INFINISOURCE
BENEFIT SERVICES

Brazosport Independent School District (CN28250)
301 W Brazoswood Drive
Clute, TX 77531

Dear Flexible Spending Account Customer:

Infinisource, Inc. is pleased to provide you with the model Plan Document(s) and Summary Plan Description(s) (SPD) identified below. The benefit plans to which the plan document(s) and SPD(s) below relate are required to be maintained and administered pursuant to a written plan and these documents are intended to help you satisfy that requirement. Please be aware that Infinisource is not a law firm and as such, it is not authorized to, nor should it be construed as providing tax or legal advice. We have prepared these documents in accordance with the applicable standard of care for your convenience; however, you are solely responsible for determining the legal and tax status of your plans. Since the plans are required to be maintained pursuant these documents, we recommend that you seek the advice of your company's legal counsel before finalizing these documents. If for any reason the Plan changes, you must notify Infinisource of those changes at least thirty (30) days before the effective date of such changes.

Included within this packet are the following:

1. **Cafeteria Plan Document –** This document is intended to help satisfy the written plan document requirement in Internal Revenue Code Section 125, which enables employees to make pre-tax contributions for certain qualified benefits.
2. **Appendix A –** This is a sample Health FSA Plan Document that is incorporated into and made a part of the Cafeteria Plan Document (when offered by the employer). Code Section 105 (and ERISA, where applicable) requires Health FSAs to be maintained pursuant to a written plan document and this Appendix A is intended to help you satisfy that requirement.
3. **Appendix B –** This is a sample Dependent Care FSA plan document that, like Appendix A, is part of the Cafeteria Plan Document. Code Section 129 requires the Dependent Care FSA to be maintained pursuant a written plan and this Appendix B is intended to help you satisfy this requirement.
4. **Combined Cafeteria Plan, Health FSA and Dependent Care Summary Plan Description –** The Summary Plan Description is the primary communication vehicle that describes the benefits of the Plan, including Claims Procedures and Election Changes Summary.

The SPD and the Cafeteria Plan Document (including Appendices A and B) constitute the governing plan document. In order for the plans identified above (or any changes to such plans) to be effective, your board of directors (or other authoritative person(s), if delegated) must formally adopt these plans prior to the effective date of the plan (or effective date of the changes reflected in the documents). You should then furnish a copy of the SPD to your plan participants. Federal regulations require SPD distribution to plan participants within 90 days after they become participants on the plan; however, we recommend that you furnish them sooner if possible.

Our goal is to help you keep your plan in compliance; therefore, Infinisource recommends that two nondiscrimination tests be performed in your plan year. One at the start of your plan and one about 90 days prior to your plan ending. Our nondiscrimination test is available online at www.infinisource.com .

You should perform your first test no later than 30 days from the start of the plan. Please contact our Customer Service department at 866-350-3040 with any questions.

Please note also that while Infinisource does provide relevant information from our system to assist with your plan's Form 5500 compliance, completion of this form is the sole responsibility of the employer. The IRS has made Form 5500 completion easier with standard online forms that you may use at www.irs.gov/instructions/i5500/index.html

If you have any questions regarding this information, please contact a Customer Service Representative at 866-350-3040 or by e-mail at fsa@infinisource.com.

Sincerely,

Fringe Benefits Administration
Infinisource, Inc.

Brazosport Independent School District
FLEXIBLE BENEFIT PLAN

(As Adopted Effective September 1, 2020)

Amended and Restated Effective May 24, 2019

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PREAMBLE

Effective **September 1, 2020**, **Brazosport Independent School District** established the Flexible Benefit Plan (the "Plan") for its employees for purposes of providing eligible employees with the opportunity to choose from among the Benefit Package Options available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125.

The Dependent Care Flexible Spending Account ("Dependent Care FSA"), if adopted by the Employer, is intended to qualify as a Code Section 129 dependent care assistance plan, and the Health Care Flexible Spending Account ("Health FSA"), if adopted by the Employer, is intended to qualify as a Code Section 105 medical expense reimbursement plan. Although printed within this document, the Dependent Care FSA and Health FSA are separate written plans for purposes of administration and non-discrimination requirements imposed by Sections 105 and 129 of the Code and all applicable provisions of ERISA.

Brazosport Independent School District
Flexible Benefit Plan

ARTICLE I – DEFINITIONS

1.01 "Affiliated Employer" means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m) of the Code.

1.02 "After-tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan.

1.03 "Anniversary Date" means the first day of any Plan Year.

1.04 "Benefit Package Options" means those Qualified Benefits available to a participant under this Plan as set forth in the Summary Plan Description, as amended and/or restated from time to time.

1.05 "Board of Directors" means the Board of Directors or other governing body of the Employer (the "Board"). The Board of Directors, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

1.06 "Change in Status" means any of the events described in the Summary Plan Description, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125 that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election midyear. Note: See the Summary Plan Description for requirements that must be met to permit certain midyear election changes on account of a Change in Status.

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

1.08 "Compensation" means the cash wages or salary paid to an Employee by the Employer.

1.09 "Dependent" means any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a) except as otherwise set forth in Code Section 21 (for Dependent Care FSA purposes), Code Section 105 (for health plan purposes) and Code Section 223 (for Health Savings Account purposes, if offered under the Plan)..

1.10 "Dependent Care Reimbursement" shall have the meaning assigned to it by Section 5.01 (b) of the Plan.

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

1.12 "Effective Date" of this Plan means the effective date, or the amended and restated effective date, set forth in the SPD.

1.13 "Eligible Employment Related Expenses" means those Qualifying Employment Related Expenses (as defined below) paid or incurred incident to maintaining employment after the date of the Employee's participation in the Dependent Care FSA and during the Plan Year, other than amounts paid to :

a. An individual with respect to whom a Dependent deduction is allowable under Code Sec. 151(c) to the Participant or his Spouse.
b. The Participant's Spouse.
c. A child of the participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

1.14 "Eligible Medical Expenses" means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the Health FSA and during the Plan Year to the extent that the expense satisfies the conditions set forth in the Summary Plan Description and are for "medical care" as defined by Code Section 213(d). For purposes of this Plan, the following expenses are not considered "Eligible Medical Expenses" even if they otherwise constitute "medical care" under Code Section 213(d):

a. Expenses for qualified long-term care services (as defined in Code § 7702B).
b. Expenses for health insurance premiums.
c. Expenses incurred for a medicine or a drug that is not prescribed by a physician, unless it is insulin. These are often referred to as over-the-counter medicines or drugs.

For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

1.15 "Employee" means an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any of the following: (1) any leased employee (including, but not limited to, those individuals defined in Code § 414(n)); (2) an individual classified by the Employer as a contract worker or independent contractor; (3) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll; and (4) any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," Manpower," etc., or any employee covered under a collective bargaining agreement, except as otherwise provided for in the collective bargaining agreement.

1.16 "Employer" means the Employer as listed and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Employer. Notwithstanding the previous sentence, when the Plan provides that the Employer has a certain power (e.g., the appointment of a third party administrator, entering into a contract with a third party insurer or amendment or termination of the plan) the term "Employer" shall mean only the Employer as listed on page 32. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein. Affiliated Employers who have adopted the Plan are set forth in the Summary Plan Description.

1.17 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.18 "Health Care Reimbursement" shall have the meaning assigned to it by Section 5.01(b) of the Plan.

1.19 "Highly Compensated Individual" means an individual defined under Code Section 105(h), 125(e), or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.20 "Key Employee" means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.

1.21 "Non-elective Contribution(s)" means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the Benefit Package Option(s) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Package Option(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the Summary Plan Description or enrollment material, the Employer may make Non-elective Contributions available to Participants and allow Participants to allocate the Non-elective Contributions among the various Benefit Package Options offered under the Plan in a manner set forth in the Summary Plan Description or enrollment material. In no event will any Non-elective Contribution be disbursed to a Participant in the form of additional, taxable Compensation except as otherwise provided in the Summary Plan Description or enrollment material.

1.22 "Participant" means an Employee who becomes a Participant pursuant to Article II.

1.23 "Plan" means this Flexible Benefits Plan.

1.24 "Plan Administrator" means the person(s) or Committee identified in the Summary Plan Description that is appointed by the Employer with authority, discretion and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.25 "Plan Year" shall be the period of coverage set forth in the Summary Plan Description.

1.26 "Pre-tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan. This amount shall not exceed the contributions attributable to the most costly Benefit Package Option afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.27 "Qualified Benefit" means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 124, 127 or 132 and any other benefit permitted by the Income Tax Regulations (i.e., any group term life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Sec. 79) Notwithstanding the previous sentence, long-term care insurance is not a "Qualified Benefit."

1.28 "Qualifying Employment-Related Expenses" means those expenses that would be considered to be employment-related expenses under Section 21(b) (2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services.

1.29 "Qualifying Individual" means:

a. A Dependent of the Participant who is under the age of thirteen (13).
b. A Dependent of a participant who is mentally or physically incapable of caring for himself or herself.
c. The Spouse of a Participant who is mentally or physically incapable of caring for himself or herself.

1.30 "Qualifying Services" means services relating to the care of a Qualifying Individual that enable the participant or his Spouse to remain gainfully employed which are performed:

a. In the Participant's home.
b. Outside the participant's home for (1) the care of a Dependent of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

1.31 "Reimbursement Account(s)" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Reimbursement (as defined in Section 1.18 herein) and Dependent Care Reimbursement (as defined in Section 1.10 herein) to the extent adopted by the Employer as set forth in the Summary Plan Description. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant account(s).

1.32 "Salary Reduction Agreement" means the actual or deemed agreement pursuant to which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Package Options with Pre-tax or After-tax Contributions and/or Benefit Credits (if offered under the Plan) in accordance with Article III herein. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the Salary Reduction Agreement may be maintained on an electronic database in accordance with all applicable federal and/or state laws.

1.33 "Spouse" means an individual who is legally married to a Participant (and who is treated as a spouse under the Code), but for purposes of the Dependent Care Reimbursement Plan provisions, shall not include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual. A "Spouse" includes same-sex spouses lawfully married under state law, regardless of their state of residence.

1.34 "Summary Plan Description" or **"SPD"** means the Flexible Benefits Plan SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and attached to this Plan Document as Attachment I, as amended from time to time. The SPD and appendices are incorporated hereto by reference.

1.35 "Student" means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full-time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.

ARTICLE II – ELIGIBILITY AND PARTICIPATION

2.01 Eligibility to Participate. Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Plan as of the eligibility date set forth in the SPD. Eligibility to participate in this Plan means only that the eligible Employee is entitled to contribute his share of the cost of applicable Benefit Package Options for which he is eligible with Pre-tax Contributions. The provisions of this Article are not intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Package Options and the terms of eligibility and participation for the Benefit Package Options(s) offered under the Plan shall be subject to the requirements specified in the governing documents of the Benefit Package Options.

2.02 Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD.

2.03 Eligibility of Participate in Reimbursement Accounts. Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in the Reimbursement Accounts, if adopted by the Employer, on the applicable Eligibility Date set forth in the SPD.

2.04 Qualifying Leave under Family Leave Act. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Package Options that provide health coverage (including Health FSA benefits to the extent offered under the Plan) on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave and payment options(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.05 Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Package Options chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD and implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Package Options chosen by the Participant, the election change rules in Section 3.04 will apply. If such policy requires coverage to continue during the leave, but permits a Participant to discontinue contributions while on leave, the participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

ARTICLE III –ELECTIONS

3.01 Election of Contributions. A Participant may elect any combination of Pre-tax Contributions or After-tax Contributions (as set forth in the SPD) to fund any Benefit Package Option available under the Plan, provided that only Qualified Benefits may be funded with Pre-tax Contributions. The Employer may, but is not required, to allocate Non-elective Contributions to one or more Benefit Package Options offered under the Plan and to the extent set forth in the SPD or enrollment material, may allow the Participants to allocate his allotted share of Non-elective Contributions among the various Benefit Package Options in a manner set forth in the SPD or enrollment material.

3.02 Initial Election Period.

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Plan as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date. The elections made by the participant on this initial Salary Reduction Agreement shall be effective, subject of Section 3.04, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied the Plan's Waiting Period.** An Employee who becomes eligible to become a Participant in this Plan after the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the initial election period set forth in the SPD or the enrollment material. Participation will commence under this Plan as set forth in the SPD. Coverage under the component Benefit Package Options will be effective in accordance with the governing provisions of such Benefit Package Options.

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.03 or 3.04.

3.03 Annual Election Period. Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his right to become a Participant in this Plan, to continue participation in the Plan or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right; such period of time shall be known as the annual election period. The date on which the annual election period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the annual election period in the manner set forth in the SPD. The consequences of failing to make an election during the annual election period will be set forth in the SPD.

3.04 Change of Elections. A Participant shall not make any changes to the Pre-tax Contribution amount or, where applicable, to the Participant's elected allocation of Non-elective Contributions except for election changes permitted under this Section 3.04, and for changes made during the annual election period (Section 3.03), changes caused by termination of employment (Section 3.05) and changes pursuant to the FMLA (Section 2.04).

Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption or placement for adoption of a child, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier that the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later. The circumstance under which a participant may change his election under this Plan is set forth in the SPD.

3.05 Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment of cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3.05, no new election with respect to Pre-tax Contributions may be made by such Participant during remainder of the Plan Year. Rules governing elections for former participants rehired during the same Plan Year shall be set forth in the SPD.

ARTICLE IV –PAYMENTS, CREDITS AND DEBITS TO ACCOUNTS

4.01 Source of Benefit Funding. The cost of coverage under the component Benefit Package Options shall be funded by Participant's Pre-tax and/or After-tax Contributions and/or any Non-elective Contributions provided by the Employer. The required contributions for each of the Benefit Package Options offered under the Plan shall be made known to employees in enrollment materials. Pre-tax or After-tax Contributions (as elected by the Employee on the Salary Reduction Agreement and permitted by the Employer) shall equal the contributions required from the Participant less any available Non-elective Contributions allocated thereto by the Employer, or where applicable, the Participant for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Package Options elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pre-tax Contributions or After-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pre-tax Contributions, plus any Non-elective Contributions made available by the Employer, shall not exceed the aggregate cost of the Benefit package Options elected.

