MESSA OptionALL Plan

Providing Tax and Welfare Benefits under Section 125 of the Internal Revenue Code

As Amended and Restated, effective January 1, 2024

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INTRODUCTION

The entity listed in the Employer-Specific Information Section as the employer (the "**Employer**") sponsors this MESSA OptionALL Plan (the "**Plan**") for your benefit and the benefit of your family, if you are an Eligible Employee of the Employer. The Plan allows you to make an election between Cash and a range of qualified benefits some of which are offered through employee benefit plans sponsored by the Employer that are not part of this Plan (the "**Underlying Plans**"), and others that are provided under this Plan (the "**Benefit Programs**"). These Benefit Programs are:

- an "**HSA Contribution Program**" that allows individuals enrolled in an Underlying Plan that is a high deductible health plan ("**HDHP**"), and who are enrolled in no other health plan that provides coverage for anything other than disregarded coverage (*e.g.*, coverage for workers compensation, tort liability, use or ownership of property, specific diseases, *per diem* hospitalization payments, dental, vision or long term care) or preventative care. This includes a General Purpose FSA (*i.e.*, an "**HSA Eligible Individual**"). The HSA Contribution Program allows HSA Eligible Individuals to have employer contributions made to their health savings account ("**HSA**"), either through salary reduction or direct employer contributions. The maximum amount that can be contributed to an HSA for an HSA Eligible Individual is the amount established by the IRS for self-only and family coverage.

  Individuals who are enrolled in the General Purpose FSA at the time they enroll in an Underlying Plan which is an HDHP will not become an HSA Eligible Individual until the end of the Plan Year for the General Purpose FSA, or the applicable Grace Period for the General Purpose FSA, if any. If the General Purpose FSA contains a Carryover Provision and a Limited Purpose FSA is not elected, the Carryover Provision must be waived prior to the end of the Plan Year for the General Purpose FSA in order to become an HSA Eligible Individual.

  All contributions to the HSAs of Eligible Individuals under this Premium-Only Plan Program will be deemed as having been made through a cafeteria plan.

- a "**Premium-Only Plan Program**" that allows you to pay with *pre-tax* dollars your share of the cost of the Underlying Plans;

- a "**Cash in Lieu of Benefits Program"** that pays you the cash bonus listed in the Employer-Specific Information Section for the Plan Year if you elect not to be covered under the Employer's health care benefit plans;

- a **Dependent Care Flexible Spending Account Program** (the "**Dependent Care FSA Program**") that allows you to pay for Eligible Dependent Care Expenses on a *pre-tax basis* up to an annual maximum of $5,000 ($2,500 if married and filing separately); and

- a **Health Care Flexible Spending Account Program** (the "**Health Care FSA Program**") that allows you to pay for unreimbursed medical expenses on a *pre-tax basis* up to the annual maximum listed in the Employer-Specific Information Section – *i.e.*, the General Purpose FSA. If you are enrolled in the HDHP and wish to make contributions to your HSA through the Plan, you cannot enroll in the General Purpose FSA, but can elect to participate in the Limited

Purpose FSA if it has been selected by your Employer, in order to preserve your status as an HSA Eligible Individual.

The Benefit Programs are Self-funded. **"Self-funded"** means that the benefits are paid from the Employer's general assets and are not provided through an insurance contract.

You may also receive booklets and/or summaries from the third-party administrators describing your benefits under one or more of the Benefit Programs ("**Booklets**"). This document – including the section that contains Employer-Specific Information – along with those Booklets and/or summaries, together serve as the documentation for the Plan.

This document and the accompanying Benefit Program Booklets describe the provisions of the Plan as of January 1, 2024. The provisions of this Plan apply uniformly to all Participants. Please read these documents carefully and keep them with your personal records for future reference. Throughout this document, capitalized words have specific meanings and are defined terms. Where a term is defined, it also appears in bold print and in quotes. For your convenience, an Index of Defined Terms appears at the end of this document with page references to each defined term.

If you have any questions about a Benefit Program or the Plan in general, please contact the Employer's office or department designated for that purpose at the address and phone number listed in the Employer-Specific Information Section, or MESSA at the address and phone number listed in the Benefit Program Information Chart.

OBTAINING AND CHANGING COVERAGES

ELIGIBILITY

Employee Eligibility

If you are an employee of the Employer designated in the Employer-Specific Information Section as an Eligible Employee, you are eligible to participate in each Benefit Program on the date set forth in the Employer-Specific Information Section. The time between your date of hire and that date is the ("**Waiting Period**"). There is no Waiting Period to participate in the Premium-Only Plan Program, but to participate in that Benefit Program you must be a participant in an Underlying Plan, that requires Benefit Contributions.

Only common law employees may participate in the Plan. You are ***not*** eligible to participate in the Plan if you are a leased employee or an independent contractor.

