefit Plan for the current Plan Year, or has a carryover balance from an existing Account Plan, when a Carryover is allowed as indicated above. 'You' and 'Your' are also referred to as a 'Participant'.

Purpose. Your Employer has adopted this Plan to allow You to pay for benefit options (called Qualified Benefit Plans) for Yourself, Your spouse, and Your dependents via pre-taxed salary reduction contributions. You may choose from these "tax free" Qualified Benefit Plans in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code. This Plan allows You to reduce Your taxable income in direct proportion to (a) Your contribution to the cost of Your elected Qualified Benefit Plans and (b) Your contribution to any Account Plan.

Qualified Benefit Plans. A Qualified Benefit Plan is a tax advantaged Plan pursuant to Section 125(f) of the Internal Revenue Code. The list of Account Plan(s) made available for the current Plan Year is provided above. The list of other Qualified Benefit Plans is provided in the Enrollment Materials provided by Your Employer at the time of enrollment, expressly incorporated by reference into this Summary Description.

If You are not eligible to participate in this Plan but are allowed to participate in any Qualified Benefit Plan then Your costs will be paid with taxable income and Your compensation will not be reduced by the Employer.

Employer Contributions. Your Employer may provide additional contributions in the way of cash or spending credits that You may use for Qualified Benefits Plans and/or other limited purposes as specified in the Enrollment Materials. These Employer contributions will continue to be provided to You while on approved FMLA Leave to the same extent as they would be provided to an Employee actively at work.

Enrollment Materials. The Enrollment Materials are expressly incorporated by reference into this Summary Description and include benefit guides and summary benefit descriptions that provide the following detail for the Qualified Benefit Plans offered by Your Employer:

1) Complete detailed schedules of benefits, and all exclusions and limitations on benefits including subrogation rights and instances in which benefits will be coordinated with other sources of payment;
2) Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services;
3) The procedures governing claims for benefits including procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any applicable time limits, and remedies available under the Plan for the redress of claims which are denied in whole or in part. Additional detail required by law for specific claims and appeals will be furnished as separate documents without charge;
4) Cost-sharing provisions including any deductibles, coinsurance and copayment amounts for which the Participant or beneficiary will be responsible;
5) Any annual or lifetime caps and all other limits on benefits;
6) The extent to which preventive services are covered;
7) Whether, and under what circumstances, existing and new drugs are covered;
8) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
9) Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
10) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under a Benefit Plan;
11) A general description of the provider networks applicable to each Benefit Plan. A complete listing of providers in a network will be furnished to Participants and beneficiaries as a separate document at no charge;
12) Any circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, suspension, offset, reduction, or recovery of any benefits; and,
13) Whether and to what extent benefits under the Benefit Plan are guaranteed under a contract or policy of insurance issued by the Insurance Company, and the nature of any administrative services (e.g., payment of claims) provided by the Insurance Company or Third-Party Administrator.

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An Employee's right to enroll in and maintain coverage under the Qualified Benefit Plans are described in detail in the Enrollment Materials provided by the Employer, including:

1) Under what circumstances a spouse, dependents and other persons may be enrolled including any proof of a relationship needed to meet the eligibility requirements (note that group health Plans are required to cover dependent children placed with a Participant for adoption under the same terms and conditions as apply in the case of dependent children who are Your natural children);
2) The existence of any waiting periods and how they are applied;
3) When enrollment is allowed and a description of the enrollment procedures;
4) When coverage will be effective and when it will end including the events that can occur that will terminate coverage;
5) Details regarding when special enrollment rights allowing individuals who previously declined health coverage for themselves and their dependents have an opportunity to enroll (regardless of any open enrollment period). The Special Enrollment Notice, a copy of which was previously furnished to each Participant, also contains important information about the potential special enrollment rights including a 30 day time limit for requesting the enrollment. You can contact Your Benefits Coordinator to receive an additional copy of that notice; and,
6) Details regarding when special enrollment rights for an employee who is eligible, but not enrolled for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) when either:
   (a) The employee or dependent were covered under a Medicaid Plan or under a State Child Health Plan (SCHIP) and that coverage is terminated as a result of loss of eligibility; or,
   (b) The employee or dependent becomes eligible for premium assistance from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

This Plan defines an eligible Employee to be an individual classified by the Employer as a common-law employee who is typically on the employer's W-2 payroll. 'Employees' does not include self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Administration. Your Employer has sole discretionary powers and is responsible for the administration of this Plan and the Qualified Benefit Plans. Should You need to see any records or have any questions regarding these Plans, contact Your Employer. Your Employer has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. The Employer has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time.

No Continued Employment. No provisions of the Plan or this Summary Description grant any Employee any rights of continued employment with the Employer or in any way prohibit changes in the terms of employment of any Employee covered by the Plan.

ACCOUNT PLANS

The Account Plans offered for the current Plan Year are listed above on the first page of this Summary Description. Your Employer appoints TASC as its Service Provider to maintain certain Account Plan records and to be responsible for the Account Plan's day-to-day administration. TASC is not a Plan and has no discretionary authority over the Plan.

The Participant Reference Guide. The Participant Reference Guide which is incorporated by express reference into this Summary Description, includes all the information You need to access Your Account Plans and submit requests for reimbursement. By signing into Your online Account Plan, You may access information about Your enrollment, available funds, annual election, total contributions, and total reimbursements.

Age Requirement. No maximum age requirement may be imposed for participation in an Account Plan.

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Re-employment of Former Employees. A former Employee rehired within thirty (30) days of termination will immediately be reinstated into their original Account Plan elections. A former Employee rehired after thirty (30) days of termination will be allowed to make new Account Plan elections.

Excess Payments. Upon any benefit payment made to an Accountholder in error under an Account Plan, said Accountholder will be informed and required to repay the errant amount. This includes and is not limited to amounts over the Accountholder's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid Request for Reimbursement (RFR) upon request is not provided. The Employer may take reasonable steps to recoup the excess payment including withholding the amount from future salary or wages and subtracting from future benefit reimbursement(s). You will be allowed to submit valid claims to offset any amount due.

Non-Assignment of Benefits. No Accountholder or beneficiary may transfer, assign or pledge any Account Plan benefits except as may be required pursuant to a "Qualified Medical Child Support Order" (which provides for Plan coverage for an alternate recipient), other applicable law, or payment made directly to a healthcare provider.

Termination Of Participation. Accountholders are enrolled in the Account Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be an Accountholder due to the following events:

a. Your death, resignation or termination of employment with the Employer;
b. This Plan terminates;
c. You fail to pay any required premium (including payment by salary reduction) under the Plan;
d. You no longer meet the requirements for eligibility in the Plan; or,
e. You revoke Your election under a qualifying change in status event.