4.02 Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pre-tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

4.03 Health Care Reimbursement. To the extent offered under the Plan, each Participant's Health FSA will be credited for Health Care Reimbursement with amounts withheld from the Participant's Compensation and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with Article V of this document. The entire amount elected by the Participant on the Salary Reduction Agreement as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed to the Participant for Expenses incurred during the plan year shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Account (provided that the periodic contributions have been made). Thus, the maximum amount of Health Care Reimbursement at any particular time during the Plan Year will not relate to the amount that a Participant has had credited to his Health FSA. In no event will the amount of Health Care Reimbursements in any Plan Year exceed the annual amount specified for the Plan Year in the Salary Reduction Agreement for Health Care Reimbursement. Any amount credited to the Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Health Care Reimbursement within the run-out period set forth in the SPD. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor or Internal Revenue Service Regulations. The maximum annual reimbursement under the Health FSA shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

4.04 Dependent Care Reimbursement. To the extent offered under the Plan, each Participant's Dependent Care FSA will be credited for Dependent Care Reimbursement with amounts withheld from the Participant's Compensation, and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Dependent Care Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with Article V of this document. In the event that the amount in the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months within the same Plan Year, to be paid out as the Dependent Care Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Account for any Plan Year. Any amount allocated to the Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Dependent Care Reimbursement for the Plan Year within the run out period set forth in the SPD. Amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law. The maximum annual reimbursement amount shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

ARTICLE V – BENEFITS

5.01 Qualified Benefits. The maximum benefit a participant may elect under this Plan shall not exceed the sum of 1) the aggregated premium for all Benefit Package Option(s) set forth in the SPD (other than Health and Dependent Care FSA); 2) the maximum annual Health Care Reimbursement under the Health FSA as set forth in the SPD (if offered under the Plan); and 3) the maximum annual Dependent Care Reimbursement under the Dependent Care FSA as set forth in the SPD (if offered under the Plan). Notwithstanding the previous sentence, for plan years starting on or after January 1, 2013, the annual salary reduction contribution limit for the Health FSA shall be subject to Code §125(i), including an annual cost-of-living adjustment as published by the IRS for later plan years. For the plan year starting in 2015, the §125(i) limit is $2,550.

a) **Special Rules for Health Care Reimbursement.** To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Dependents while he is a Participant during the Plan Year for which the Participant's election is effective provided that the substantiation requirements of Section 6.10 herein are satisfied.

b) **Special Rules for Dependent Care Reimbursement.** To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Employment Related Expenses incurred by him while a Participant, during the Plan Year for which the Participant's election is effective, provided that the substantiation requirements of Section 6.10 have been satisfied.

5.02 Cash Benefit. To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as a Pre-tax Contribution or After-Tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Non-elective Contributions may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment material.

5.03 Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses and/or Eligible Employment Related Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6.10 herein, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

5.04 Termination of Reimbursement Accounts. Coverage under the Health Care and/or Dependent Care FSA shall cease as of the day in which a Participant is no longer employed by the Employer or when a payment for the respective plan(s) has been missed for any reason. Provided, however, that Participants may submit claims for reimbursement for Eligible Employment Related Expenses arising during the Plan Year at any time until the end of the run-out period set forth in the SPD. Participants in the Health FSA may submit claims for reimbursement for Eligible Medical Expense arising during the Plan Year <u>and</u> before the date of separation from service at any time until the end of the run-out period set forth in the SPD. Unless a COBRA election is made as set

forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment ceases under this Section. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) shall be treated in accordance with Sections 4.03 or 4.04.

5.05 Coordination of Benefits under the Health FSA. The Health FSA is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other Plan.

ARTICLE VI – PLAN ADMINISTRATION

6.01 Allocation of Authority. The Board of Directors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies or omissions in the Plan and the SPD issued in connection with the Plan. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

a. To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan.

b. To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan.

c. To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan.

d. To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the plan; to inform the Employer, insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part.

e. To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan. Such entity will be referred to as a third party administrator and shall be identified in the SPD.

f. To keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan.

g. To do all things necessary to operate and administer the Plan in accordance with its provisions.

6.02 Provision for Third Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons, as it may deem necessary or desirable in connection with the operation of the Plan and to rely upon all tables, valuations, certificates, reports and opinions furnished thereby. Such entity will be identified in the SPD as a third party administrator. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

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

6.04 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but the Employer shall pay all reasonable expenses incurred in the performance of their duties.

6.05 Bonding. Unless otherwise determined by the Employer, or unless required by any federal or state law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

6.06 Payment of Administrative Expenses. The Employer currently pays all reasonable expenses incurred in administering the Plan.

6.07 Funding Policy. The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefit Package Options offered under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by, the Employer. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this plan. Such limitation shall include, but not be limited to, losses or obligations that pertain to the following:

a. Once insurance is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer.

b. To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which results from such failure.

c. The employer will not be liable for the payment of any insurance premium or any loss that may result from the failure to pay an insurance premium if the benefits available under this plan are not enough to provide for such premium cost at the time it is due. In such circumstances, the Employee will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if available benefits under this plan are not enough to provide for an insurance premium, but will not be liable for any failure to make such notification.

d. When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this plan, and the Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

6.08 Disbursement Reports. The Plan Administrator shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Plan.

6.09 Indemnification. The Plan Administrator shall be indemnified by the Employer against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect or willful misconduct.

6.10 Substantiation of Expenses. Each Participant must submit a written claim form to the third party administrator identified in the SPD to receive reimbursements for Health Care and/or Dependent Care FSA, on a form provided by the Plan Administrator accompanied by a written statement/bill from an independent third party stating that the expense has been incurred, and the amount thereof. The forms shall contain such evidence as the Plan Administrator shall deem necessary as to substantiate the nature, the amount and timeliness of any expenses that may be reimbursed.

6.11 Reimbursement. Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan Administrator.

6.12 Statements. The Plan Administrator or its designated third party administrator may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Health Care and/or Dependent Care Reimbursement and the respective Reimbursement Account Balance(s).

ARTICLE VII – FUNDING AGENT

The Plan shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements and/or Non-elective Contributions provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations promulgated by the Department of Labor ("DOL") taking into consideration any enforcement procedures adopted by the DOL.

ARTICLE VIII – CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Plan, and those claims review procedures are set forth in the SPD. The Plan's claim review procedures set forth in the SPD shall only apply to issues germane to the Pre-tax benefits available under this Plan (i.e., such as a determination of a Change in Status, change in cost or coverage, or eligibility and participation matters under this Cafeteria Plan document), and to the extent offered under the Plan, claims for benefits under the Reimbursement Accounts.

ARTICLE IX – AMENDMENT OR TERMINATION OF PLAN

9.01 Permanency. While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 9.02 and 9.03, below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

9.02 Employer's Right to Amend. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business (e.g., by approval by the Board of Directors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Package Option shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

9.03 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

9.04 Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine. No amendment, discontinuance or termination shall allow the return to any Employer of any Reimbursement Account balance for its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries except as provided in Section 4.03(a) and 4.04(a) herein.

ARTICLE X – GENERAL PROVISIONS

10.01 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

10.02 Applicable Laws. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of Texas to the extent not preempted.

10.03 Post-mortem Payments. Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving Spouse, otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

10.04 Non-alienation of Benefits. Except as expressly provided by the Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

10.05 Mental or Physical Incompetency. Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

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

10.07 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

10.08 Source of Payments. The Employer and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

10.09 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

10.10 Tax Effects. Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any Pre-tax contributions made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated as a "cafeteria plan" under Section 125 of the Code.

10.11 Gender and Number. Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

10.12 Headings. The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

10.13 Incorporation by Reference. The actual terms and conditions of the separate component Benefit Package Options offered under this Plan are contained in separate, written documents governing each respective benefit, shall govern in the event of a conflict between the individual plan document and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. In addition, the SPD for this Plan contains many of the actual terms and conditions of this Plan. To that end, the SPD, as amended from time to time, is incorporated herein.

10.14 Severability. Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder thereof shall be given effect to the maximum extent possible.

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

10.16 Forfeiture of Unclaimed Reimbursement Account Benefits. Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Health or Dependent Care Expense was incurred shall be forfeited.

10.17 HIPAA Privacy and Security with respect to Health FSA.

a. The Health FSA (the "Plan") will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as defined in the Privacy Notice distributed to Plan Participants.

The Plan will disclose PHI to the Employer only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions in Subsection (b) below.

b. With Respect to PHI, the Employer agrees to certain conditions.
The Employer agrees to:

- Not use or disclose PHI other than as permitted or required by the Plan document or as required by law.
- Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
- Not use or disclose PHI for employment related actions and decisions unless authorized by an individual.
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual.
- Report to the Plan any PHI use or disclosures provided of which it becomes aware.
- Make PHI available to an individual in accordance with HIPAA's access requirements.
- Make PHI available to comply with HIPAA's individual right of access requirements.
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.
- Make available the information required to provide an accounting of disclosures.
- Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA.
- 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 PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

c. Adequate separation will be maintained between the Plan and the Employer. Only the individuals identified in the Privacy Notice distributed to Participants in accordance with HIPAA may have access to PHI. The persons described in the Privacy Notice may only use and disclose PHI for Plan administration functions that the Employer performs for the Plan. If the persons described herein do not comply with the Plan document, the Employer shall provide an effective mechanism for resolving issues of noncompliance, including disciplinary sanctions.

d. This section 10.17 shall be effective as of the applicable date(s) set forth in HIPAA and the applicable regulations issued thereunder.

ARTICLE XI – CONTINUATION COVERAGE UNDER COBRA

The SPD includes provisions that shall be applicable to the Health FSA, if offered under the plan, to the extent the Health FSA is a "group health plan" as defined by Code §4980B and 5000 (b)(1) and the regulations promulgated thereunder and to the extent it is offered under the Plan. The intent of those provisions (as incorporated in this Article) is to extend continuation rights required by COBRA.

IN WITNESS WHEREOF, the Employer has executed this Cafeteria Plan as of the date set forth below.

Brazosport Independent School District

By: _____

Title: _____

Date: _____

SUMMARY PLAN DESCRIPTION
For The

Cafeteria Plan
Health Flexible Spending Account
Dependent Care Flexible Spending Account

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Brazosport Independent School District

FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

GENERAL INFORMATION ABOUT THE PLAN

Brazosport Independent School District(the "Employer") is pleased to sponsor an employee benefit program known as the Flexible Benefit Plan (the "Plan") for you and your fellow employees. It is so-called because it lets you choose from several different benefit programs (which we refer to herein as "Benefit Plan Options") according to your individual needs, and allows you to use Pre-tax Contributions to pay for the benefits by entering into a salary reduction arrangement with your Employer. This Plan helps you because the benefits you elect are nontaxable (i.e., you save Social Security and income taxes on the amount of your salary reduction). Alternatively, you may choose to pay for any of the available benefits with After-tax Contributions on a salary deduction basis to the extent described in your enrollment materials.

This Plan has four components:

a. **A Cafeteria Plan Component**. The Cafeteria Plan Component allows you to pay your share of certain underlying welfare benefit plans (called "Benefit Plan Options") with Pre-tax Contributions.
b. **The Health Flexible Spending Account** (Health FSA). The Health FSA allows you to elect to use a specified amount of Pre-tax Contributions to be used for reimbursement of Eligible Medical Expenses. The Health FSA is intended to qualify as a Code Section 105 self-insured medical reimbursement plan.
c. **The Dependent Care Spending Account** (Dependent Care FSA). The Dependent Care FSA allows you to elect to use a specified amount of Pre-tax Contributions to be used for reimbursement of Employment Related Expenses. The Dependent Care FSA is intended to qualify as a Code Section 129 dependent care assistance plan.
d. **Health Savings Account** (HSA) Contributions. To the extent that Health Savings Accounts are identified as a Benefit Option in the Plan Information Summary, you may be permitted to make contributions to a Health Savings Account, as defined in Code Section 223, in accordance with the terms of the Health Savings Account Contribution Summary.

Each of the four components is summarized in this document. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary. For example, you can find the identity of the third party administrator, the Employer and the Plan Administrator in the Plan Information Summary as well as the Plan Number and any applicable contact information. Each summary and the attached Appendices constitute the Summary Plan Description for the Flexible Benefit Plan. The SPD (collectively, the Summary Plan Description or "SPD") describes the basic features of the Plan, how it operates and how you can get the maximum advantage from it. The Plan is also established pursuant to a plan document into which the SPD has been incorporated. However, if there is a conflict between the official plan document and the SPD, the plan document will govern. Certain terms in this Summary are capitalized. Capitalized terms reflect important terms that are specifically defined in this Summary or in the Plan Document into which this Summary is incorporated. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under this Plan.

Participation in the Plan does not give any Participant the right to be retained in the employ of his Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator (who is identified in the Plan Information Summary).

CAFETERIA PLAN COMPONENT SUMMARY

Q-1 What is the purpose of the Cafeteria Plan?

The purpose is to allow eligible employees to pay for certain benefit plans (Benefit Plan Options) with pre-tax dollars ("Pre-tax Contributions"). The Benefit Plan Options to which you may contribute with Pre-tax Contributions under this Cafeteria Plan are described in the Plan Information Summary.

To the extent Health Savings Accounts are a Benefit Plan Option under this Plan, you may be able to contribute to your personal Health Savings Account (HSA, as defined in Code Section 223) under this Plan. If you are permitted to contribute to an HSA, the rules for HSA contributions will be set forth generally in the Plan Information Summary.

Q-2 Who can participate in the Cafeteria Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who (1) satisfies the Cafeteria Plan Eligibility Requirements and (2) is also eligible to participate in any of the Benefit Plan Options will be eligible to participate in this Cafeteria Plan no earlier than the Cafeteria Plan Eligibility Date. No Pre-tax Salary Reduction may be made unless a proper election is made in accordance with the terms of this SPD. The Cafeteria Plan Eligibility Requirements and Eligibility Date are described in the Plan Information Summary. If you are eligible to participate in this Cafeteria Plan, it does not necessarily mean you are eligible to participate in the Benefit Plan Options. For details regarding eligibility provisions, benefit amounts and premium schedules for each of the Benefit Plan Options, please refer to the plan summary for each Benefit Plan Option.

Q-3 When does my participation in the Cafeteria Plan end?

Your coverage under the Cafeteria Plan ends on the earliest of the following to occur

a. The date that you make an election not to participate in accordance with this Cafeteria Plan Summary.
b. The date that you no longer satisfy the Eligibility Requirements of this Cafeteria Plan or all of the Benefit Plan Options.
c. The date that you terminate employment with the Employer.
d. The date that the Cafeteria Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

If your employment with the Employer is terminated during the Plan year or you otherwise cease to be eligible, your active participation in the Cafeteria Plan will *automatically* cease. If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan (or you become eligible again), you may make new elections if you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility (subject to any limitations imposed by the Benefit Plan Option[s]). If you are rehired or again become eligible within 30 days of your termination date, your Cafeteria Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

Q-4 How do I become a Participant?

If you have otherwise satisfied the Cafeteria Plan's eligibility requirements, you become a Participant by signing an individual Salary Reduction Agreement (sometimes referred to as an "Election Form") on which you agree to pay your share of the Benefit Plan Options that you choose with Pre-tax Contributions. You will be provided with a Salary Reduction Agreement on or before your Cafeteria Plan Eligibility Date. You must complete the form and submit it to the Plan Administrator or the third party Administrator (per the instructions provided on or with your Salary Reduction Agreement) during one of the election periods described in **Q-6** below. You may also enroll during the year if you previously elected not to participate and you experience a change described below that allows you to become a Participant during the year. If that occurs, you must complete an election change form during the Election Change Period described in **Q-8** below. The election that you make under this Plan (whether to make Pre-tax Salary Reductions or not) is generally irrevocable during the Plan Year except as set for in **Q-6** below.