Your actual termination date due to these events will vary depending on the Account Plan and Your Employer's Account Plan design. Check with Your Employer for Your actual termination date. After Your termination in an Account Plan, you can only be reimbursed for services rendered prior to your eligibility end date and submitted before the end of the Run Out Period specified on the first page of this Summary Description.

Change In Status Events. The laws governing Account Plans generally do not allow You to change Your benefit and contribution elections during a Plan Year (except for Health Savings Accounts; see below). Your elections are irrevocable and any balance in Your account at the close of the Plan Year is forfeited and becomes the property of Your Employer (refer to the first page of this Summary Description to see if there is a Grace Period or Carryover). This irrevocable election rule does not apply if You experience a qualifying change in status event. The election change request must be on account of and consistent with the change in status event.

Any request to change Your election must be submitted in writing within 30 days of the occurrence of a change in status event. The new benefit elections start after the change in status event has occurred and the paperwork has been filed. This Plan is intended to allow any change in status event that is allowed by the IRS. The following change in status events are applicable:

1. A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).
2. The adoption, birth, or death of a child or dependent.
3. Dependent satisfies or ceases to satisfy dependent eligibility requirements.
4. The change in employment status of You, Your spouse or dependent.
5. Change in Your residence. *
6. Beginning or ending adoption proceedings.
7. Automatic changes upon cost increases or decreases. *
8. Significant cost increases. *
9. Significant curtailment of coverage. *
10. Addition or elimination of similar benefits package option. *
11. Change in coverage of a spouse or dependent under an employer Plan. *
12. FMLA.

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13. HIPAA special enrollment rights. *
14. Qualifying continuation event.
15. Loss of group health coverage sponsored by governmental or education institution. *
16. A judgment, decree or order requiring coverage for a spouse or child.
17. Medicare or Medicaid entitlement.
18. Termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. *
19. Eligibility for Employment Assistance under Medicaid or SCHIP. *
20. Exchange Event – A loss of eligibility under the terms of the Plan due to a reduction in hours (less than 30) – even when the Employer allows the coverage to continue in effect during the 'Stabilization Period' to satisfy the Affordable Care Act coverage requirements. *
21. Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment period.*
22. Exchange Event – Exchange enrollment by one or more of the participant's dependents and/or spouse who are enrolled in the Employer provided group health insurance plan during an Exchange special enrollment period or open enrollment period. (Effective January 1, 2023) *

**These qualifying change in status events do not apply to the Healthcare FSA.*

Notes:

1. If You are making tax free contributions to a Health Savings Account (HSA) under this Plan, You do not need a change in status event to change Your HSA election. You may prospectively change Your HSA election at any time during the Plan Year.

2. For the termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the Employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

Grace Period or Carryover. As a terminated Accountholder, You are not eligible for the Grace Period or Carryover (when offered by Your Employer) unless You are an active Accountholder in the Plan and Your Paid Coverage Period continues through the last day of the Plan Year.

The Family And Medical Leave Act ('THE FMLA') and Unpaid Leave. The FMLA requires employers with 50 or more employees to provide unpaid leave for eligible employees under circumstances that are prescribed by applicable federal law, including the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) as amended.

The payment option(s) for coverage while on unpaid Family Medical Leave Act leave and for unpaid leave for Healthcare Account Plans are:

1) Pre-pay. Under this option, you will pay Your election amounts that will be due during your leave, before your FMLA leave begins. The payments may be either pre-tax or after-tax, according to the terms of your Salary Reduction Agreement.
2) Pay-as-you-go. Under this option, You will pay your share of Your election amounts on the same schedule as if You were not on leave. If You fail to make payments under this Pay-as-you-go option, Your Employer is not required to continue coverage. However, if Your Employer chooses to continue coverage, Your employer is entitled to collect these amounts from you after You return from the FMLA leave.

If an Accountholder's coverage under the Plan ceased while on FMLA leave, the Accountholder will be entitled to resume coverage upon return from leave on the same participation basis in effect prior to the leave, or as otherwise required under the FMLA. The Accountholder will be entitled to elect reinstatement in the Plan at the coverage level that was in effect before the FMLA leave, with increased contributions if necessary to reach their annual election. Or, the Accountholder can continue with the amount withheld from the Accountholder's compensation on payroll-by-payroll basis equal to the amount withheld before the FMLA leave.

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HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA). The first page of this Summary Description indicates whether this Plan includes a Healthcare Flexible Spending Account. All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Accountholder, Accountholder 's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan.

Uniform Coverage Rule. The entire amount of your annual Healthcare FSA election is available to You for services rendered on any day of the Plan Year that you are covered by the Healthcare FSA.

Limitations and Exclusions. The following examples—even those recommended by a doctor—do not qualify as expenses eligible for reimbursement under the Healthcare FSA: insurance premiums; expenses for cosmetic procedures or cosmetic items; items that are for an Accountholder's general wellbeing; items the Accountholder would have purchased even if the Accountholder had no medical condition (for example, a toothbrush); vacation and travel expenses even if for rehabilitation or prescribed by a doctor; long-term care expenses that are not for actual medical care; expenses incurred in stockpiling over-the-counter items in quantities that could not reasonably be used during the current Plan Year.

Qualified Reservist Distribution**.** An Accountholder who is called to active duty in the US Armed Services and enrolled in the Healthcare FSA may elect to receive a Qualified Reservist Distribution of all or a portion of the unused balance in his/her individual Healthcare FSA subject to the requirements of Code Section 125(h) and the applicable regulations thereunder. The Employer may limit this distribution to the amount You have contributed to the account that has not been used to reimburse You for RFRs submitted.

Qualified Medical Child Support Order (QMCSO). The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of an Accountholder in a group health Plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health Plan under which an Accountholder or other beneficiary is entitled to receive benefits. Accountholders may obtain, without charge, a copy of the Plan's procedures from the Plan.

Family and Medical Leave Act (FMLA). If You go on a qualifying leave under FMLA, to the extent required by the FMLA, Your Employer will continue to maintain Your benefit package options providing health coverage (including the Healthcare FSA) on the same terms and conditions as if You were still active (that is, Your Employer will continue to pay its share of the contribution to the extent You opt to continue coverage). Your Employer may require You to continue coverage while You are on paid leave (as long as Accountholders on non-FMLA paid leave are required to continue coverage). If so, You will pay Your share of the contributions by the method normally used during any paid leave.

If Your coverage ceases while on FMLA leave, You will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as You had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which You did not make contributions. Your coverage may be automatically reinstated as well, but only if coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

Unpaid FMLA Leave**.** If You are going on unpaid FMLA leave and You opt to continue Your Medical and Dental Insurance Benefits and Healthcare FSA Benefits, then You may pay Your share of the contributions in one of three ways:

(1) Prepay. Your share of contributions due during Your leave may be paid either pre-tax or after-tax before Your leave begins provided any pre-tax pre-payments do not fund coverage for the next Plan Year.

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(2) Pay-as-You-go. Your share of contributions will be paid on the same schedule as if You were not on leave or under another schedule. Per the Department of Labor regulations, if You fail to make payments under this option, Your Employer is not required to continue coverage. If Your Employer chooses to make payment and thereby continue coverage, Your Employer is entitled to recoup these amounts from You after You return from leave.
(3) Catch-up. Your Employer may advance Your share of contributions while You are on leave. Upon Your return from leave, Your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with Your Employer to determine if this option is available under Your Plan.

Non-FMLA Leave**.** If You go on an unpaid leave of absence that does not affect eligibility, then You will continue to participate and the contribution due from You will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan. If You go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

Military Leave**.** If You take a leave of absence due to military service, You may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Health Savings Account (HSA): If You contribute to a Health Savings Account (HSA) then You may only enroll in a ***Limited Purpose Healthcare FSA*** **(LPFSA**). Qualified Expenses under an LPFSA are limited to dental and vision services or supplies excluded from coverage under Your high deductible health plan, or unpaid amounts incurred after the HDHP statutory annual deductible has been satisfied. The LPFSA will not provide reimbursement for any other service or supply regardless of whether that service or supply is allowed by the IRS as a medical expense or allowed under a General-Purpose Healthcare FSA.

HealthCare FSA Continuation Coverage Rights Under The Public Health Services Act. Under the Public Health Service Act §2201 [42 USC §300bb-1] as amended, continuation coverage is mandated. This Summary Description describes Your rights for the Healthcare FSA. Your rights under any of the other Qualified Benefits Plans offered by Your Employer are described in the Summary Description(s) for that Plan and may be obtained from Your Plan.

If You elect to participate under the Healthcare FSA and are considered an Accountholder on the day before experiencing a qualifying event, continuation ends on the last day of the Plan Year in which the qualifying event occurred. Further, continuation coverage will not be offered if on the day of Your qualifying event, the amount of Your annual election less any reimbursed payments is less than the amount of premium required to continue the Healthcare FSA Plan until the end of the Plan Year. Continuation under an excepted Healthcare FSA Plan is available until the end of the Plan Year in which the qualifying event occurs.

An Accountholder who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect continuation coverage. Your Employer has 44 days from the date of the loss of coverage in which to send the Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Plan of their desire to continue coverage within sixty days of either the date of notification or date of loss of coverage, whichever is later. If the Plan does not receive notification within this time period, You will lose Your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date that termination from the Plan would have occurred.

Continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of Your monthly contribution. The Employer may require the payments be apportioned for the remainder of the Plan Year.

Listed below are qualifying events.

(1) Termination of employment (for reason other than "gross misconduct"); and
(2) Reduction of employee's work hours.

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DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT. The first page of this Summary Description indicates whether this Plan includes a Dependent Care Flexible Spending Account. This account provides employees with tax free dependent care assistance only when the assistance is necessary for the Accountholder to leave the home to engage in activity directly related to his/her employment. Qualified expenses under the Dependent Care FSA include any expenses that You could take as a credit against tax on Your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of Your payroll deduction on the date the RFR is processed. The tax laws further limit how much You may contribute to this account.

Under the law and the terms of the Plan, You may defer no more than the lesser of Your actual income for the year (or, if You are married and it is less, Your spouse's actual income) or $7500 per year to this Program. A married Accountholder who files separate tax returns is limited to $3750 per year. A married Accountholder who files joint returns can split this limit as they see fit.

HEALTHCARE PREMIUM (NESP) REIMBURSEMENT ACCOUNT. The first page of this Summary Description indicates whether this Plan includes a Healthcare Premium (NESP) Reimbursement Account. This account provides reimbursement for premiums You paid for employee-owned health insurance policies. Employer-provided insurance Plans and coverage offered through the Marketplace, (a state or federal Plan under the Affordable Care Act), do not qualify. Premiums eligible for reimbursement are for a period in which You were a covered Accountholder under this account.

REIMBURSEMENT DENIALS FOR ACCOUNT PLANS

Reimbursements under the Healthcare FSA, Limited Purpose Healthcare FSA, Dependent Care FSA, or Healthcare Premium (NESP) Reimbursement Account. The RFR procedure described below will apply if (a) a RFR under the Healthcare FSA, Limited Purpose Healthcare FSA, Dependent Care FSA, or Healthcare Premium (NESP) Reimbursement Account components of the salary reduction Plan is wholly or partially denied, or (b) You are denied a benefit under the salary reduction Plan due to an issue germane to Your coverage under the Plan.

If Your RFR is denied in whole or in part, You will be notified in writing within 30 days after the date the Plan received Your request. (This time-period may be extended for an additional 15 days for matters beyond the control of the Plan, including in cases where an RFR is incomplete.) The Plan will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan is expected. When an RFR is incomplete, the extension notice will also specifically describe the required information, will allow You 45 days from receipt of the notice in which to provide the specified information, and will effectively suspend the time for a decision on Your RFR until the specified information is provided.)

Notification of a denied RFR will detail:

- specific reason(s) for the denial;
- specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for You to validate the RFR and an explanation of why such material or information is necessary;

Appeals. If Your RFR is denied in whole or part, then You (or Your authorized representative) may request review upon written application to the Plan. Your appeal must be made in writing within 180 days after Your receipt of the notice that the RFR was denied. If You do not appeal on time, You will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that You feel Your RFR should not have been denied. It should include any additional facts and/or documents that You feel support Your RFR. You will have the opportunity to ask additional questions and make written comments, and You may review (upon request and at no charge) documents and other information relevant to Your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

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Decision on Review. Your appeal will be reviewed, and a determination made within a reasonable time, defined as not later than 60 days after receipt of Your appeal. If the decision on review affirms the initial denial of Your RFR, You will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of Your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request.

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INTRODUCTION and INSTRUCTIONS

Materials, Use and Limited License
TASC is granting a non-exclusive, non-assignable, limited license to use this Plan Document only in connection with the provisions of the Subscription Services. It is understood that the Plan Document and related materials are the confidential property of TASC, they are not "work for hire", and no additional rights to use the Materials are granted. The Purchaser is responsible for its use and the protection of the confidentiality of Materials and shall be liable for any unauthorized use or disclosure.