In some cases, the Employer may *require* you to pay your share of the Benefit Plan Option coverage that you elect with Pre-tax Contributions. If that is the case, your election to participate in the Benefit Plan Option(s) will constitute an election under this Cafeteria Plan.

You may be required to complete a Salary Reduction Agreement via telephone or voice response technology, electronic communication or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an authorization form authorizing issuance of a personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5 What are tax advantages and disadvantages of participating in the Cafeteria Plan?

You save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. There is an example in the Plan Information Summary that illustrates the tax savings. Cafeteria Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-6 **What are the election periods for entering the Cafeteria Plan?**

The Cafeteria Plan basically has three elections periods: (1) the "Initial Election Period," (2) the "Annual Election Period" and (3) the "Election Change Period", which is the period following the date you have a Change in Status Event (described below). The following is a summary of the Initial Election Period and the Annual Election Period.

6a. *What is the Initial Election Period?*

If you want to participate in the Cafeteria Plan when you are first hired, you must enroll during the "Initial Election Period" described in the enrollment materials you will receive. If you make an election during the Initial Election Period, your participation in this Cafeteria Plan will begin on the later of your Eligibility Date or the first pay period coinciding with or next following pay period date that your election is received. If you are newly hired and make your election no later than thirty (30) days after your hire date, the effective date of coverage is retroactive to the hire date, if permitted by the governing documents of the Benefit Plan Options. This retroactive hire date rule does not apply to any employee who terminates employment and is rehired within 30 days after termination or returns to employment following an unpaid leave of absence of less than 30 days. Otherwise, the effective date of coverage under the Benefit Plan Options will be effective on the date established in the governing documents of the Benefit Plan Options.

The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status Event described in **Q-8** below. If you do not make an election during the Initial Election Period, you will be deemed to have elected not to Participate in this Cafeteria Plan for the remainder of the Plan Year. Failure to make an election under this Cafeteria Plan generally results in no coverage under the Benefit Plan Options; however, the Employer may provide coverage under certain Benefit Plan Options automatically. These automatic benefits are called "Default Benefits." Any Default Benefit provided by your Employer will be identified in the enrollment material. In addition, your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a Pre-tax basis. You will be notified in the enrollment material whether there will be a corresponding Pre-tax Contribution for such default benefits.

6b. *What is the Annual Election Period?*

The Cafeteria Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you have a Change in Status Event described below. If you fail to complete, sign and file a Salary Reduction Agreement during the Annual Election Period, you may be deemed to have elected to continue Participation in the Cafeteria Plan with the same Benefit Plan Option elections that you had on the last day of the Plan Year in which the Annual Election Period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an "Evergreen Election." Alternatively, the Plan Administrator may deem you to have elected not to participate in the Cafeteria Plan for the next Plan Year if you fail to make an election during the Annual Election Period. The consequences of failing to make an election under this Cafeteria Plan during the Annual Election Period are described in the Plan Information Summary.

Special Rule for Reimbursement Accounts (and Health Savings Account contribution elections, if offered under the Plan): Evergreen elections do not apply to Reimbursement Accounts (and Health Savings Account contribution elections unless specifically stated by the employer in the enrollment material). Consequently, you generally must make an election each Annual Election Period in order to participate in the Reimbursement Accounts or to contribute to a Health Savings Account during the next Plan Year.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7 How is my Benefit Plan Option coverage paid for under this Plan?

When you elect to participate both in a Benefit Plan Option and this Cafeteria Plan, an amount equal to your share of the annual cost of those Benefit Plan Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use Pre-tax Contributions (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

An Employer may choose to pay for a share of the cost of the Benefit Plan Options you choose with Non-elective Employer Contributions. The amount of Non-elective Employer Contributions that is applied by the Employer towards the cost of the Benefit Plan Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the employer's sole discretion at any time. The Non-elective Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Non-elective Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material or in the Plan Information Summary.

The Employer may provide you with employer contributions over which you have discretion to choose how to apply to the various Benefit Plan Options available under the Cafeteria Plan. These elective employer contributions are called "Flexible Credits" or "Benefit Credits." The Flexible or Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

Where applicable, Salary Reduction amounts from the last month of one Plan Year may be applied to pay health plan premiums during the first month of the immediately following Plan Year, as long as your employer does this on a uniform and consistent basis with respect to all Participants.

In addition, if applicable, a terminating employee may elect to have COBRA premiums paid on a pre-tax basis from severance pay for Plan coverage.

Q-8 Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your election under this Cafeteria Plan during the Plan Year. There are, however, a few exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Cafeteria Plan or under all of the Benefit Plan Options that you have chosen.

Second, you may voluntarily change your election during the Plan Year if you satisfy the following conditions (prescribed by federal law):

a. You experience a "Change in Status Event" or "Cost of Coverage Change" that affects your eligibility under this Cafeteria Plan and /or a Benefit Plan Option.
b. You complete and submit a written Election Change Form within the election Change Period described in the Plan Information Summary.

Change in Status Events and Cost of Coverage Changes recognized by this Cafeteria Plan, and the rules surrounding election changes in the event you experience a Change in Status Event or Cost or Coverage Change are described in the Election Change Chart attached to this SPD. Note: If you elect to contribute to a Health Savings Account (to the extent permitted under this Plan and identified as a Benefit Plan Option in the Plan Information Summary), there are special rules regarding midyear changes to your HSA elections. The Rules regarding Health Savings Account elections (if offered under the Plan) will be set forth in the Plan Information Summary.

Third, an election under this Cafeteria Plan may be modified during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Cafeteria Plan from becoming discriminatory with the meaning of the applicable federal income tax law.

If coverage under a Benefit Plan Option ends, the corresponding Pre-tax Contributions for that coverage will automatically end. No election is needed to stop the contributions.

Q-9 What happens to my participation under the Cafeteria Plan if I take a leave of absence?

Your Employer may elect to continue coverage under one or more of the Benefit Options that you chose while you are absent on a paid leave. If so, you will pay your share of the cost of such coverage that you are required to pay during such a leave by the method normally used during any paid leave (for example, with Pre-tax Salary Reductions).

In the event of unpaid leave (or paid leave where coverage is not required to be continued), you will be permitted to pay your share of the cost of any such Benefit Options that you are permitted to continue during the leave in accordance with policies adopted by your Employer. The payment options offered by the Employer in accordance with such policies will be established in accordance with Code Section 125, FMLA (to the extent applicable), and any other applicable federal or state law(s) and any applicable regulations issued.

Q-10 How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

Q-11 **What happens if my request for a benefit under this Cafeteria Plan (e.g., an election change or other issue germane to Pre-tax Contributions) is denied?**

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

HEALTH FSA COMPONENT SUMMARY

Q-1 Who can participate in the Health FSA?

Each employee who satisfies the Health FSA Eligibility requirements is eligible to participate on the Health FSA Eligibility Date. The Health FSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary. Participation does not begin unless a proper election is made.

Q-2 How do I become a Participant?

You become a Participant in the Health FSA by electing Health Care Reimbursement benefits during the Initial or Annual Election Periods described in the Cafeteria Plan Summary. Your participation in the Health FSA will be effective on the date that you make the election or your Health FSA Eligibility Date, whichever is later. If you wish to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Health FSA elections.

You may also become a Participant if you experience a change in status event or cost or coverage change that permits you to enroll midyear (see **Q-8.** of the Cafeteria Plan Summary for more details regarding midyear election changes and the effective date of those changes).

Once you become a Participant your "Eligible Dependents" also become covered. For purposes of the Health FSA, Eligible Dependents are the following:

a. Your legal Spouse (including same-sex spouses lawfully married under state law, regardless of their state of residence).
b. Any other individuals who would qualify as a tax dependent under Code Section 105 and the regulations issued by Treasury under Code Section 106.
c. Any adult child who has not yet attained the age of 27 by the end of the current calendar year, as defined in Code Section 105(b).

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. "Alternate recipients" include any child of the Participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health Care Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

NOTE: You may be able to elect to cover only yourself under the Health FSA to the extent chosen by your Employer in the Plan Information Summary. This would allow your spouse to establish a Health Savings Account as defined in Code Section 223. If this option is available, it will be described in more detail in the Plan Information Summary. Otherwise, your participation in this Health FSA could disqualify your spouse from establishing and making/receiving tax-favored contributions to a Health Savings Account.

Q-3 What is my "Health Care Account?"

If you elect to participate in the Health FSA, the Employer will establish a "Health Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Health FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4 When does coverage under the Health FSA end?

Your coverage under the Health FSA ends on the earlier of the following to occur:

a. The date that you elect not to participate in accordance with the Cafeteria Plan Summary.
b. The last day of the Plan Year unless you make an election during the Annual Election Period.
c. The date that you no longer satisfy the Health FSA Eligibility Requirements.
d. The date that you terminate employment.
e. The date that the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You may be entitled to elect Continuation Coverage (as described in **Q-16** below) under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your Eligible Dependents ends on earlier of the following to occur:

a. The date your coverage ends.
b. The date that your Eligible Dependents cease to be eligible (e.g., you and your spouse divorce or your Eligible Dependent ages out).
c. The date the Plan is terminated or amended to exclude the individual or the class of Eligible Dependents of which the individual is a member from coverage under the Health FSA.

You and/or your Eligible Dependents may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail below.

Q-5 Can I ever change my Health FSA election?

You can change your election under the Health FSA in the following situations:

a. *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.
b. *Following a Change in Status Event.* You may change your Health FSA election during the Plan Year only if you experience an applicable Change in Status Event. See **Q-8** of the Cafeteria Plan Summary for more information on election changes. **NOTE: You may not make Health FSA election changes as a result of any cost or coverage changes.**

Q-6 What happens to my Health Care Account if I take an approved leave of absence?

Refer to the Cafeteria Plan Summary and the Election Change Chart to determine what, if any, specific changes you can make during a leave of absence. If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at either a) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or b) at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

Q-7 What is the maximum annual Health Care Reimbursement that I may elect under the Health FSA, and how much will it cost?

You may elect any annual reimbursement amount subject to the maximum annual Health Care Reimbursement Amount and Minimum Reimbursement Amount described in the Plan Information Summary. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-8 How are Health Care Reimbursement benefits paid for under this Plan?

When you complete the Salary Reduction Agreement, you specify the amount of Health Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Non-elective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment material will indicate if Non-elective Contributions or Benefit Credits are available for Health FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Health Care Account.

Q-9 **What amounts will be available for Health Care Reimbursement at any particular time during the Plan Year?**

So long as coverage is effective, the full, annual amount of Health Care Reimbursement you have elected, reduced by the amount of previous Health Care Reimbursements received during the Year, will be available at any time during the Plan Year; without regard to how much you have contributed.

Q-10 **How do I receive reimbursement under the Health FSA?**

Under this Health FSA, you have two reimbursement options. You can complete and submit a written claim for reimbursement (see "Traditional Paper Claims" below for more information). Alternatively, you can use an electronic payment card (see "Electronic Payment Card" below for more information) to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work.

Traditional Paper Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's third party administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the third party administrator. You must include with your Request for Reimbursement Form a written statement for an independent third party (e.g., a receipt, Explanation of Benefits [EOB], etc.) associated with each expense that indicates the following:

a. The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug.
b. The date the expense was incurred.
c. The amount of the expense.

The third party administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Medical Expense you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the run-out period. The run-out period is described in the Plan Information Summary.

Reimbursement of Traditional Paper Claims will occur at least monthly or when the total amount of the claims to be submitted is at least $10.00.

Electronic Payment Card: The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

a. *You must make an election to use the card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Election Period. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program during the preceding Annual Election Period. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.
b. *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.
c. *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable Election Period that the amounts in your Health FSA will only be used for Eligible Medical Expenses (i.e., medical care expenses incurred by you, your spouse, and your Eligible Dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.
d. *Health FSA reimbursement under the card is limited to health care providers (including pharmacies).* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you will not be able to use the card at a regular retail store. (e.g., a supermarket, grocery store or discount store with a pharmacy) unless such store uses an Information Inventory Approval System as indicated below.
e. *You swipe the card at the health care provider like you do any other credit or debit card.* When you incur an Eligible Medical Expense at a doctor's office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider's office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Health FSA (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Health FSA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source not will you seek reimbursement from another source.
f. *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the health care provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

    - The nature of the expense (e.g., what type of service or treatment was provided. If the expense is for an over-the-counter drug,* the written statement must indicate the name of the drug);
    - The date the expense was incurred; and
    - The amount of the expense.

    You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party statement is required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the claims administrator that a third party statement is needed. You must provide the third party statement to the claims administrator within 45 days (or such longer period provided in the letter from the claims administrator) of the request.

g. *There are situations where the third party statement will not be required to be provided to the Claims Administrator.* There may be situations in which you will not be required to provide the written statement to the claims administrator. More detail as to which situations apply under your Plan is specified in the Cardholder Agreement.

- **Co-pay Match:** As specified in the Cardholder Agreement, no written statement is necessary if the Electronic Payment Card payment matches a specific co-payment you have under the component medical plan for the particular service that was provided or a multiple of such co-payment(s) (up to five times the co-payment amount). For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, you will not be required to provide the third party statement to the claims administrator.
- **Previously Approved Claim Match:** As specified in the Cardholder Agreement, no written statement is required if the expense is the same as the amount, duration and provider as a previously approved expense. For example, the claims administrator approves a 30 count prescription with three refills that was purchased at ABC Pharmacy. Each time the card is swiped for subsequent refills at ABC Pharmacy, the receipt need not be provided to the claims administrator if the expense incurred is the same amount.
- **Provider Match Program:** As specified in the Cardholder Agreement, no third party statement is required to be submitted to the claims administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g., your prescription benefits manager) that identifies the nature of your expense and verifies the amount.
- **Expenses Approved Through an Information Inventory Approval System (IIAS):** When you use the electronic Payment Card at a participating merchant that uses an IIAS, the system compares the items purchased with the Card against a pre-approved list of Eligible Medical Expenses. Unapproved expenses must be purchased via other means (e.g., cash or other credit card).

Note: You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the claims administrator does request it.

h. *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the claims administrator, you must repay the Plan for the unsubstantiated expense as set forth below. The deadline for repaying the Plan is set forth in the Cardholder Agreement. In addition, if you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under either HRA. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement). Lastly, the Employer may treat the un-reimbursed amount as a bad business debt, which could have income tax implications for you. Also, your usage of the card may be terminated by the Employer.

i. *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the Electronic Payment Card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

Q-11 What is an "Eligible Medical Expense"?

a. *General Rule*

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your Eligible Dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d).
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. **"Medical care" includes, but is not limited to, prescription drugs, insulin and physician-prescribed over-the-counter drugs (and over-the-counter products and devices). Over-the-counter drugs without a valid prescription by a physician are not reimbursable.** Not every health related expense you or your Eligible Dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care," as that term is defined by the Code, if it is merely for the beneficial health of you and/or your Eligible Dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury or birth defect. You may, in the discretion of the third party administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. "Stockpiling" of prescribed over-the-counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code is not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long-term care services;
- Expenses incurred for a medicine or a drug that is not prescribed by a physician, unless it is insulin. These are often referred to as over-the-counter medicines or drugs; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Summary.

b. *Limited Reimbursement Option*

You may be able to make a special election under this Health FSA to limit the scope of reimbursement that will enable you or your spouse to participate in a Health Savings Account (as defined in Code Section 223). If that option is available, it will be described in more detail in the Plan Information Summary.

Q-12 When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred ***during*** the Plan Year and while you are a Participant in the Plan. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses arising before the Health FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year, or after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

There are two exceptions to this rule:

- **Orthodontia:** The Plan may reimburse you for orthodontia services before the services are provided but only to the extent that you have actually made payments in advance of the orthodontia services in order to receive the services. These orthodontia services are deemed to be incurred when you make the advance payment.
- **Durable Medical Equipment:** The Plan may reimburse you for medical equipment with a useful life extending beyond the period of coverage. For example, the Plan may reimburse you for the total cost of a wheelchair even though it has a useful life beyond the Plan year in which it was purchased.

Q-13 What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Health Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual coverage level you have elected. Any amount allocated to a Health Care Account will be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement for expenses incurred during the Plan Year that are submitted for reimbursement within the run-out period described in the Plan Information Summary. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's discretion).

Q-14 What happens if a claim for benefits under the Health FSA is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

Q-15 What happens to unclaimed Health Care Reimbursements?

Any Health Care Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

Q-16 What is COBRA continuation coverage?

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to this Health FSA unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the employer is a "small employer" or the Health FSA is a church plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). These rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

<u>When Coverage May Be Continued</u>

Only Qualified Beneficiaries are eligible to elect continuation coverage if they lose coverage as a result of a qualifying event. A Qualified Beneficiary is the Employee, covered spouse and/or Eligible Dependent at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

	Covered Employee	Covered Spouse	Eligible Dependent
1. Covered Employee's termination of employment or reduction in hours of employment	X	X	X
2. Divorce or legal separation		X	
3. Child ceasing to be an Eligible Dependent			X
4. Death of the covered Employee		X	X

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health FSA upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your Spouse or your Eligible Dependents must notify the COBRA Administrator (if a COBRA Administrator is not identified in the Plan Information Summary, then contact the Plan Administrator) in writing of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the later of (1) date of the event (2) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the Qualified Beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any Eligible Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g., divorce decree).

An Employee or Spouse or Eligible Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health Plan.

Election Procedures and Deadlines

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the election form(s) and return it to the COBRA Administrator identified in the Plan Information Summary within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the first day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-elective Contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- If the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium or $50, you will be given 30 days to cure the shortfall);
- If you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- If you become entitled to Medicare; or
- If the employer no longer provides group health coverage to any of its employees.

Q-17 What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g., reimbursements were make for expenses incurred for the care of an individual who was not a Qualifying Individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways during the Plan Year that you received an excess payment: (1) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty (60) days of receipt of such notification. (2) The Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement or (3) Withhold such amounts from your pay (to the extent permitted under applicable Law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (1) – (3), or if for any reason the steps in (1)-(3) are not applied during the Plan Year that the excess reimbursement was made, the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

Q-18 Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the Employer's health privacy policies.

Q-19 How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Q-20 How does this Health FSA interact with a Health Reimbursement Arrangement (HRA) sponsored by the Employer?

Typically, a Health FSA is the payer of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in an HRA that covers expenses covered by this Health FSA, the employer may require the Health FSA pay first, rather that the HRA. If the Health FSA pays first, you must exhaust your Health Care Account before using funds allocated to your HRA. The Plan Information Summary will indicate whether the Health FSA or HRA must pay first.

Q-21 Is there a grace period or is there a carryover available for my Health FSA?

The grace period is a period of two months and 15 days after the end of the plan year during which the Plan will reimburse your eligible medical expenses incurred during the grace period from your unused balance. Any remaining balance after the grace period ends is forfeited.

MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

ERISA Rights (not applicable to non-ERISA Plans)

The Health FSA Plan may be an ERISA welfare benefit plan if your employer is a private employer. If this is an ERISA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contract, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents will have to pay for such coverage. You should review **Q-16** of this Health FSA Summary for more information concerning your COBRA continuation coverage rights.

(To the extent the Health FSA is subject to HIPAA's portability rules). You may be eligible for a reduction or elimination of exclusionary periods of coverage for a pre-existing condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. If you are eligible for this reduction or elimination, you will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan Participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the material were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEPENDENT CARE FSA COMPONENT SUMMARY

Q-1 Who can participate in the Plan?

Each employee who satisfies the Dependent Care FSA Eligibility Requirements is eligible to participate in the Dependent Care FSA on the Dependent Care FSA Eligibility Date. The Dependent Care FSA Eligibility Requirements and Eligibility Date are described in the Plan Information Summary.

Q-2 How do I become a Participant?

If you have otherwise satisfied the Dependent Care FSA'S Eligibility Requirements, you become a Participant in the Dependent Care FSA by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in **Q-6** of the Cafeteria Plan Summary. Your participation in the Dependent Care FSA will be effective on the date that you make the election or your Dependent Care FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Dependent Care FSA elections.

You may also become a Participant if you experience a change in status event or cost or coverage change that permits you to enroll midyear (see **Q-8** of the Cafeteria Plan Summary for more details regarding midyear election changes and the effective date of those changes).

Q-3 What is my "Dependent Care Account"?

If you elect to participate in the Dependent Care FSA, the Employer will establish a "Dependent Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care FSA are paid as needed from the Employer's general assets except as otherwise set forth in the Plan Information Summary.

Q-4 When does my coverage under the Dependent Care FSA end?

Your coverage under the Dependent Care FSA ends on the earlier of the following to occur:

a) The date that you elect not to participate in accordance with the Cafeteria Plan Summary;
b) The last day of the Plan Year unless you make an election during the Annual Election Period;
c) The date that you no longer satisfy the Dependent Care FSA Eligibility Requirements;
d) The date that you terminate employment; or
e) The date that the Plan is terminated or you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

If you terminate employment or you cease to be eligible during the Plan Year, you may submit for reimbursement Eligible Employment Related Expenses incurred after the date of separation up to the amount of your Dependent Care Account to the extent set forth in the Plan Information Summary.

Q-5 Can I ever change my Dependent Care FSA election?

You can change your election under the Dependent Care FSA in the following situations:

a. *For any reason during the Annual Election Period.* You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

b. *Following a Change in Status Event or Cost or Coverage Change.* You may change your Dependent Care FSA election during the Plan Year only if you experience an applicable Change in Status Event or there is a significant cost or coverage change. See **Q-8** of the Cafeteria Plan Summary for more information on election changes.

Q-6 What happens to my Dependent Care Account if I take an unpaid leave of absence?

Refer to the Cafeteria Plan Summary and the Election Change Chart to determine what, if any, specific changes you can make during a leave of absence.

Q-7 What is the maximum annual Dependent Care Reimbursement that I may elect under the Dependent Care FSA?

The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently $5,000 per Plan Year, if you:

a. Are married and file a joint return;
b. Are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return and you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or
c. Are single.

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax-free basis during the Plan Year cannot exceed the lesser of your earned income (as defined in Code Section 32) or your spouse's earned income.

Your Spouse will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your Spouse is:

a. Physically or mentally incapable of caring for himself or herself, or
b. A full-time student (as defined by Code Section 21).

Q-8 How do I pay for Dependent Care Reimbursements?

When you complete the Salary Reduction Agreement, you specify the amount of Dependent Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Non-elective Employer Contributions (or Benefit Credits), to the extent available. Your enrollment material will indicate if Non-elective Contributions or Benefit Credits are available for Dependent Care FSA Coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Non-elective Employer Contributions and/or Benefit Credits allocated to your Dependent Care Account.

Q-9 What is an "Eligible Employment Related Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses ("Eligible Employment Related Expenses"). Generally, an expense must meet all of the following conditions for it to be an Eligible Employment Related Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.
2. Each individual for whom you incur the expense is a "Qualifying Individual". A Qualifying Individual is:

    a. An individual age 12 or under who (1) has the same principal place of abode as you, (2) does not provide over half of his/her own support and (3) is your "child" (son, daughter, grandchildren, stepchildren, brother, sister, niece and nephew); <u>or</u>
    b. A Spouse or other tax dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

    Note: There is a special rule for children of divorced parents. The child is a Qualifying Individual of the "custodial parent," as defined in Code Section 152(e).

3. The expense is incurred for the <u>care</u> of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expense is not paid or payable to a "child" (as defined in Code Section 152(f) (1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a dependent.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 *"Your Federal Income Tax"* for further guidance as to what is or is not an Eligible Employment Related Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-10 **How do I receive reimbursement under the Dependent Care FSA?**

Under this Dependent Care FSA, you may have two reimbursement options. You can complete and submit a written claim for reimbursement ("traditional paper claim") or, alternatively, if offered with your Plan, you can use an electronic payment card to pay the expense. The following is a summary of how both options work.

Traditional Paper Claims: If you have elected to participate in the Dependent Care FSA, you will have to take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an Eligible Employment Related Expense, you submit a written or electronic claim to the Plan's Administrator. The written claim form will be supplied to you. If there are enough credits to your Dependent Care Account, you will be reimbursed for your Eligible Employment Related Expenses on the next scheduled processing date.

If your claim was for an amount that was more than your current Dependent Care Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available, annual credits to your Dependent Care Account. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Employment Related Expenses – only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

Reimbursement of Traditional Paper Claims will occur at least monthly or when the total amount of the claims to be submitted is at least $10.00.

If Your Employer Offers the Electronic Payment Card: The electronic payment card allows you to pay for Eligible Employment Related Expenses at the time that you incur the expense. Here is how the electronic payment card works.

a. *You must make an election to use the card.* If you wish to use an electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program (including limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.) both during the Initial Election Period and during each Annual Election Period. An electronic Payment Card Program Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Electronic Payment Card Program Agreement during the preceding Annual Election Period. The Electronic Payment Card Agreement is part of the terms and conditions of your Plan and this SPD.

b. *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan.

c. *You must certify proper use of the card.* As specified in the Electronic Payment Card Program Agreement, you certify during the applicable Election Period that the card will only be used for Eligible Employment Related Expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. **You also certify that you will not use the card for expenses in advance of the date the services giving rise to such expenses are provided.** Failure to abide by this certification will result in termination of card use privileges.

d. *The card may be limited to certain providers.* Use of the card may be limited to certain merchants who are dependent care providers. As set forth in the Electronic Payment Card Program Agreement, you will not be able to use the card at a regular retail store.

e. *You swipe the card at the day care provider like you do any credit or debit card.* When you incur an Eligible Employment Related Expense, you swipe the card much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available at that time you swipe the card. Every time you swipe the card, you agree to make the same certifications referenced in (c) above.

f. *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the day care provider (e.g., receipt, invoice, etc.) each time you swipe the card that includes the following information:

- The nature of the expense (e.g., what type of service or treatment was provided).
- The dates the services giving rise to the expense were provided.
- The amount of the expense.

Even though payment is made under the electronic payment card arrangement, a written third party statement is required to be submitted to substantiate the expense. If you do not submit a written third party statement, you will receive a letter from the claims administrator that a third party statement is needed. You must provide the third party statement to the claims administrator within 45 days of the request.

g. *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the claims administrator, you must repay the Plan for the unsubstantiated expense as set forth below. In addition, you usage of the card may be terminated by the Employer.

h. *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may submit claims under the traditional paper claims approach discussed above.

Q-11 **When must the expenses be incurred in order to receive reimbursement?**

Eligible Employment Related Expenses must be incurred ***during*** the Plan Year. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Salary Reduction Agreement or Election Form becomes effective, or for any expenses incurred after the close of the Plan Year and unless noted otherwise in the Plan Information Summary, after your participation in the Dependent Care FSA ends.

Q-12 **What if the eligible employment related expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Reimbursement?**

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred, on the one hand, and the annual Dependent Care Reimbursement you have elected and paid for, on the other. Any amount credited to a Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year by the end of the run-out period following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs or an otherwise permitted under applicable law.

Q-13 **Will I be taxed on the Dependent Care Reimbursement benefits I receive?**

You will not normally be taxed on your Dependent Care Reimbursement so long as your family's aggregated Dependent Care Reimbursement (under this Dependent Care FSA and/or another employer's dependent care FSA) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-14 **If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?**

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit.

Q-15 What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals), to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your gross income over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 – 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

Q-16 What happens to unclaimed Dependent Care Reimbursements?

Any Dependent Care Reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment Related Expense was incurred shall be forfeited.

Q-17 What happens if my claim for reimbursement under the Dependent Care FSA is denied?

You will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

Q-18 What happens if I received erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Dependent Care FSA that exceed the amount of Eligible Employment Related Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a Qualifying Individual), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways during the Plan Year that receive an excess payment: (1) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty (60) days of receipt of such notification, (2) The Plan Administrator may offset the excess reimbursement against any other eligible Employment Related Expenses submitted for reimbursement or (3) Withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursements by the means set forth in (1)–(3), or if for any reason the steps in (1)-(3) are not applied during the Plan Year that the excess reimbursement was made, the Plan administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse tax consequences to you.

Q-19 How long will the Dependent Care FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

Q-20 Is there a grace period available for my Dependent Care FSA?

Yes. **[IF GRACE PERIOD]** The grace period is a period of two months and 15 days after the end of the plan year during which the Plan will reimburse your Eligible Employment Related Expenses incurred during the grace period from your unused balance. Any remaining balance after the grace period ends is forfeited.

PLAN INFORMATION SUMMARY

This Appendix provides information specific to Brazosport Independent School District. The Effective Date of this Plan Information Summary is May 24, 2019. This Plan Information Summary replaces and supersedes any other Plan Information Summary with an earlier effective date.

EMPLOYER/PLAN SPONSOR/THIRD PARTY ADMINISTRATOR INFORMATION

Name, address and telephone number of the Employer/Plan Sponsor	**Brazosport Independent School District** **301 W Brazoswood Drive** **Clute, TX 77531** **979-730-7000**
Name, address and telephone number of the Plan Administrator: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies or omissions in the Plan and the SPD issued in connection with the Plan.	**Brazosport Independent School District** **301 W Brazoswood Drive** **Clute, TX 77531** **979-730-7000**
Employer's federal tax identification number:	**7460000885**
Plan number:	**501**
Effective Date of the Plan: This is the date that the Plan was first established.	**September 1, 2020**
Effective date of this SPD Note: This is the most recent date of the SPD other than the Plan Information Summary and the Appendices.	**May 24, 2019**
Plan year: **Short plan year:**	**September 1 through August 31**
Adopting Employers participating in the Plan:	**1.** **2.** **3.** **4.**
Third party administrator:	**Infinisource, Inc.**

II. CAFETERIA PLAN COMPONENT INFORMATION

(a) **Eligibility Requirements and Eligibility Date.** Each Employee who are employed and who is eligible for coverage or participation under any of the Benefit Plan Options (Cafeteria Plan eligibility requirements) will be eligible to participate in this Plan on the first day of the month following or coinciding with date of hire(Cafeteria Plan Eligibility Date).