Effect of Termination
The terms of the limited license to use this Plan Document continue after the termination of any or all agreements between TASC and the Purchaser.

Instructions
This Plan Document does not stand alone.

- This Plan Document incorporates by reference your Enrollment Materials. Place a copy of your entire enrollment package for each enrollment period, along with any changes that are communicated during the year, in a file with this Plan Document for easy access for participant requests or for an audit.
- This Plan Document refers to the Summary Description for specific details such as the plan year, plan name and other necessary demographics. These instances are spelled out in the Plan Document.
- Any amendment made by competent legal counsel should be attached to this Plan Document. TASC does not need to review such amendments. TASC will have no liability for any losses or penalties related to such amendments.

This Plan Document should be saved each year with a copy of the Summary Description and Enrollment Materials attached for ease in responding to any audits or Participant requests.

Important Notice
This Plan Document is intended as a prototype Plan Document for use with a TASC Subscription Service. TASC and its representatives are not attorneys and do not provide legal advice. Any questions regarding state or local requirements, and any requests for revisions or additional terms should be sent to your benefit advisor or legal counsel.

Adoption
This Plan Document is adopted by the Purchaser by its acts to download and save this Plan Document per these instructions. The Purchaser is advised to inquire internally and follow any and all specific or formal requirements for the adoption of a benefit plan.

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PLAN DOCUMENT
For the
CAFETERIA PLAN, and ACCOUNT PLANS

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8.11 Dependent Care Flexible Spending Account

Article II: Purpose

2.01 Adoption and Purpose. The Employer adopts this Cafeteria Plan under the terms and conditions set forth in this Plan Document as well as through the Enrollment Materials that are expressly incorporated by reference into this Plan Document. The plan allows Participants to elect between cash compensation or certain nontaxable Qualified Benefits Plans maintained by the Employer as identified in the Enrollment Materials. The Employer intends that this plan qualify as a Cafeteria Plan under Section 125 of the Internal Revenue Code. If any term in this Plan Document is found to be in conflict with federal or state law, the term will automatically be amended to comply with the federal or state law. Neither the Employer nor its designated representatives 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.

2.02 Plan Detail and Demographics. This Plan Document expressly incorporates by reference the following demographics from the Summary Description: The Plan Name; the Plan Sponsor's name and address; and the Plan Year.

Article III: Definitions

3.01 Change in Status Event. A Change in Status Event allows a Participant to revoke or change his/her pre-tax election during the Plan Year, and outside of the scheduled open enrollment period. The Employer allows all of the Change in Status Events published by the IRS for this type of plan under 26 CFR 1.125-4, as amended. A Participant who becomes eligible under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") for coverage under an accident or health benefit offered by the Employer will be allowed to make a consistent election, or election changes under this Cafeteria Plan.

Additional 'Change in Status' Event Election Change for Group Health Plan Coverage. Effective January 1, 2023, provided that the conditions set forth below are satisfied, this election change provision permits You to prospectively revoke Your election for family coverage under Your Employer's group health insurance plan in order to allow one or more Related Individuals (as defined below) to enroll in a Qualified Health Plan through a Health Insurance Exchange ("Exchange") in the individual market ("Marketplace Coverage"). A "Related Individual" is any individual who is enrolled in the Employer provided group health insurance plan because of a relationship to You.

You may prospectively revoke an election of family coverage under Your Employer's group health insurance plan, provided the following conditions are satisfied:

(1) One or more Related Individuals are eligible for a special enrollment period to enroll in Marketplace Coverage pursuant to guidance issued by the Department of Health and Human Services (DHS) and any other applicable guidance, or one or more already-covered Related Individuals seeks to enroll in a Marketplace Coverage during the Exchange's annual open enrollment period; and
(2) The revocation of the election of coverage under Your Employer's group health insurance plan corresponds to the intended enrollment of the Related Individual(s) in Marketplace Coverage for new coverage that is to be effective beginning no later than the day immediately following the last day of

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the coverage that is being revoked pursuant to Your election pursuant to this Additional Change in Status Event.

If You do not enroll in Marketplace Coverage, You must elect self-only coverage (or family coverage including one or more already-covered Related Individual) under Your Employer's group health insurance plan.

When making a revocation election pursuant to this Additional Change in Status Event, You will be required to represent that You and/or Related Individual(s) have enrolled or intend to enroll in Marketplace Coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked in accordance with these Additional Change in Status Event provisions and Your Employer may rely on such representation.

3.02 **Code.** The Internal Revenue Code of 1986, as amended from time to time.

3.03 **Compensation.** All the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Internal Revenue Code.

3.04 **Dependent.** For the purpose of the tax advantages available under this plan, a Dependent is an individual who is a dependent of a Participant within the meaning of Section 152(a) of the Internal Revenue Code, and any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). For the purposes of the tax advantages available under Qualified Benefit Plans that provide accident and health benefits as defined under Sections 105 and 106 of the Code, a Dependent is determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof and includes any child (as defined in Code § 152(f)(1)) of the Participant who at the end of the taxable year has not attained age 27.

3.05 **Eligible Employee.** An Employee who is eligible to participate in the one or more Qualified Benefits Plans sponsored by the Employer, limited to an "Employee" as defined below in Section 3.06, who meets additional requirements defined in the Employer's Enrollment Materials and not including the following:

(a) Employees who are Non-Resident Aliens (within the meaning of Section 7701(b)(1)(B) of the Internal Revenue Code) who are deriving no earned income (within the meaning of Section 911(d)(2) of the Code) from the Employer which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code); and,

(b) Employees who are self-employed individuals (as described in Section 401(c) of the Internal Revenue Code) including sole proprietors, partners in a partnership, or more than 2% owners of subchapter "S" Corporations. This exclusion applies to the Spouse, children, parents, and grandparents under the Code Section 318 attribution rules.

If an Employee is not eligible to participate in this plan and allowed to participate under any Qualified Benefits Plan, then the Employee cost will be paid with taxable income, and the Compensation will not be reduced by the Employer.

3.06 **Employee.** An Employee is a person who is currently or hereafter employed by the Employer, or by any other Employer aggregated under Sections 414(b), (c), (m), (n), or (o) of the Internal Revenue Code and the regulations thereunder, including a leased Employee subject to Section 414(n) of the Code.

3.07 **Employer.** The Employer adopting this plan and any affiliate or subsidiary that, with the consent of the Employer becomes an Employer, by adopting the plan, or any successor business organization that assumes the obligations of the Employer.