The employee's commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in this SPD. Eligibility for coverage under any given Benefit Plan Option shall be determined not by this Plan but by the terms of that Benefit Plan Option.

(b) **Annual Election Rules.** With respect to Benefit Plan Option elections (other than the Health FSA and Dependent FSA elections), failure to make an election during the Annual Election Period will result in one of the following deemed elections(s):

{N/A} The employee will be deemed to have elected not to participate during the subsequent plan year. Coverage under the Benefit Plan Options offered under the Plan will end the last of the Plan Year made.

{N/A} The Employee will be deemed to have elected to continue his or her Benefit Plan Option elections in effect as of the end of the Plan Year in which the Annual Election Period took place. This is called an "Evergreen election."

(c) **Change of Election Period.** If you experience a Change in Status Event or Cost or Coverage Change as described in the Cafeteria Plan Summary and in the Election Change Chart, you may make the permitted election changes described in the Election Change Chart if you complete and submit an election change form within 30 days after the date of the event. If you are participating in an insured arrangement that provides a longer election change period, the election change period described in the insurance policy will apply.

(d) **Benefit Plan Options.** The Employer elects to offer to eligible Employees the following Benefit Plan Option(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Plan Options. These Benefit Plan Options(s) are specifically incorporated herein by reference. The maximum Pre-tax Contributions a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Plan Options selected reduced by any Non-elective Contributions made by the Employer. It is intended that such Pre-tax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute contributions for the state insurance law purposes.

The following Benefit Plan Options are made available under the Plan to all those eligible Employees who make an appropriate election.

1. Premium Conversion Plan
2. Health Care Flexible Spending Account
3. Dependent Care Assistance Program
4. Health Savings Account

Special Rule for Health Savings Accounts (if identified above as a benefit plan option):

The following describes your rights and obligations concerning contributions made under this Plan to your Health Savings Account (as defined in Code Section 223).

Q-1. What is a Health Savings Account for which contributions can be made under this Plan?

A Health Savings Account ("HSA") is a personal savings account established with a custodian or trustee to be used primarily for reimbursement of "eligible medical expenses" you (the Account Beneficiary) and your Eligible Dependents (as defined in Code Section 152) incur, as set forth in Code Section 223. The HSA is administered by the HSA custodian or trustee or its designee and the terms of the HSA are set forth in the custodial or trust agreement. The HSA is not an Employer sponsored employee benefit plan. The Employer's role with respect to the HSA if limited to making an HSA available to you and to making contributions to the HSA on your behalf through this Plan (through Non-elective Employer contributions and/or pre-tax salary reductions elected by the Account Beneficiary). The fact that contributions to the HSA are made through this Plan should not be construed as endorsement of the HSA by the Employer. The Employer has no authority or control over the funds deposited in the Account Beneficiary's HSA. As such, the HSA identified in the Plan Information Summary is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Q-2. Who is eligible for an HSA?

Only individuals who satisfy the following conditions are eligible for an HSA offered under this Plan:

(a) You are enrolled in a qualifying High Deductible Health Plan maintained by your Employer that is identified as a benefit plan option in the Plan Information Summary;
(b) You have opened an HSA with the custodian chosen by the Employer;
(c) You are not covered under any other non-high deductible health plan maintained by the Employer that is determined by the Employer to offer disqualifying health coverage. (Note that you are not eligible for an HSA if you are covered under any non-qualifying coverage whether maintained by the Employer or not [including but not limited to coverage maintained by your spouse's employer] and it is solely your responsibility to ensure that any other coverage you have that is not maintained by the Employer qualifies under Code Section 223) and
(d) You have certified that you are otherwise eligible to participate in the HSA (i.e., you: 1) cannot be claimed as a tax dependent; 2) are not enrolled in Medicare coverage; 3) have qualifying high deductible health plan coverage; and 4) have no disqualifying coverage from any other source); and
(e) You are otherwise eligible for this Plan.

Q-3. Who is an account beneficiary?

An account beneficiary is an eligible Participant who has properly enrolled in an HSA in accordance with the terms of the applicable custodial agreement.

Q-4. Who is a custodian or trustee?

The custodian or trustee is the entity with whom the account beneficiary's HSA is established (for purposes of this Plan, use of the term "custodian" includes a reference to both custodian and Trustee). The HSA is not sponsored by or maintained by the Employer. The custodian or its designee will provide each account beneficiary with a custodial agreement and other information that describes how to enroll in the HSA and your rights and obligations under the HSA. The Employer may choose to restrict contributions made through this Plan to HSA's maintained by a particular custodian; however, you will be permitted to rollover funds from the HSA offered under this Plan to another HSA of your choosing (in accordance with the terms of the custodial agreement).

Q-5. What are the rules regarding contributions made to an HSA under the Plan?

Contributions made under this Plan may consist of both employee Pre-tax Contributions made pursuant to a Salary Reduction Agreement and/or Non-elective Employer contributions (if any). You may elect to contribute an amount to the HSA that you wish, however, the maximum amount of all contributions that can be made to the HSA through this Plan (including both Employer Non-elective and Pre-tax salary reductions) during the Plan Year cannot exceed the maximum amount set for in Code Section 223(b)(2) (as adjusted for inflation).

If the account beneficiary is age 55 or older and properly certifies his age to the Employer, the maximum contribution amount described above may be increased by the "additional annual contribution" amount (as set forth in Code Section 223(b) (3)), but only to the extent set forth in the separate written HSA material provided by the Employer and/or the custodian.

To the extent set forth in the Plan's enrollment material or the HSA communication material, the Employer may automatically withhold Pre-tax Contributions from your compensation to contribute to an HSA unless you affirmatively indicate that you do not wish to contribute to the HSA with Pre-tax Contributions. Pre-tax Contributions will equal the maximum annual contribution amount set forth above (reduced by any Employer Non-elective Contributions) divided by the number of pay periods remaining during the Plan Year. Non-elective Employer Contributions may be made at any time during the Plan Year in a lump sum amount or through periodic contributions (as determined in the sole discretion of the Employer) and communicated in Plan or HSA enrollment materials.

Your HSA election under this Plan will not be effective until the later of the date that you make your election or the date that you establish your HSA. The Employer may adjust contributions made under this Plan as necessary to ensure the maximum contribution amount is not exceeded.

Any Pre-tax Contributions that cannot be made to the HSA because you have been determined to be ineligible for such contribution will be returned to you as taxable compensation or as otherwise set forth in the Plan enrollment material. Any Non-elective Contributions that cannot be made to the HSA because the employee is not eligible for such contribution will be returned to the Employer except as otherwise set forth in the applicable communication material.

The Employer may advance contributions to you up to your annual HSA pre-tax salary reduction election made through the Plan (reduced by any prior pre-tax contributions made by you during the Plan Year) or such other amount established by the Employer, whichever is less. Advance contributions will be made available to all Participants on non-discriminatory terms and conditions; the Employer may condition the advance of such contributions on the occurrence of certain events identified by the Employer in separate written material relating to the Plan. Moreover, you will be required to repay the Employer for advances made through this Plan through means established by the Employer.

In the event excess contributions are made to the Participant's HSA (i.e., the HSA has received contributions in excess of the Maximum Annual Contribution Amount), it will be the sole responsibility of the Participant to work with the custodian to remove the excess contribution (plus earnings on such contributions) prior to the due date of the Participant's tax return for that tax year and to report the contributions (and earnings) as income when filing taxes at the end of the year.

Q-6. What are the election change rules under this Plan for HSA elections?

You may change your HSA contribution election at least once per month during the plan year for any reason by submitting an election change form to the Plan Administrator (or its designee). Your election change will be prospectively effective as of the first day of the next pay period following the day that you properly submit your election change (or such later date as uniformly applied by the Plan Administrator to accommodate payroll changes). Your ability to make Pre-tax Contributions under this Plan to the HSA ends on the date that you cease to meet the eligibility requirements under this Plan.

Q-7. Where can I get more information on my HSA and its related tax consequences?

For details concerning your rights and responsibilities with respect to your HSA (including information concerning the terms of eligibility, qualifying High Deductible Health Plan, contributions to the HSA and distributions from the HSA), please refer to your HSA custodial agreement and/or the HSA communication material provided by your Employer.

Special rule for vacation buy/sell benefits (if offered under the Plan).

Employees may elect to buy up to 0 vacation days in addition to the vacation days provided by the employer. In addition, employees may elect to sell up to 0 accrued vacation days in exchange for taxable compensation (such compensation will be prorated by the number of paychecks in the Plan Year and such amount will be included in each paycheck). All elections to purchase or sell vacation days must be made in accordance with the Plan's election procedures. If you buy vacation days or choose not to sell vacation days in accordance with the Employer's policies, then you must use the days you purchased or could have sold by the date established by the Employer (but in no event after the end of the Plan Year) or you will lose them. You will receive the value of unused elective vacation days in your paycheck at the end of the year. In determining whether you have unused elective vacation days, all non-elective vacation days provided by the Employer will be deemed to be used first. You will not receive cash for any unused non-elective vacation days except as otherwise provided pursuant to the Employer's internal policies and procedures.

III. HEALTH FSA COMPONENT INFORMATION

(a) **Health FSA eligibility Requirements and Eligibility Date.** Each Employee who are employed is eligible to participate in the Health FSA on the first day of the month following or coinciding with date of hire.

(b) **Annual Health Care Reimbursement Amounts.** The maximum annual reimbursement amount each year may not exceed the lesser of the Health FSA reimbursement amount elected for that year or $2,700.00. The minimum reimbursement amount that may be elected under the Health FSA is $0.00. Notwithstanding the previous sentences, for plan years starting on or after January 1, 2013, the annual salary reduction contribution limit for the Health FSA shall be subject to Code §125(i), including an annual cost-of-living adjustment as published by the IRS for later plan years.

(c) **Run-out Period.** The run-out period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.

1. The run-out period for active employees ends 90 days after plan year ends.
2. The run-out period for terminated employees ends 30 days after termination date.

(d) **COBRA Administrator.** The COBRA administrator for the Health FSA is **Infinisource.**

(e) **Interaction with HRA.** See below regarding this Health FSA's rules with respect to coordination with an HRA:

Does the Employer sponsor an HRA?	No
Does this Health FSA or the HRA pay first with respect to any expenses that are covered by both the HRA and Health FSA?	

(f) **Method of Funding.** Health FSA benefits are paid from general assets.

(g) **Limited Reimbursement Option.**

Does the Employer offer a limited reimbursement option under the Health FSA?	Yes **If "Yes", the following rules apply.**

According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA Participant will not be able to make/receive tax favored contributions to a Code Section 223 Health Savings Account unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the following expenses (as determined in the sole discretion of the Plan Administrator):

a. Services or treatments for dental care (excluding premiums).
b. Services or treatments for vision care (excluding premiums).

c. Services or treatments for "preventive care." Preventive care is defined in accordance with applicable rules and regulation. This may include any prescription or over-the-counter drugs to the extent such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic), (2) to prevent the recurrence of a condition from which the eligible individual has recovered or (3) as part of a preventive care treatment program (e.g., a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.

A Health FSA Participant may make an election during the annual enrollment period and/or the initial enrollment period to limit reimbursement under this Health FSA to medical expenses described above. The election that you make in accordance with this paragraph during the annual enrollment period will be effective as of the first day of the following plan year. The election that you make during the initial enrollment period will be effective the same date that any other election made during the initial enrollment period would be effective.

(h) **Self-only Election.**

Does the Employer offer a self-only election under the Health FSA?	No **If "Yes," the following rule applies.**

Your participation in this Health FSA could disqualify your spouse from establishing a Health Savings Account as defined in Code Section 223 or from making/receiving tax favored contributions to the Health Savings Account (unless you have elected the limited reimbursement option set forth above). If a spouse maintains a Code Section 223 Health Savings Account or wishes to establish a code Section 223 Health Savings Account, the Health FSA Participant may make an election during the initial enrollment period and/or the annual enrollment period to exclude all family members from coverage and cover only the Participant. The election that you make in accordance with this paragraph during the annual enrollment period will be effective as of the first day of the following plan year. The election that you make during the initial enrollment period will be effective the same date that any other election made during the initial enrollment period would be effective.

IV. DEPENDENT CARE FSA COMPONENT INFORMATION

(a) **Dependent Care FSA Eligibility Requirements and Eligibility Dates.**

Each Employee who are employed is eligible to participate in the Dependent Care FSA on the first day of the month following or coinciding with date of hire.

(b) **Run-out Period.**

The run-out period is the period during which expenses incurred during a Plan Year must be submitted to be eligible for reimbursement.

1. The run-out period for active employees ends after plan year ends 90 days.
2. The run-out period for terminated employees ends 30 days after termination date.

(c) **Expense Incurred After Termination of Employment.**

You may not be reimbursed for Eligible Employment Related Expenses incurred after you terminate employment up to the amount in your account balance, subject to the reimbursement rules set forth in the SPD.

(d) **Method of Funding.**

Dependent Care FSA Benefits are paid from general assets.

APPENDIX I - CLAIMS REVIEW PROCEDURE CHART

The effective date of this Appendix I is May 24, 2019. It should replace and supersede any other Appendix I with an earlier date.

The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan. The Procedure set forth below does not apply to benefit claims filed under the Benefit Plan Options other than the Health FSA and Dependent Care FSA.

Step 1. *Notice is received from third party administrator.*

If your claim is denied, you will receive written notice from the third party administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the third party administrator, the third party administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the third party administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2. *Review your notice carefully.*

Once you have received your notice from the third party administrator, review it carefully. The notice will contain:

a. The reason(s) for the denial and the Plan provisions on which the denial is based;
b. A description of any additional information necessary for you to perfect your claim, why the information is necessary and your time limit for submitting the information;
c. A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d. A right to request all documentation relevant to your claim.

Step 3. *If you disagree with the decision, file an appeal.*

If you do not agree with the decision of the third party administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4. *Notice of denial is received from third party administrator.*

If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the third party administrator.

Step 5. *Review your notice carefully.*

You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third party administrator.

Step 6. *If you still disagree with the third party administrator's decision, file a second level appeal with the Plan Administrator.*

If you still do not agree with the third party administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the third party administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your second level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- (Health FSA only) Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.

APPENDIX II - TAX ADVANTAGES EXAMPLE

The effective date of this Appendix II is May 24, 2019. It should replace and supersede any other Appendix II with an earlier date.

As indicated in the SPD, participating in the Plan can actually increase your take-home pay. Consider the following example:

You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $2,400 in premiums ($400 for your share of the employee-only premium, plus $2,000 for family coverage under the Employer's major medical insurance plan). You earn $50,000 and your spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Cafeteria Plan.	If you do not participate in the Cafeteria Plan.
1. Gross income	$50,000	$50,000
2. Salary reductions for premiums	$2,400 (pre-tax)	$0
3. Adjusted gross income	$47,600	$50,000
4. Standard deduction	($9,700)	($9,700)
5. Exemptions	($9,300)	($9,300)
6. Taxable income	$28,600	$31,000
7. Federal income tax (Line 6 x applicable tax schedule)	($3,590)	($3,590)
8. FICA tax (7.65% x Line 3 amount	($3,641)	($3,825)
9. After tax contributions	($0)	($2,400)
10. Pay after taxes and contributions	$40,365	$39,981
11. Take-home pay difference	$544	

APPENDIX III - ELECTION CHANGE CHART

The effective date of this Appendix III is May 24, 2019. It should replace and supersede any other Appendix III with an earlier date.

The following is a summary of the election changes that are permitted under this Plan. Also, election changes that are permitted under this Plan may not be permitted under the Benefit Plan Option (e.g., the insurance carrier may not allow a change). If a change is not permitted under a Benefit Plan Option, no election change is permitted under the Plan. Likewise, a Benefit Plan Option may allow an election change that is not permitted by this Plan. In that case, your pre-tax reduction may not be changed even though a coverage change is permitted. For a description of the election change rules for Health Savings Accounts (if made available through the Plan), see the Health Savings Account Contribution Appendix.

First, we describe the general rules regarding election changes that are established by the IRS. Then, you should look to the chart to determine under what circumstances you are permitted to make an election change under this Plan and the scope of the changes you may make.

1. **Change in Status.**

Election changes may be allowed if a Participant or a Participant's Spouse or Eligible Dependent experiences one of the Change in Status Events set forth in the chart. The election change must be on account of and correspond with the Change in Status Event as determined by the Plan Administrator (or its designated third party administrator). With the exception of enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective (generally the first of the month following the date you make a new election with the third party administrator, but it may be earlier depending on the Employer's internal policies or procedures). A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Eligible Dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements:

Loss of Dependent Eligibility. For accident and health benefits (e.g., health, dental and vision coverage), the election change must be consistent with the Change in Status. This applies to a Change in Status involving a divorce, annulment or legal separation, the death of a Spouse or Eligible Dependent or an Eligible Dependent ceasing to satisfy the eligibility requirements for coverage. However, there are instances in which you may be able to <u>increase</u> your Pre-tax Contributions to pay for COBRA coverage of an Eligible Dependent. Contact the third party administrator for more information.

Example: Employee Mike is married to Sharon, and they have one child. Mike elects family coverage for himself, his wife Sharon and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility while the child is still eligible for coverage under the plan. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon and change to employee-plus-one dependent is consistent with this Change in Status.

Gain of Coverage Eligibility under another Employer's Plan. For a Change in Status in which a Participant, Spouse or Eligible Dependent gain eligibility for coverage under another employer's cafeteria plan or benefit plan as a result of a change in marital status or a change in employment status, an election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

Dependent Care Reimbursement Plan Benefits. With respect to the Dependent Care FSA benefit, an election change is permitted only if (1) such change or termination is made on account and corresponds with a Change in Status that affects eligibility for coverage under the Plan: or (2) the election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent Care FSA expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12-year old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year the daughter turns 13-years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

Group Term Life Insurance, Disability Income or Accidental Death and Dismemberment Benefits (if offered under the Plan. See the list of Benefit Plan Options offered under the Plan). For group term life insurance, disability income and accidental death and dismemberment benefits only if a Participant experiences a Change in Status (as described above), an election to either increase or decrease coverage is permitted.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group term life insurance coverage (and other benefits) through salary reduction. Before the plan year, Mike elects $10,000 of group term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.**

If a Participant, Participant's Spouse and/or Eligible Dependent are entitled to special enrollment rights under a Benefit Plan Option that is a group health plan, an election change to correspond with the special enrollment right is permitted. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan summary description for an explanation of special enrollment rights.

Example: Employee Mike is married to Sharon. He declines enrollment in medical coverage for himself, Sharon and one child because of outside medical coverage. They then lose coverage due to certain reasons (e.g., legal separation, divorce, death, termination of employment, reduction in hours or exhaustion of COBRA period). Mike may now elect medical coverage under the Plan for himself, Sharon and the child. Furthermore, Mike gains a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, he may also be able to enroll himself, his Spouse and the newly acquired Dependent, provided that a request for enrollment is made within the Election Change Period.

3. **Certain Judgments, Decrees and Orders.**

If a judgment, decree or order from a divorce, separation, annulment or custody change requires a Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, an election change to provide coverage for the Dependent child identified in the order is permissible. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.**

If a Participant or the Participant's Eligible Dependents become entitled to Medicare or Medicaid, an election to cancel that person's accident or health coverage is permitted. Similarly, if a Participant or Participant's Eligible Dependents who have been entitled to Medicare or Medicaid loses eligibility for such, you may elect to begin or increase that person's accident or health coverage.

5. **Change in Cost.**

If the cost of a Benefit Plan Option significantly increases, a Participant may choose to make an increase in contributions, revoke the election and receive coverage under another Benefit Plan Option that provides similar coverage, or drop coverage altogether *if no similar coverage exists.* If the cost of a Benefit Plan Option significantly decreases, a Participant who elected to participate in another Benefit Plan Option may revoke the election and elect to receive coverage provided under the Benefit Plan Option that decreased in cost. In addition, otherwise eligible employees who elected not to participate in the Plan may elect to participate in the Benefit Plan Option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plan Option options, however, Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above Change in Cost exceptions are applicable to a Health FSA, to the extent offered under the Plan).

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under another health plan option.

6. **Change in Coverage.**

If coverage under a Benefit Plan Option is significantly curtailed, a Participant may elect to revoke an election and elect coverage under another Benefit Plan Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, a Participant may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, a Participant may revoke his election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, a Participant may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the employer or another employer), so long as (a) the other employer plan permits its Participants to make an election change permitted under the IRS regulations;: or (b) the Plan Year for

this Plan is different from the plan year of the other employer plan. Finally a Participant may change his election to add coverage under this Plan for the Participant, the Participant's Spouse or Eligible Dependents if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above Change in Coverage exceptions are applicable to the Health FSA, to the extent offered under the Plan.)

The following is a summary reflecting the election changes that may be made under the Plan with respect to each Benefit Plan Option. In addition, election changes that are permitted under this Plan are subject to any limitations imposed by the Benefit Plan Options. If an election change is permitted by this Plan but not by the Benefit Plan Option, no election change under this Plan is permitted.

ELECTION CHANGE SUMMARY

I. Change in Status

A. Change in Legal Marital Status

i. Gain of Spouse (e.g., marriage)

1. **Major Medical*:*** Employee may enroll or increase election for newly eligible Spouse and Eligible Dependents. Under "tag-along" rule, new and preexisting Eligible Dependents may be enrolled. Coverage option (e.g., HMO to PPO) change may be made. Employee may revoke or decrease Employee's or Eligible Dependent's coverage only when such coverage becomes effective or is increased under the Spouse's plan.
2. **Dental and Vision*:*** Same as Major Medical.
3. **Health FSA*:*** Employee may enroll or increase election for newly eligible Spouse or Eligible Dependents.
4. **Dependent Care FSA*:*** Employee may enroll or increase to accommodate newly eligible Qualifying Individuals or decrease or cease coverage if new Spouse is not employed or makes a Dependent Care FSA coverage election under Spouse's plan.
5. **Employee Group Life, AD &D and Disability Coverage*:*** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. Loss of Spouse (e.g., divorce, legal separation, annulment or spouse's death)

1. **Major Medical:** Employee may revoke election only for spouse. Coverage option (e.g., HMO to PPO) change may be made. Employee may elect coverage for self or Eligible Dependents that lose eligibility under spouse's plan. Under "tag-along" rule, any Eligible Dependents may be enrolled so long as at least one Eligible Dependent has lost coverage under spouse's plan.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Employee may decrease election to exclude former spouse. Employee may enroll or increase election if coverage is lost under spouse's health plan.
4. **Dependent Care FSA:** Employee may enroll or increase to accommodate newly eligible Qualifying Individuals (e.g., due to death of spouse) or decrease or cease coverage if eligibility is lost (e.g., because Qualifying Individuals now reside with ex-spouse).
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

B. Change in Number of Dependents

i. Gain of Dependent (e.g., birth or adoption)

1. **Major Medical: E**mployee may enroll or increase coverage for newly Eligible Dependent (and other Eligible Dependents not previously covered under "tag-along" rule). Coverage option (e.g., HMO to PPO) change may be made. Employee may revoke or decrease Employee's or Eligible Dependents coverage if employee becomes eligible under spouse's plan.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA*:*** Same as Major Medical.

4. **Dependent Care FSA:** Employee may enroll or increase coverage to accommodate newly eligible Qualifying Individuals (and any other Qualifying Individuals that were not previously covered under "tag-along" rule).
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. **Loss of Dependent (e.g., death)**

1. **Major Medical:** Employee may drop coverage only for the Eligible Dependent that loses eligibility. Coverage option (e.g., HMO to PPO) change may be made.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Employee may decrease or cease election.
4. **Dependent Care FSA:** Employee may decrease or cease election.
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

C. **Change in Employment Status that Affects Eligibility**

i. **Commencement of Employment/Change in Employment Status that Triggers Eligibility**

1. **For Employee:**
   a. **Major Medical:** Employee may add coverage for Employee, Spouse or Eligible Dependents. Coverage option (e.g., HMO to PPO) change may be made.
   b. **Dental and Vision:** Same as Major Medical.
   c. **Health FSA:** Same as Major Medical.
   d. **Dependent Care FSA:** Same as Major Medical
   e. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

2. **For Spouse or Other Dependent:**
   a. **Major Medical:** Employee may revoke or decrease election when a corresponding election is made to Spouse's or Eligible Dependent's coverage. Coverage option (e.g., HMO to PPO) change may be made.
   b. **Dental and vision:** Same as Major Medical.
   c. **Health FSA:** Employee may decrease or cease election if he gains coverage under Spouse's or Dependent's plan.
   d. **Dependent Care FSA:** Employee may make or increase election to reflect new eligibility (e.g., if spouse previously did not work). Employee may revoke election as to Qualifying Individual's coverage if Qualifying Individual is added to Spouse's Dependent Care FSA.
   e. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. **Employment Termination/Change in Employment Status That Causes Loss of Eligibility (e.g., full-time to part-time status, salaried to hourly pay basis).**

1. **For Employee:**
   a. **Major Medical:** Employee may revoke or decrease election for Employee, Spouse or Eligible Dependents that lose eligibility. In addition, other

previously eligible, Eligible Dependents may also be enrolled under "tag-along" rule. Coverage option (e.g., HMO to PPO) change may be made.

b. **Dental and Vision:** Same as Major Medical.
c. **Health FSA:** Employee may revoke election.
d. **Dependent Care FSA:** Employee may revoke or decrease election to reflect loss of eligibility.
e. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

2. **For Spouse or Other Dependent:**
   a. **Major Medical:** Employee may enroll or increase election for Employee, Spouse or Eligible Dependents who lose eligibility under Spouse's or Dependent's employer's plan. In addition, other previously eligible Dependents may also be enrolled under "tag-along" rule. Coverage option (e.g., HMO to PPO) change may be made.
   b. **Dental and Vision:** Same as Major Medical.
   c. **Health FSA:** Employee may enroll or increase election if Spouse or Eligible Dependent loses eligibility for health coverage.
   d. **Dependent Care FSA:** Employee may enroll or increase election if Spouse or Qualifying Individual loses eligibility under other employer's Dependent Care FSA. Employee may decrease or cease election if Spouse's loss of employment renders Qualifying Individuals ineligible.
   e. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

3. **Termination and Rehire of Employee:**
   Generally, if rehire occurs within 30 days, prior elections that were in effect at termination are reinstated unless another event has occurred that allows a change. Alternatively, employer may prohibit participation until the next plan year. If rehire occurs after 30 days, employee may make new elections.

D. **Change in Employment Status that Does Not Affect Eligibility**
   i. An employee who was expected to average 30 hours of service or more per week in a month experiences an employment status change (such as change from full-time to part-time) such that the employee is no longer expected to average 30 hours or more per week each month
      1. **Major Medical**: Employee may prospectively revoke election provided that (i) the employee makes his or her requested election change within the Plan's election change period and (ii) the employee certifies his or her intent to enroll the employee and any other dependents whose coverage is revoked in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
      2. **Dental and Vision**: No change allowed.
      3. **Health FSA**: No change allowed.
      4. **Dependent Care FSA**: No change allowed.

5. **Employee Group Life, AD&D and Disability Coverage**: No change allowed.

E. Marketplace Eligibility

i. Employee is eligible to enroll in a Qualified Health Plan offered in the Marketplace during the Marketplace's special or annual enrollment period.

1. **Major Medical**: Employee may prospectively revoke election provided that (i) employee makes his or her change within the Plan's election change period and (ii) the employee certifies his or her intent to enroll the employee and any other dependents whose coverage is revoked in new coverage under a Qualified Health Plan that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
2. **Dental and Vision**: No change allowed.
3. **Health FSA**: No change allowed.
4. **Dependent Care FSA**: No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage**: No change allowed.

F. Change of Dependent Status

i. Newly Eligible Dependent

1. **Major Medical:** Employee may enroll or increase election for affected Eligible Dependent. In addition, other previously Eligible Dependents may also be enrolled under "tag-along" rule. Coverage option (e.g., HMO to PPO) change may be made.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Employee may increase election or enroll only if Dependent gains eligibility under Health FSA.
4. **Dependent Care FSA:** Employee may increase election or enroll to take into account expenses of affected Qualifying Individual.
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. Newly Ineligible Dependent

1. **Major Medical:** Employee may decrease or revoke election only for affected Eligible Dependent. Cover option (e.g., HMO to PPO) change may be made.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Employee may decrease or revoke election to take into account ineligibility of expenses of affected Eligible Dependent, but only if eligibility is lost.
4. **Dependent Care FSA:** Employee may decrease or revoke election to take into account ineligibility of expenses of affected Qualifying Individual.
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

G. Change in Residence

i. Move Triggers Eligibility

1. **Major Medical:** Employee may enroll or increase election for newly Eligible Dependent. Also, other previously eligible Dependents may be enrolled under "tag-along" rule. Cover option (e.g., HMO to PPO) change may be made.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

ii. Move Causes Loss of Eligibility

1. **Major Medical:** Employee may revoke election or make new election if the change in residence affects eligibility.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage***:* Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

II. Insignificant Cost Changes With Automatic Increase/Decrease in Elective Contributions (Initiated by Employer or Employee)

Note: The Plan has final authority to determine when a cost change is significant or insignificant based on a reasonable assessment of the facts and circumstances.