3.08 **Enrollment Materials.** The Employer will provide written Enrollment Materials at each enrollment period and during the Plan Year for midyear enrollees. The Enrollment Materials will provide the specific process for enrollment in the Qualified Benefits Plans. The Enrollment Materials are expressly incorporated by reference into this Plan Document.

3.10 **Participant.** Any person who has been or is an Eligible Employee and who qualifies to participate and enrolls in a Qualified Benefits Plan.

3.11 **Plan Year.** Commencing on the first day of the Plan Year and each anniversary thereof, except that the first

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Plan Year may include a period of fewer than twelve (12) consecutive months.

3.12 **Qualified Benefits Plan.** Employer-sponsored plans that are allowed tax advantages under this plan pursuant to Section 125(f) of the Internal Revenue Code. The list of Qualified Plans available under this Cafeteria Plan is provided in the Enrollment Materials.

3.13 **Spouse.** Any individual who is legally married to a Participant under applicable state law.

Article IV: Administration

4.01 **Employer's Duties.** In addition to any rights, duties or powers specified in this Plan Document, the Employer will have the following rights, duties, and powers:

(a) to interpret the plan, to determine the amount, manner and time for payment of any benefits under the plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the plan;

(b) to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the plan, and from time to time, amend or supplement such rules and regulations;

(c) to determine the rights of any participant, Spouse, or Dependent to benefits under the Qualified Benefit Plans;

(d) to develop appellate and review procedures for any Participant, Spouse, or Dependent denied benefits under the plan;

(e) to maintain records, it may require in connection with the proper administration of the plan;

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

(g) to correct any defect, supply any omission, or reconcile any inconsistency in the plan in such a manner and to such extent as it shall be deemed expedient to administer the plan;

(h) to amend or terminate this plan.

4.02 **Information to be Provided to Employer.** The Employer, or any of its agents, will collect employment records of Participants under the plan. These records will include any information the Employer may need for the proper administration of the plan. A Participant will furnish the Employer the data the Employer reasonably requests to ensure the proper and efficient administration of the plan.

4.03 **Interpreting Plan Terms.** Any interpretation of any provision of this plan made in good faith by the Employer as to the terms of this plan is final and will be binding upon the parties.

4.04 **Misstatements.** Any misstatement or other mistake of fact will be corrected as soon as reasonably possible upon notification to the Employer and any adjustment or correction attributable to such misstatement or mistake of fact will be made by the Employer as he considers equitable and practicable.

4.05 **Review Procedures.** An Employee or his/ her authorized representative can appeal a decision made to deny enrollment in a Qualified Benefits Plan or a decision to disallow an election change by sending a written request for an appeal to the Employer within 60 days of the decision to deny enrollment or an election change. The appeal will be performed in a manner that does not afford deference to the initial determination and will be conducted by the Employer or designee. A Participant can request, free of charge, reasonable access to, and copies of, all documents and records relevant to the decision. Benefit appeals for denied claims are addressed in the Qualified Benefits Plan descriptions provided by the Employer.

4.06 **Medical Child Support Orders.** The Employer will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which complies with federal or applicable state law, including 29 USC Sec. 1169 relating to Qualified Medical Child Support Orders (QMCSO), including any federal regulations or state laws relating to the same. On the date coverage is provided as directed by a QMCSO the Employee-parent will become eligible to participate in this plan in order to pay his/her share of the cost of the coverage on a pre-tax basis.

4.07 **The Privacy Rule.** Protected Health Information ("PHI") is defined as information that is created or received by the Employer which relates to the past, present, or future physical or mental health or condition of a Participant; or, the provision of healthcare to a Participant; or the past, present, or future payment for the provision of healthcare to a Participant; and that identifies the Participant. The test is whether there is a reasonable basis to

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believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

- **Access to PHI:** The Employer's access to PHI is restricted to the minimum information necessary to administer the Healthcare FSA. This includes obtaining Participant elections and reimbursements for payroll administration. The Employer has access to PHI submitted for claims reimbursement when that claim is on an appeal from an adverse decision. Only the Benefits Coordinator and Employees trained in the federal privacy rule will have access to the PHI.
- **Permitted and Required Uses and Disclosures of PHI by the Employer:** The Employer may use and disclose PHI for plan administration functions only as permitted and required by this Plan Document, or as required by law. The Employer will not use or disclose PHI for employment-related actions or in connection with any other Employee benefits plan. When necessary, the Benefits Coordinator will disclose the PHI to consultants and experts as required by the Department of Labor for a full and fair review or to perform plan non-discrimination testing as required by law.
- **Complaints:** If a Participant has any complaints regarding the way in which the Employer has handled PHI said Participant may complain to the Benefits Coordinator. No response from the Benefits Coordinator is required. A copy of this complaint procedure shall be provided to the Participant upon request. The Benefits Coordinator will keep a copy of the complaint, applicable documentation, and disposition if any, for a period of 6 years from the end of the Plan Year in which the act occurred.
- **No Retaliation:** No Employee will intimidate, threaten, coerce, discriminate against, or take other retaliatory action against Participants for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under the federal Privacy Rule.
- **Firewall:** The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of the group health plan; and ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

  Employer will do the following:

  (1) Ensure that any subcontractors or agents to receive PHI agree to the same restrictions described above,
  (2) report to the health plan any use or disclosure that is inconsistent with this Plan Document or the federal Privacy Rule,
  (3) make the PHI information accessible to the Participants,
  (4) allow Participants to amend their PHI,
  (5) provide an accounting of its disclosures of PHI as required by the Privacy Rule,
  (6) make its practices available to the Secretary of Health and Human Services for determining compliance, and
  (7) return and destroy all PHI when no longer needed, if feasible.

4.08 The Federal Security Rule. This rule is intended to bring the plan into compliance with the "HIPAA Security Rule" as published on February 20, 2003 by the United States Department of Health and Human Services (HHS), and amended, including the final Security Standards under the Health Insurance Portability and Accountability Act of 1996 and the HITECH Act (Health Information Technology for Economic and Clinical Health Act) of the 2009. The Electronic Media contemplated by the HIPAA Security Rule includes the following:

(a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission. In order to send and receive Protected Health Information ("PHI" as defined in the Plan Document) necessary for plan administration by Electronic Media, the Employer will implement reasonable and appropriate

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safeguards for electronic PHI created, received, maintained or transmitted to or by the Employer on behalf of the group health plan; ensure that electronic "firewalls" are in place to secure the electronic PHI; ensure that all agents and subcontractors with access to electronic PHI comply with the security requirements; Report to the group health plan any security incident of which it becomes aware.