1. **Major Medical:** Plan may automatically increase or decrease (on a reasonable and consistent basis) affected Employees' elective contributions under the Plan.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage.** Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

III. Significant Cost Changes

Note: The Plan has final authority to determine when a cost change is significant or insignificant bases on a reasonable assessment of the facts and circumstances.

i. Significant Cost Increase

1. **Major Medical:** Employee may increase election or revoke election and elect coverage under another benefit option providing similar coverage. If no other option providing similar coverage is available, Employee may revoke election.
2. **Dental and Vision:** Same as Major Medical
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical. A significant cost increase may include any cost change imposed by: (a) a dependent care provider who is not a relative of the employee, (b) a change in dependent care provider, or (c) a change in the hours of care of the dependent care provider.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

ii. Significant Cost Decrease

1. **Major Medical:** Employee may decrease election or elect coverage with decreased cost while revoking election for similar coverage option. In the latter case, the "tag-along" rule applies.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical. A significant cost decrease may include any cost change imposed by: (a) a dependent care provider who is not a relative of the employee, (b) a change in dependent care provider, or (c) a change in the hours of care of the dependent care provider.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

IV. Significant Coverage Curtailment (e.g., significant increase in deductibles, co-payments or out–of-pocket maximums)

Note: The Plan has final authority to determine when coverage curtailment is significant or insignificant based on a reasonable assessment of the facts and circumstances.

i. Without Loss of Coverage

1. **Major Medical:** Employee may revoke election and make new prospective election for coverage under another benefit option providing similar coverage.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Election change may be made if provider or dependent care hours change.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

ii. With Loss of Coverage

1. **Major Medical:** Employee may revoke election and make new prospective election for coverage under another benefit option providing similar coverage. Alternatively, employee may revoke election for similar coverage option.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Election change may be made if the dependent care provider or dependent care hours change.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

V. Addition or significant Improvement of Benefit Option

1. **Major Medical:** Eligible Employee (whether currently participating or not) may revoke their existing election and elect the newly added or improved option. The "tag-along" rule applies.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

VI. Change in Coverage Under Other Employer's Plan (including Open Enrollment)

i. Other Employer's Plan Increases Coverage

1. **Major Medical:** For an election of or increase in the other employer's coverage, employee may decrease coverage or revoke election in Employer's Plan. For a revoked election of or decrease in the other employer's coverage, employee may increase coverage or make an election in Employer's Plan. During Open Enrollment under other Employer's plan, employee can make corresponding changes to Employer's Plan.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

VII. Loss of Group Health Coverage Sponsored by Governmental or Educational Institution

1. **Major Medical:** Employee may enroll or increase election for Employee, Spouse or Eligible Dependent that loses coverage sponsored by a governmental or educational institution. The "tag-along" rule applies.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

VIII. FMLA Leave

Note: Employees who continue coverage under FMLA may-at Employer's sole discretion-pay for coverage according to one of the following methods:

- *Prepay on a pre-tax basis (so long as the leave does not cover two plan years).*
- *Pay on an ongoing basis, as determined by Employer's FMLA policy (pre-tax if receiving salary continuation).*
- *Catch up upon returning from leave.*

i. Commencement of Leave

1. **Major Medical:** Employee can make same elections as Employee on Non-FMLA leave. In addition, Employer must allow an Employee on unpaid FMLA leave either to revoke coverage or to continue coverage but allow Employee to discontinue payment of his share of the contribution during the leave (the Employer may recover the Employee's share of contributions when the Employee returns to work). FMLA also allows an Employer to require that Employees on paid FMLA leave continue coverage if Employees on Non-FMLA paid leave are required to continue coverage.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Same as Major Medical.
4. **Dependent Care FSA:** Employee may revoke election and make another election as provided under FMLA.
5. **Employee Group Life, AD&D and Disability Coverage:** Same as Major Medical.

ii. Return from Leave

1. **Major Medical:** Employee may make a new election if coverage terminated while on FMLA leave. In addition, an Employer may require an Employee to be reinstated in his or her election upon return from leave if employees who return from a Non-FMLA paid leave are required to be reinstated in their elections.
2. **Dental and Vision:** S ame as Major Medical.

3. **Health FSA:** Same as Major Medical. Upon return, an employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make up unpaid premiums) or at a level reduced prorate for the missed contributions.
4. **Dependent Care FSA:** Same as Major Medical.
5. **Employee Group Life, AD&D and Disability Coverage*:*** Same as Major Medical.

IX. HIPAA Special Enrollment Rights

i. Loss of Other Health Coverage

1. **Major Medical*:*** Employee may elect coverage for Employee, Spouse or Eligible Dependent that has lost other coverage.
2. **Dental and Vision:** No change allowed.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

ii. Acquisition of New Dependent by Birth, Marriage, Adoption or Placement for Adoption (newly born/adopted dependents have coverage retroactive to birth/adoption date)

1. **Major Medical:** Employee may elect coverage for Employee, Spouse or Eligible Dependent.
2. **Dental and Vision:** No change allowed.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

iii. Termination of Medicaid or CHIP Coverage.

Effective April, 1, 2009, if the employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health insurance plan (CHIP) under Title XXI of such Act and such coverage is terminated as a result of loss of eligibility, the employee must make a written request to the Plan Administrator no later than 60 days after coverage is terminated.

1. **Major Medical:** Employee may elect coverage for Employee, Spouse or Dependent.
2. **Dental and Vision:** No change allowed.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

iv. Eligibility for Employment Assistance under Medicaid or CHIP.

If the employee or Eligible Dependent becomes eligible for Medicaid or CHIP assistance with respect to coverage under the Major Medical Plan (including any waiver or demonstration project under Medicaid or CHIP), the employee must make a written request to the Plan Administrator no later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

1. **Major Medical:** Employee may elect coverage for Employee, Spouse or Eligible Dependent.
2. **Dental and Vision:** No change allowed.
3. **Health FSA:** No change allowed.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

X. COBRA and State Continuation Coverage Qualifying Events

1. **Major Medical:** Employee may increase pre-tax contributions under Employer's plan for coverage if the qualifying event occurs with respect to the Employee, Spouse or Eligible Dependents.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Same as Major Medical.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

XI. Judgment, Decree or Order

i. Order Requiring Employee to Cover Child (e.g., QMCSO)

1. **Major Medical:** Employee may change election to provide coverage for the child.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Same as Major Medical.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

ii. Order Requiring Spouse, Former Spouse or Other Individual to Cover Child

1. **Major Medical:** Employee may change election to terminate coverage for child.
2. **Dental and Vision:** Same as Major Medical.
3. **Health FSA:** Same as Major Medical.
4. **Dependent Care FSA:** No change allowed.
5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

Medicare or Medicaid

i. **Medicare or Medicaid Entitlement (i.e., enrollment) Other Than Coverage Solely for Pediatric Vaccines.**
   1. **Major Medical:** Employee may revoke an election or decrease coverage for Employee, Spouse or Eligible Dependent, as applicable.
   2. **Dental and Vision:** No change allowed.
   3. **Health FSA:** No change allowed.
   4. **Dependent Care FSA:** No change allowed.
   5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

ii. **Loss of eligibility for Medicare or Medicaid Other Than Coverage Solely for Pediatric Vaccines.**
   1. **Major Medical:** Employee may commence or increase coverage for Employee, Spouse or Eligible Dependent, as applicable.
   2. **Dental and Vision:** No change allowed.
   3. **Health FSA:** No change allowed.
   4. **Dependent Care FSA:** No change allowed.
   5. **Employee Group Life, AD&D and Disability Coverage:** No change allowed.

HEALTH FLEXIBLE SPENDING ACCOUNT
APPENDIX A TO THE FLEXIBLE BENEFIT PLAN

The effective date of this document is

May 24, 2019

PREAMBLE

Effective as of the effective date set forth below, the Brazosport Independent School District established this Health Flexible Spending Account (the Health FSA) to help provide full and complete medical care for those Employees who participate in the Employer's Cafeteria Plan ("Plan") and who, pursuant to the election procedures set forth in the Plan, choose to contribute to a Health Care Reimbursement Account established pursuant to this Health FSA Plan. This Health FSA is intended to provide reimbursement of certain Eligible Medical Expenses incurred by the Participant and his eligible Dependents. The Employer intends that the Health FSA qualify as a Code Section 105 self-insured medical reimbursement plan and that the benefits provided under the Health FSA be eligible for exclusion from the Participant's income for federal income tax purposes under Section 105 (b) of the Code. This Health FSA is a component of and incorporated by reference into, the Cafeteria Plan and Articles VI, VII, VIII and IX of the Cafeteria Plan document apply also to this Health FSA.

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ARTICLE IA - DEFINITIONS

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

1.01A "Dependent" means any individual who is described in Code Section 105(b). This includes any tax dependent of the Participant and any adult child who has not yet attained the age of 27 by the end of the current calendar year.

1.02A "Effective Date" of this Health FSA means **September 1, 2020.**

1.03A "Eligible Medical Expenses" means those expenses that are eligible for reimbursement under this Health FSA as set forth in the SPD.

1.04A "Health Care Reimbursement" shall have the meaning assigned to it by Section 4.01A of this Health FSA.

1.05A "Highly Compensated Individual" means an individual defined under Code Section 105(h), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.06A "Reimbursement Account" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Reimbursement (as defined in Section 1.04A herein). No money shall actually be allocated to any individual Participant account(s); any such account(s) shall be of a memorandum nature, maintained by the administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant account(s).

ARTICLE IIA - ELIGIBILITY AND PARTICIPATION

2.01A Eligibility to Participate. Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Health FSA as of the Health FSA eligibility date set forth in the SPD.

2.02A Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD.

2.03A Qualifying Leave Under Family Medical Leave Act. Notwithstanding any provision to the contrary in this Health FSA, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's coverage under this Health FSA on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.04A Non-FMLA Leave. If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Health FSA, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD and implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Health FSA, the election change rules in Section 3.03A of this Health FSA will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the participant during the leave.

ARTICLE IIIA - ELECTION TO PARTICIPATE

3.01A Initial Election Period

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Health FSA as of the effective date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the election period (as specified by the Plan Administrator) immediately preceding the effective date of the Health FSA in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Agreement shall be effective, subject to Section 3.02A for the Plan Year beginning on the Effective Date.

(b) **New employees and Employees Who Have Not Yet Satisfied the Health FSA'S Waiting Period.** An Employee who becomes eligible to become a Participant in this Health FSA after the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the initial election period set forth in the SPD or the enrollment material. Participation will commence under this Health FSA as set forth in the SPD (but in no event prior to the election).

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.02A or 3.03A.

3.02A Annual Election Period. Each Employee who is a Participant in this Health FSA or who is eligible to become a Participant in this Health FSA shall be notified, prior to each anniversary date of this Health FSA, of his right to become a Participant in this Health FSA, to continue participation in this Health FSA, or to modify or to cease participation in this Health FSA and shall be given a reasonable period of time in which to exercise such right; such period of time shall be known as the annual election period. The date on which the annual election period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the annual election period in the manner set forth in the SPD. The consequences of failing to make an election during the annual election period will be set forth in the SPD.

3.03A Change of Elections. A Participant shall not make any changes to his election except for election changes permitted under the SPD and for changes made during the annual election period, changes caused by termination of employment or cessation of eligibility and changes pursuant to the Family and Medical Leave Act. Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier that the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later.

3.04A Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except

as provided below, if revocation occurs under this Section 3.04A, no new election with respect to the Health FSA may be made during the remainder of the Plan Year except as set forth in the SPD.

3.05A Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Health FSA may fail to satisfy for such Plan Year and requirement imposed by the Code or any limitation on Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation.

ARTICLE IVA - REIMBURSEMENTS

4.01A Health Care Reimbursement. Each Participant's Health FSA Reimbursement Account will be credited with amounts withheld from the Participant's Compensation and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with this Article IVA. The entire amount elected by the Participant on the Salary Reduction Agreement as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed to the participant for expenses incurred during the Plan Year shall be available to the Participant at any time during the Plan Year without regard to the amount of contributions made (provided that the periodic contributions have been made). In no event will the amount of Health Care Reimbursements in any Plan Year exceed the annual amount specified for the Plan Year in the Salary Reduction Agreement for Health Care Reimbursement. Any amount credited to the Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Health Care Reimbursement within the run out period set forth in the SPD. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor or Internal Revenue Service regulations. The maximum annual reimbursement under the Health FSA shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD. Notwithstanding anything else in this document, for plan years starting on or after January 1, 2013, the annual salary reduction contribution limit for the Health FSA shall be subject to Code §125(i), including an annual cost-of-living adjustment as published by the IRS for later plan years.

4.02A Receiving Health Care Reimbursement. Payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Dependents while he is a Participant during the Plan Year for which the Participant's election is effective provided that the substantiation requirements of Section 4.03A herein are satisfied. However, if the employer so chooses the Participant may choose to make payment for Eligible Medical Expense with an electronic payment card arrangement. The terms of the electronic payment card arrangement, if applicable, will be set forth in the SPD.

4.03A Substantiation of Expenses. Each Participant must submit an expense for reimbursement in accordance with the terms of the SPD and provide the required substantiation set forth in the SPD or as otherwise requested by the Plan Administrator (or its designee).

4.04A Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been substantiated by such Participant during the Plan Year as required by Section 4.03A herein or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator shall recoup the excess reimbursements in one or more of the following ways: (1) The Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification. (2) The Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted). (3) The Plan Administrator shall withhold such amounts from the Participant's pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement through the means set forth in (1) – (3), the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt.

4.05A Reimbursement Following Cessation of Participation. Participants in the Health FSA may submit claims for reimbursement for Eligible Medical Expenses incurred during the Plan Year and before the date of participation in the Health FSA ceases so long as the claim is submitted prior to the end of the run out period set forth in the SPD. Unless a COBRA election is made as set forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment and/or eligibility ceases under this Section. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) shall be treated in accordance with Section 4.01A.

4.06A Coordination of Benefits Under the Health FSA. The Health FSA is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

4.07A Disbursement Reports. The Plan Administrator shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Health FSA.

4.08A Timing of Reimbursements. Reimbursements shall be made as soon as administratively feasible after the Plan Administrator or its designee has received the required forms.

4.09A Statements. The Plan Administrator or its designated third party administrator may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Health Care Reimbursement under the Health FSA.

4.10A Post-mortem Payments. Any benefit payable under the Health FSA after the death of a Participant shall be paid to his surviving Spouse, or if no spouse, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

4.11A Non-alienation of Benefits. Except as expressly provided by the Administrator, no benefit under the Health FSA shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Health FSA shall in any manner be liable for or subject to the debt, contracts, liabilities, engagements or torts of any person.

4.12A Mental or Physical Incompetence. Every person receiving or claiming benefits under the Health FSA shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

4.13A Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Health FSA because he cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited after a reasonable time after the date any such payment first became due.

4.14A Tax Effects of Reimbursements. Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any reimbursements made under the Health FSA will be treated as excludable from gross income for local, state or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or beneficiary are includable in an Employee's gross income for local, state or federal income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Health FSA is designed and is intended to be operated as a self-insured medical reimbursement plan under Section 105 of the Code.

4.15A Forfeiture of Unclaimed Reimbursement Account Benefits. Any Health FSA Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

ARTICLE VA - FUNDING AGENT

The Health FSA shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements and/or Non-elective Contributions provided by the Employer, if any. The employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and to the extent applicable, shall comply with all applicable regulations promulgated by the Department of Labor (DOL) taking into consideration any enforcement procedures adopted by the DOL.