Article V: Eligibility and Participation

5.01 **Eligibility Requirements.** Each Employee who enrolls in a Qualified Benefits Plan must be eligible to participate in this plan to receive the tax advantages made available under this plan. The eligibility requirements for this plan are set forth in the Enrollment Materials.

5.02 **Re-employment of Former Employees.** A Participant whose employment terminates and is subsequently re-employed within 30 days of his/her separation of service and within the same Plan Year will immediately rejoin the plan with the same benefit elections. Should the Participant return within 30 days of his/her separation of service during the following Plan Year, the Participant will be allowed to change elections through the plan enrollment process. A Participant whose employment terminates and who is subsequently re-employed with more than 30 days separation of service will need to re-satisfy plan eligibility requirements to rejoin the plan. Any unused reimbursement benefits account balance prior to the initial separation of service date will be forfeited.

5.03 **Termination of Participation.** A Participant will automatically cease to be a Participant on the earliest of the following dates:

(a) the date on which this plan or any Qualified Benefits Plan is terminated by the Employer;
(b) the end of the Plan Year, unless the Participant enrolls in a Qualified Benefits Plan for the next Plan Year;
(c) the date on which the Participant fails to pay any required premium (including payment by salary reduction);
(d) when the Participant's employment is terminated the plan will terminate on the earlier of the day of the termination or the day using the rule stated in the Summary Description.

5.04 **Family Medical Leave Act.** The Family & Medical Leave Act of 1993 (29 U.S.C. 2611) as amended, is referred to as FMLA. FMLA Leave will not be available to Employees for Plan Years in which the Employer has fewer than 50 Employees as counted in that Act. For Plan Years in which the Employer has 50 or more Employees, the Employer is required to make FMLA Leave available to Eligible Employees under circumstances that are prescribed by applicable federal law, including a period in which an Employee is off due to the FMLA shall be treated in accordance with the rules for a layoff or a leave of absence and provided to the ex- tent required by the FMLA (e.g., the employer will continue to pay its share of the contribution to the extent the Participant opts to continue coverage). If the Employer is subject to the FMLA, a Participant may revoke or continue an election through the plan upon commencement of the FMLA Leave, whether such leave is paid or unpaid. This provision applies in addition to any other right to revoke and reelect benefits under the plan. Upon return from FMLA Leave, a Participant may be reinstated to all pre-leave elections.

5.05 **Uniformed Services Employment & Re-employment Rights Act (USERRA).** The Employer shall permit Participants to continue benefits elections as required under the Uniformed Services Employment & Reemployment Rights Act and shall provide such reinstatement rights as required by such law.

5.06 **Layoff, Leave of Absences, and Sabbaticals.** Continuation under the plan may occur in one of the following ways:

(a) In the case of a planned layoff, an Employee may be able to pre-fund a Qualified Benefits Plan through the end of the planned leave or the end of the Plan Year.
(b) During the period which the Employee is off and receiving a salary, the pre-tax deductions may continue. If the Employee is not receiving a salary, he/she may continue to fund his/her election with after-tax dollars while on leave. (Payment schedule to be agreed upon between the Employer and Employee prior to the commencement of the leave.)

Article VI: Elections

6.01 **Election Maximum Amounts.** The maximum election amounts for each Qualified Benefit Plan will be

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included in the Enrollment Materials and the literature available for each Qualified Benefits Plan.

6.02 **Failure to Elect.** An Accountholder failing to complete the enrollment process on or before the specified due date for the Plan Year, or a midyear enrollee during the Plan Year, shall be deemed to have elected to receive Compensation in cash.

6.03 **Effective Periods for Elections.** The election must be made by each Participant prior to the commencement of each Plan Year and shall be irrevocable for the Plan Year except as provided for in a Change in Status Event that would allow an election change.

6.04 **Non-Discrimination.** The plan is not intended to discriminate in favor of highly compensated individuals or key Employees as to eligibility to participate or contributions and benefits as required by the Code. The Employer may exclude or limit certain highly compensated individuals from participation in the plan, in the Employer's judgment, such actions serve to assure that the plan does not violate applicable non-discrimination rules. The Employer can make necessary adjustments to Employee contributions during the Plan Year to assure that the plan passes the required discrimination tests.

Article VII: Contributions

7.01 **Employer Contributions.** The Employer will contribute out of its general assets the amounts necessary to meet its obligations under the plan. The Employer may provide additional contributions in the way of cash or spending credits that can be used for any Qualified Benefits Plan or used in a limited manner as defined by the Employer. The Enrollment Materials will include the amount of any Employer contribution, the rules defining how the Employer contributions can be used by the Participants, and any limitations on the use of Employer contributions. Employer contributions will continue to be provided while on approved FMLA Leave to the same extent provided to an Employee actively at work.

7.02 **Employee Salary Reductions.** The participant shall agree to reduce his/her Compensation from the Employer by such amounts as are necessary to provide for those Qualified Benefits Plans which the Participant has elected. No Participant shall have, by virtue of the plan, any interest in any specific asset or assets of the Employer. A Participant has only an unsecured contractual right to receive the benefits defined and limited by the Qualified Benefits Plans.

7.03 **Administrative Fees.** The Employer may charge the Employee reasonable cafeteria plan administrative fees.

7.04 **SIMPLE Section 125 Cafeteria Plan**. If the Employer intends to offer a SIMPLE Plan, as set forth in Code Section 125(j), under the Employer's Cafeteria Plan, then the Employer contributions are limited as follows;

a) Uniform Percentage Contribution Requirements: Employer must contribute to provide Qualified Benefits on behalf of each Qualified Employee, regardless of whether an Employee makes a salary contribution of their own. The Uniform Percentage Contribution method requires the Employer to contribute a uniform percentage (of at least two percent) of an Eligible Employee's compensation for the Plan Year.

b) Matching Contribution Requirements: Employer must contribute to provide Qualified Benefits on behalf of each Qualified Employee, regardless of whether an Employee makes a salary contribution of their own. The Matching Contribution method requires the Employer to make an annual contribution in an amount equal to the lesser of the following 2 options (select the lesser option): (1) 6% of each Employee's Plan Year compensation, or (2) 2x the amount of salary reduction contributions from each Qualified Employee.

Article VIII: Account Plans

8.01 **Account Plan Availability.** The Employer will notify Accountholders in the Enrollment Materials if Account Plans are offered, and if included for the Plan Year the following terms apply.

8.02 **Forfeiture (Use-it-or-lose-it Rule).** An Accountholder forfeits any amount of his/her annual election that exceeds the reimbursement during any Plan Year. An Accountholder who terminates coverage during the Plan Year has a runout period in which to submit eligible claims. An Accountholder who is covered through the end of the Plan Year will have a runout period in which to submit eligible claims. The duration of these run out (the number of run out days will be provided in the Summary Description) provided by the Employer. Upon such forfeiture, An Accountholder's accrual will be reduced to zero. Forfeited funds can be retained by the Employer, or at the

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discretion of the Employer, forfeitures of benefits under the plan can be reallocated to Accountholders in any reasonable manner that has no relation to prior claims history. Forfeitures of benefits also may be applied towards the cost of administering the plan. Forfeitures of benefits will become the sole property of the Employer.

8.03 **Accountholder Certification and Debit Card Use.** The Plan requires the Accountholder to certify that each expense submitted for reimbursement has actually been incurred and has not previously been reimbursed (i.e., there is no "double-dipping"), and reimbursement will not be sought from any other source, such as another health plan for medical tax advantaged account services. The Plan requires the Accountholder to certify that upon enrollment in a TASC Subscription Service that includes the use of a TASC Debit Card, for the immediate service year and any service year thereafter, that the card will only be used for legitimate eligible expenses, limited to persons eligible for reimbursement. This Certification is printed on the back of the TASC Debit Card and reaffirmed each time the TASC Debit Card is used. The TASC Debit Card will be shut off and should not be used after the Accountholder's termination of employment, except for spending down MyCash that has been accumulated.

8.04 **Death of Accountholder**. In the event of the death of the Accountholder prior to the payment of any claims, payment will be made in the following priority:

a) Executor of the Estate of the deceased Accountholder,
b) Spouse, or,
c) Family member held responsible for payment of deceased's medical bills.

8.05 **Amounts Paid in Error**. Upon any benefits payment made in error, an Accountholder will be required to repay the Plan. The Employer may take reasonable steps to recoup such an amount, including reducing the amount of future benefits reimbursements by the amount paid in error.

8.06 **Grace Period.** The Summary Description will indicate whether there is a Grace Period for any Account Plan. The Grace Period extends two - and one-half months after the last day of your Plan Year. The last day of the Grace Period is the fifteenth day of the third month following the end of the Plan Year.

Services that are rendered after the last day of this Grace Period will not be considered for reimbursement under the prior Plan Year. An Accountholder must be enrolled through the end of the last day of the Plan Year in order for this Grace Period to apply. Services that qualify for reimbursement and are rendered during the Grace Period will be reimbursed using any balance in the prior Plan Year annual election first, and then reimbursed from any new Plan Year annual election. If an Accountholder terminates coverage for any reason prior to the end of the last day of the Plan Year, then the Accountholder may not submit any claims for services that were rendered after your date of termination.

8.07 **Healthcare Flexible Spending Account (FSA). (CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED)** This plan is intended to provide reimbursement for certain medical expenses incurred and not otherwise covered by insurance or by the Employer. The Employer intends that the plan qualify as an accident and health plan under Section 105 and 106 of the Internal Revenue Code, and that the nontaxable benefits provided under the plan be eligible for exclusion from an Accountholder's incomes under Section 105(b) of the Code. The Employer will provide a Summary Description within 90 days of enrollment or on request.

Qualified Expenses. All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Accountholder, Accountholder's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan.

Benefits. Benefits are provided from the Employer's general assets. There are no segregated funds established for this plan. The amount of an Accountholder's annual election is available on each day of the Plan Year in which the

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Employee is an Accountholder. An Accountholder is entitled to benefits under the plan for a Plan Year in an amount that does not exceed an Accountholder's annual election, and Employer contributions, if any. The amount of an Accountholder's annual election will be uniformly available during the Plan Year.

Claims. Each claim will be substantiated by the submission of a third-party statement that shows that the claim is for a Qualified Benefits Expense, or by automated means that comply with guidelines established under IRS Rev. Rul. 2003-43. If claims are submitted electronically, an Accountholder will sign a certification upon Enrollment or acceptance of an electronic card that claims submitted under the card have not been reimbursed by any other insurance or self-insured plan, and that an Accountholder is not seeking reimbursement under any other insured or self-insured plan. Services purchased under a prefunded debit card can be automatically substantiated as allowed under IRS Notice 2006-69, including claims that are automatically substantiated using the Inventory Information Approval System (IIAS), amounts that are a multiple of a health plan copayment (up to five multiple copayments).

Limited Coverage (Spouse covered under an HSA). Section 1201 of the Medicare Prescription Drug, Improvement & Modernization Act of 2003, added Section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning on or after December 31, 2003. In order to allow an Employee's Spouse to contribute to an HSA Account, an Employee is required to submit a written request to the Benefits Coordinator requesting "single" or "Parent and Child(ren)" enrollment in this Healthcare FSA. Qualified Expenses are limited to covered services or supplies provided to the Employee and Dependents that are not covered under the Spouse's HSA. No claims for family members covered under the HSA can be submitted under this plan.

Carryover. The Allowed Carryover Maximum, if any, will be communicated on the first page of the Summary Description provided to each Eligible Employee at open enrollment or when a new or existing Employee becomes eligible for enrollment in the plan. The Carryover Maximum will be the lessor of the amount communicated in the Enrollment Communications or maximum allowed. The Allowed Carryover will be the lesser of the Allowed Carryover Maximum or the unused benefit balance at the end of the Runout Period. A Runout Period immediately follows the end of a Plan Year during which an Accountholder may request reimbursement of expenses incurred for qualified benefits during the Plan Year.

The duration of any Runout Periods will be detailed in the Summary Description provided by the Employer. The amount carried over has no effect on the ability to elect the maximum salary reduction allowed under the plan for the new Plan Year. If an Accountholder elects the maximum salary reduction allowed under the plan, then the amount carried over will be in addition to that election.

Military Cash Out Option. An Accountholder in the plan will receive a Qualified Reservist Distribution upon written request provided to the Employer. A Qualified Reservist Distribution means a distribution to an Accountholder of all or a portion of the balance in the employee's account under the plan, if:

(a) an Accountholder was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United State Code)) ordered or called to active duty for a period of 180 days or more, or for an indefinite period; and,

(b) the distribution is requested and made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the plan for the Plan Year in which an Accountholder received the order or call.

The balance that can be distributed is limited to the amount of an Accountholder's actual payroll deductions made as of the date of the request, less any amount that has already been disbursed for valid claims submitted.