ARTICLE VIA - CLAIMS PROCEDURES

The Health FSA has established procedures for reviewing claims denied under this Health FSA and those claims review procedures are set forth in the SPD.

ARTICLE VIIA - CONTINUATION COVERAGE UNDER COBRA

The SPD includes COBRA continuation of coverage provisions that shall be applicable to the Health FSA, to the extent the plan sponsor is subject to COBRA (as it amended ERISA, the Code, and the Public Health Service Act).

ARTICLE VIIIA - HIPAA PRIVACY AND SECURITY

8.01A Scope and Purpose. The Health FSA (the "Plan") will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as set forth below.

8.02A Effective Date. This article VIII is effective on such applicable effective date(s) set forth in HIPAA and the applicable regulations issued there under.

8.03A Use and Disclosure of PHI.

(a) General. The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plan.

(b) Disclosure to the Employer. The Plan will disclose PHI to the Employer, or where applicable, an affiliate only upon receipt of written certification from the Employer that:

1. The Plan document has been amended to incorporate the provisions in this Article VIIIA; and
2. The employer agrees to implement the provisions in Section 8.04A herein.

8.04A Conditions Imposed on Employer. Notwithstanding any provision of the Plan to the contrary, the Employer agrees:

(a) Not to use or disclose PHI other than as permitted or required by this Article VIIIA or as required by law;
(b) To ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI received or created on behalf of the Plan;
(c) Not to use or disclose an Individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual;
(d) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Employer unless authorized by the Individual;
(e) To report to the Plan any use or disclosure of PHI that is inconsistent with this Article VIIIA, if it becomes aware of an inconsistent use or disclosure;
(f) To provide individuals with access to PHI in accordance with the current HIPAA Regulations;
(g) To make available PHI for amendment and incorporate any amendments to PHI in accordance with the current HIPAA Regulations;
(h) To make available the information required to provide an accounting of disclosures in accordance with the current HIPAA Regulations;
(i) To make 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 the Plan's compliance with HIPAA;

(j) If feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

(k) To ensure adequate separation between the Plan and Employer as required by the current HIPAA Regulations and described in this Article VIIIA.

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

8.05A Designated Employees Who May Receive PHI. In accordance with the Privacy Rules, only certain Employees who perform Plan administrative functions may be given access to PHI. Those Employees who have access to PHI from the Plan are listed in the Privacy Notice, either by name or individual position.

8.06A Restrictions on Employees with Access to PHI. The Employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI for Plan Administration functions that the Employer performs for the Plan, as set forth in the Privacy Notice, including but not limited to, quality assurance, claims processing auditing and monitoring.

8.07A Policies and Procedures. The employer will implement Policies and Procedures setting forth operating rules to implement the provisions hereof.

8.08A Organized Health Care Arrangement. The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit under a covered health plan (under the current HIPAA Regulations) provided by the Employer.

8.09A Privacy Official. The Plan shall designate a Privacy Official, who will be responsible for the Plan's compliance with HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, broker's consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition and notwithstanding any provision of this Plan to the contrary, the Privacy Official shall have the authority to and be responsible for:

(a) Accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article VIIIA;
(b) Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to Employer;
(c) Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the requirements of HIPAA;
(d) Establishing and overseeing proper training of the Plan, or employer personnel who will have access to Protected Health Information;
(e) Any other duty or responsibility that the Privacy Official, in his sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of this Article VIIIA.

8.10A Noncompliance. The Employer shall provide an effective mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Article VIIIA.

8.11A Definitions. As used in this Article VIIIA, each of the following capitalized terms shall have the respective meaning given below:

> **"Individual"** means the person who is the subject of the health information created, received or maintained by the Plan or Employer.
>
> **"Organized Health Care Arrangement"** means the relationship of separate legal entities as defined in the current HIPAA Regulations.
>
> "**Privacy Notice"** means the notice of the Plan's privacy practices distributed to Plan participants in accordance with the current HIPAA Regulations.
>
> **"Privacy Rules"** means the privacy provision of HIPAA and the current HIPAA Regulations.
>
> **"Protected Health Information or PHI"** means individually identifiable health information as defined in the current HIPAA Regulations.
>
> **"Security Incident"** has the same meaning as the term "security incident" in the current HIPAA Regulations.
>
> **"Security Rules"** means the Security Standards and Implementation Specifications in the current HIPAA Regulations.

8.12A Interpretation and Limited Applicability. This Article VIIIA serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Article VIIIA nor the duties, powers, responsibilities and obligations listed herein shall be taken into account in determining the amount or nature of the Benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Article VIIIA are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

8.13A Services Performed for the Employer. Notwithstanding any other provision of this Plan to the contrary, all services performed by a business associate for the Plan in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plan and subject to the administrative simplification provisions of HIPAA contained in the current HIPAA Regulations, except services that relate to eligibility and enrollment in the Plan. If a business associate of the Plan performs any services that relate to eligibility and enrollment to the Plan, these services shall be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Plan.

IN WITNESS WHEREOF, the employer has executed this Health FSA as of the date set forth below.

Brazosport Independent School District

By: _____

Title: _____

Date: _____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT
APPENDIX B TO THE FLEXIBLE BENEFIT PLAN

The effective date of this document is
May 24, 2019

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PREAMBLE

Effective as of the date set forth below, **Brazosport Independent School District** established this Dependent Care Spending Account (the Dependent Care FSA) to help provide dependent care assistance for those Employees who participate in the Employer's Cafeteria Plan ("Plan") and who, pursuant to the election procedures set forth in the Plan, choose to make contributions to a Dependent Care Reimbursement Account established pursuant to this Dependent Care FSA. This Dependent Care FSA is intended to provide reimbursement of certain eligible Employment Related Expenses incurred by the Participant for care of a Qualifying Individual. The Employer intends that the Dependent Care FSA qualify as a Code Section 129 dependent care assistance plan and that the benefits provided under the Dependent Care FSA be eligible for exclusion from the Participant's income for federal income tax purposes under Section 129 of the Code. This Dependent Care FSA is a component of and incorporated by reference into the Cafeteria Plan and Articles VI, IX and X of the Cafeteria Plan document applies also to this Dependent Care FSA.

ARTICLE IB - DEFINITIONS

Unless otherwise specified, terms that are capitalized in this Appendix IB to the Cafeteria Plan have the same meaning as the defined terms in the Cafeteria Plan. The definitions of terms defined in the Appendix IB, but not defined in the Cafeteria Plan, shall be applicable only with respect to this Appendix IB to the Extent a term is defined both in the Cafeteria Plan and in this Appendix IB, the term as defined in the Cafeteria Plan shall govern the interpretation of the Cafeteria Plan and the term as defined in this Appendix IB shall govern the interpretation of this Dependent Care FSA.

1.01B "Dependent" means any individual who is a tax dependent of the Participant as defined in Code Section 152 except that a child with respect to whom Code Section 21(e)(5) applies shall be considered a Dependent of the custodial parent (as defined in Code Section 152[e]) for purposes of this Dependent Care FSA.

1.02B "Dependent Care Reimbursement" shall have the meaning assigned to it by Section 4.01B of this Dependent Care FSA.

1.03B "Earned Income" means all income derived from wages, salaries, tips, self-employment and other Compensation (such as disability or wage continuation benefits) but only if such amounts are includible in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code Section 32(c)(2), such as amounts received under a pension, or annuity, or pursuant to worker's compensation.

1.04B "Effective Date" of this Dependent Care FSA means **September 1, 2020.**

1.05B "Eligible Employment Related Expenses" means those expenses that would be considered to be employment-related expenses under Section 21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services other than amounts paid to:

(a) An individual with respect to whom a Dependent deduction is allowable under Code Section 151(c) to the Participant or his Spouse;
(b) The Participant's Spouse; or
(c) A child (as defined in Code Section 152[f][1]) of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

1.06B "Highly Compensated Individual" means an individual defined under Code Section 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

107B "Reimbursement Account(s)" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Dependent Care Reimbursement (as defined in Section 1.02B herein). No money shall actually be allocated to any individual participant account(s); any such account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the participant account(s).

1.08B "Qualifying Individual" means:

(a) A qualifying child as defined in Code Section 152(a (1) who is under the age of thirteen (13) and;
(b) A Dependent of a Participant who is mentally or physically incapable of caring for himself and who has the same principal place of abode as the Employee for more than half the year; or
(c) The Spouse of a Participant who is mentally or physically incapable of caring for himself and who has the same principal place of abode as the Employee for more than half the year.

1.09B "Qualifying Services" means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed which are performed:

(a) In the Participant's home; or
(b) Outside the Participant's home for (1) the care of a Dependent of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility) the center must comply with all applicable state and local laws and regulations.

ARTICLE IIB - ELIGIBILITY AND PARTICIPATION

2.01B Eligibility to Participate. Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Dependent Care FSA as of the Dependent Care eligibility date set forth in the SPD.

2.02B Termination of Participation. Participation shall terminate on the earliest of the dates set forth in the SPD.

2.03B Qualifying Leave Under Family Medical Leave Act. Notwithstanding any provision to the contrary in this Dependent Care FSA, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA") then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's coverage under this Dependent Care FSA in accordance with the SPD. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

ARTICLE IIIB - ELECTION TO PARTICIPATE

3.01B Initial Election Period.

(a) **Currently Eligible Employees.** An employee who is eligible to become a Participant in this Dependent Care FSA as of the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Dependent Care FSA in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Agreement shall be effective, subject to Section 3.02B, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied the Dependent Care FSA's Waiting Period.** An employee who becomes eligible to become a Participant in this Dependent Care FSA after the Effective Date must complete, sign and file a Salary Reduction Agreement with the Plan Administrator (or its designated third party administrator as set forth on the Salary Reduction Agreement) during the initial election period set forth in the SPD or the enrollment material. Participation will commence under this Dependent Care FSA as set forth in the SPD (but in no event prior to the election).

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement in accordance with paragraph (a) or (b) above during an initial election period may become a participant on a later date in accordance with Section 3.02B or 3.03B.

3.02B Annual Election Period. Each Employee who is a Participant in this Dependent Care FSA or who is eligible to become a Participant in this Dependent Care FSA shall be notified, prior to each Anniversary Date of this Dependent Care FSA, of his right to become a Participant in this Dependent Care FSA, to continue participation in this Dependent Care FSA or to modify or to cease participation in this Dependent Care FSA, and shall be given a reasonable period of time in which to exercise such right; such period of time shall be known as the annual election period. The date on which the annual election period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the annual election period in the manner set forth in the SPD. The consequences of failing to make an election during the annual election period will be set forth in the SPD.

3.03B Change of Elections. A Participant shall not make any changes to his election except for election changes permitted under the SPD and for changes made during the annual election period, changes caused by termination of employment or cessation of eligibility and changes pursuant to the Family and Medical Leave Act. All election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later.

3.04B Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3.04B, no new election with respect to the Dependent Care FSA may be made during the remainder of the Plan Year except as set forth in the SPD.

3.05B Reduction of Certain Elections to Prevent Discrimination. If the Plan Administrator determines, before or during any Plan Year, that the Dependent Care FSA may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation.

ARTICLE IVB - REIMBURSEMENTS

4.01B Dependent Care Reimbursement. Each Participant's Dependent Care FSA will be credited for Dependent Care Reimbursement with amounts withheld from the participant's Compensation and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Dependent Care Account will be debited for Dependent Care Reimbursements disbursed to the participant in accordance with Article IVB of this document. In the event that the amount in the account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months within the same Plan Year, to be paid out as the Dependent Care Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Account for any Plan Year. Any amount allocated to the Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Dependent Care Reimbursement for the Plan Year within the run out period set forth in the SPD, amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law. The maximum annual reimbursement amount shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

4.02B Receiving Dependent Care Reimbursement. Except as otherwise set forth in the SPD with respect to electronic payment cards, payment shall be made to the Participant in cash as reimbursement for Eligible Employment Related Expenses incurred by him while a Participant, during the Plan Year for which the participant's election is effective, provided that the substantiation requirements of Section 4.03B herein are satisfied.

4.03B Substantiation of Expenses. Each Participant must submit an expense for reimbursement in accordance with the terms of the SPD.

4.04B Repayment of Excess/Erroneous Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Dependent Care FSA that exceed the amount of Eligible Employment Related Expenses that have been properly substantiated by such Participant during the Plan Year as required by Section 4.03B herein or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator shall recoup the excess reimbursements in one or more of the following ways: (1) The Plan administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification. (2) The Plan Administrator may offset the excess reimbursement against any other Eligible Employment Related Expenses submitted for reimbursement (regardless of the Plan Year in which submitted) (3) withhold such amounts from the Participant's pay to the extent permitted under applicable law. If the Plan Administrator is unable to recoup the excess reimbursement through the means set forth in (1) – (3), the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt.

4.05B Reimbursement Following Cessation of Participation. Participants in the Dependent Care FSA may submit claims for reimbursement for Eligible Employment Related Expenses incurred during the Plan Year and before the date of participation in the Dependent Care FSA ceases so long as the claim is submitted prior to the end of the run out period set forth in the SPD. To the extent set forth in the SPD, Participants may submit claims for reimbursement of Eligible Employment Related Expenses incurred during the Plan Year and after they cease participation so long as such claims are submitted prior to the end of the run out period. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) shall be treated in accordance with Section 4.01B.

4.06B Disbursement Reports. The Plan Administrator shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Dependent Care FSA.

4.07B Timing of Reimbursements. Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan administrator or its designee.

4.08B Statements. The Plan administrator or its designated third party administrator may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Dependent Care Reimbursement under the Dependent Care FSA.

4.09B Post-mortem Payments. Any benefit payable under the Dependent Care FSA after the death of a Participant shall be paid to his surviving Spouse, otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

4.10B Non-alienation of Benefits. Except as expressly provided by the Administrator, no benefit under the Dependent Care FSA shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or change and any attempt to do so shall be void. No benefit under the Dependent Care FSA shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

4.11B Mental or Physical Incompetency. Every person receiving or claiming benefits under the Dependent Care FSA shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

4.12B Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Dependent Care FSA because he cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited after a reasonable time after the date any such payment first became due.

4.13B Tax Effects of Reimbursements. Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any reimbursements made under the Dependent Care FSA will be treated as excludable from gross income for local, state or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or beneficiary are includable in an Employee's gross income for local, state or federal income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Dependent Care FSA is designed and is intended to be operated as a dependent care assistance plan under Section 129 of the Code.

4.14B Forfeiture of Unclaimed Reimbursement Account Benefits. Any Dependent Care FSA Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Employment Related Expense was incurred shall be forfeited.

ARTICLE VB - FUNDING AGENT

The Dependent Care FSA shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements and/or Non-elective Contributions provided by the Employer, if any. The Employer will apply all such amount, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations.

ARTICLE VIB - CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Dependent Care FSA and those claims review procedures are set forth in the SPD.

IN WITNESS WHEREOF, the Employer has executed this Dependent Care FSA as of the date set forth below.

Brazosport Independent School District

By: _____

Title: _____

Date: _____