Continuation of Coverage Under The Public Health Services Act. This Plan is subject to the continuation provisions of the Public Health Service Act §2201 [42 USC §300bb-1] as amended, and implementing regulations. An Accountholder eligible for continuation coverage under this plan, shall be allowed to continue to participate in the plan until the end of the Plan Year in which the qualifying event occurred, as long as such an Accountholder complies with the provisions set out in the Public Health Service Act. An Accountholder is eligible for continuation coverage only when the cost to continue to the end of the Plan Year exceeds the remaining benefit. The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Internal Revenue Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

8.08 Limited Purpose Healthcare Flexible Spending Account. (CHECK YOUR ENROLLMENT MATERIALS TO DET DETERMINE IF THIS ACCOUNT PLAN IS OFFERED) This is a Healthcare Flexible Spending Account intended to accommodate persons who are making contributions to a Health Savings Account (HSA) and enrolled in a high deductible health plan ("HDHP") option. Any Employee who contributes to an HSA and elects to participate in this Healthcare FSA will automatically be placed in a Limited Purpose Healthcare FSA. A

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Limited Purpose Healthcare FSA provides reimbursement only for Qualified Expenses not otherwise covered by insurance or by the Employer that are for dental and vision services, and if designated as a Limited Purpose Post-Deductible Healthcare FSA, may also include qualified medical services provided after the HDHP statutory annual deductible has been satisfied.

8.09 Limited Purpose Post-Deductible Healthcare FSA. **(CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED)** A Qualified Expense under a Limited Purpose Post-Deductible Healthcare FSA is the same as a Qualified Expense under the Limited Purpose Healthcare FSA. With the Limited Purpose Post-Deductible Healthcare FSA, after the statutory annual HDHP deductible has been satisfied, Qualified Expenses that are not covered by the HDHP can be submitted and reimbursed. An Explanation of Benefits ("EOB") from the insurance carrier that administers the HDHP is required to be submitted. The EOB needs to show the statutory HDHP deductible has been satisfied and the portion of the expense that has been submitted for reimbursement under this plan was not applied to the HDHP deductible.

8.10 Non-Employer Sponsored Premium Account. **(CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED)** This plan is intended to comply with Section 125 of the Internal Revenue Code. The Healthcare Premium (NESP) Reimbursement Account is a tax advantaged plan established with the intent of providing tax free reimbursement for the premium paid by an Employee for an individual insurance, providing health and accident benefits as defined under Sections 105 and 106 of the Code. The individual insurance plan is owned by the Employee. This can include a plan provided through Employee owned insurance policy(ies) issued by an insurance company, or a contract(s) with a health maintenance organization or point of service organization. Coverage offered through the Marketplace, (a state or federal plan under the Affordable Care Act), does not qualify. The following individual plans can be covered under the Healthcare Premium (NESP) Reimbursement Account.

a) Health insurance or HMO coverage for health expenses
b) Dental insurance
c) Eye care insurance
d) Medicare premium
e) Medigap or Medicare Supplemental premium
f) Tricare premium
g) Accidental death and dismemberment insurance
h) Long-term or short-term disability insurance

8.11 Dependent Care Flexible Spending Account (FSA). (CHECK YOUR ENROLLMENT MATERIALS TO DETERMINE IF THIS ACCOUNT PLAN IS OFFERED) This plan is intended to provide reimbursement for certain Dependent Care Expenses incurred by an Accountholder. The Employer intends that the plan qualify as a dependent care assistance plan under Section 129(d) of the Internal Revenue Code, and that the nontaxable benefits provided under the plan be eligible for exclusion from an Accountholder's income under Section 129 of the Code.

Maximum Contribution. An Accountholder can defer the lesser of $7,500, their earned income, or the Spouse's earned income, per Plan Year. If a Spouse is disabled or a full-time student with no income, then the Spouse is deemed to have a monthly income of $250, if one dependent, $500 if two or more dependents. A married Accountholder who files a separate tax return is limited to $3,750 per year. Contributions to the plan are made and limited in accordance with an Accountholder's annual election.

Maximum Benefit. An Accountholder can never withdraw more funds than actually contributed on the date a claim is submitted. If an Accountholder fails to use his/her entire election at the end of the Plan Year or upon other termination of the plan, the unused election cannot be cashed out and becomes the property of the Employer.

Dependent Care Expenses. Expenses incurred by an Accountholder for the care of a Qualified Person or for related household services which would be considered employment-related expenses under Section 21(b)(2) of the Internal Revenue Code.

Qualifying Person. All child and Dependent Care Expenses must be for the care of one or more Qualified Persons. A Qualifying Person is defined as the following:

a) A child who is claimed as an Accountholder's Dependent and who was under the age of 13 when the care was provided;
b) An Accountholder' Spouse who was physically or mentally unable to care for himself/herself and lived with an Accountholder for more than half of the year;

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c) A person who was physically or mentally unable to care for himself or herself and lived with an Accountholder for more than half of the year, and either of the following:
    1) Was an Accountholder's Dependent; or
    2) Would have been an Accountholder's Dependent without the occurrence of one of the following:
    3) He or she received gross income equal to or in excess of the exemption amount for Dependents under Internal Revenue Code § 151(d);
    4) He or she filed a joint tax return;
    5) An Accountholder or an Accountholder's Spouse if filing jointly, could be claimed as a Dependent on someone else's federal tax return.

Child of divorced or separated parents. Even if an Accountholder cannot claim a child as a Dependent, he or she is treated as a Qualifying Person if one of the following applies.

a) The child was under the age of 13 or was physically or mentally unable to care for himself/herself; or
b) An Accountholder was the child's custodial parent (the parent with whom the child lived for the greater part of the calendar year), and the non-custodial parent is entitled to claim the child as a Dependent under the special rules for a child of divorced or separated parents. If this applies, the non-custodial parent cannot treat the child as a Qualifying Person.

Benefits and claims. Benefits are provided only for the reimbursement of a Qualified Person's Dependent Care Expenses that are incurred during the Plan year and during the period in which the Employee was an Accountholder. Benefits are limited to the amount that has actually been withheld from an Accountholder's Compensation on the date the claim is processed. Reimbursement will be made under the plan only on the basis of Dependent Care. To make the determination that a Dependent Care Expense subject to reimbursement has been incurred, proper evidence of any or all of the following may be required:

a) The name of the Qualified Person for whom the expenses have been incurred;
b) The nature of the services incurred;
c) The date the services were incurred;
d) The amount of the requested reimbursement; and,
e) That the expenses have not been otherwise paid through a program offered by the Employer or any other employer or reimbursed from any other source.

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