Dependent Eligibility

Certain members of your family who are dependent on you may also be eligible for coverage under the Health Care FSA Program. The Plan Administrator may require you to show proof that a dependent meets the eligibility criteria. You must notify the Plan Administrator on or before the 30th calendar day following the date of any status change that would result in a dependent no longer being an Eligible Dependent (for example, your Spouse in the event of a divorce). The Plan has a right to recover from you any payments made by the Plan on behalf of an individual who is not an Eligible Dependent (*Refer to* the section of this document entitled "Overpayments").

Eligible Dependents

Your "**Eligible Dependents**" are:

- your "**Spouse**," defined as the person to whom you are legally married;

- your son, daughter, stepson, stepdaughter, adopted son or daughter (or a son or daughter placed with you for adoption), or your Eligible Foster Child, who has not reached the end of the calendar year in which he or she turned 26 (An "**Eligible Foster Child**" is any child who is placed with you by an authorized agency or by judgment, decree, or other order of any court of competent jurisdiction (collectively "**Children**," or, individually, "**Child)** are eligible under the Plan. Children are eligible for this coverage regardless of their marital status, disability status, student status, their financial dependency status, their domicile, their status as your federal tax dependent, or any combination of these.

Any of your dependents who do not meet the criteria for being either your "qualified child" or "qualified relative" under Internal Revenue Code of 1986 as amended (the "**Code**" or "**IRC**") § 152 are not eligible to be covered under the Health Care FSA Program.

PARTICIPATION

To start participating in the Plan, you need to fill out and submit the Enrollment Forms contained in your enrollment package ("**Enrollment Forms**") to the Employer department or

office listed in the Employer-Specific Information Section. In some cases, the Enrollment Forms may be provided in electronic formats and enrollment may be done online. On the Enrollment Forms, you elect the Benefit Programs in which you wish to participate and authorize the Employer to reduce your pay in accordance with those elections. Only you, as an employee, may fill out the Enrollment Forms, make Benefit Program elections, and consent to any compensation reduction arrangements. If you have properly enrolled in the Plan, you are a "**Participant**."

An Eligible Dependent who is properly enrolled in a Benefit Program is a "**Covered Dependent**."

Newly acquired Eligible Dependents, for example, a new Spouse or a newborn Child, must be enrolled on or before the 30th calendar day following the date of the event by which they become your Eligible Dependent. If not enrolled by that 30th calendar day, they cannot be enrolled until the next Open or Special Enrollment Period or until you experience a Change Event.

Initial Enrollment Period

As a newly hired Eligible Employee, you will participate in the Benefit Programs on the date you complete the Waiting Period, as long as you have completed and returned the Enrollment Forms to the Employer department or office listed in the Employer-Specific Information Section for that purpose on or before the 30th calendar day following your date of hire ("**Initial Enrollment Period**").

Your election will be effective from the date immediately following the last day of the Waiting Period, but salary reduction amounts will only be made from compensation not yet available to you on that effective date. Elections during your Initial Enrollment Period are irrevocable until the next Open Enrollment Period, unless you are eligible to enroll during a Special Enrollment Period or you experience a Change Event.

If you fail to complete and submit your Enrollment Forms to the Employer department or office listed in the Employer-Specific Information Section on or before the 30th calendar day immediately following your date of hire, you will not be automatically enrolled in any of the Benefit Programs, and you will be able to change your coverage options only at the next Open Enrollment Period, Special Enrollment Period, or if you experience a Change Event. This will mean that any Benefit Contributions for the Underlying Plans must be paid on or after tax basis.

Open Enrollment Period

Each year the Employer establishes an "**Open Enrollment Period**," which is usually toward the end of the Plan Year. During the Open Enrollment Period, you can make new benefit choices and elections for the upcoming Plan Year.

To change your elections under the Plan or to enroll for the first time during an Open Enrollment Period, if you failed to do so during your Initial Enrollment Period or during prior Open Enrollment Periods, you must fill out the Enrollment Forms and return them to the Employer's office or department designated in the Employer-Specific Information Section for this purpose before the Open Enrollment Period ends. The "**Period of Coverage**" under the Plan is a 12-month period, usually beginning on the first day of the Plan Year. Therefore, the

choices you make during the Open Enrollment Period will be effective on the first day of the upcoming Plan Year, and once your payroll reductions have started, your choices are irrevocable for that Period of Coverage, and will remain in effect without any changes permitted through the remainder of the Plan Year, unless you experience a Change Event.

Special rules apply if you are on a leave of absence during an Open Enrollment Period. If the Open Enrollment Period occurs while you are on a leave that is either paid or qualified under the Family and Medical Leave Act of 1993 (the "**FMLA**"), you will be contacted and allowed to make an election during the Open Enrollment Period. If you are eligible to participate in the Plan, and the Open Enrollment Period occurs while you are on an unpaid leave of absence ***not*** qualifying under the FMLA, you will be presumed to have elected to continue your elections from the prior year. Your elections for the Dependent Care FSA and the Health Care FSA Programs, however, will be terminated as of the last day of the Plan Year in which your leave began, although you may seek reimbursement, up to the reimbursement deadline for that Plan Year, of eligible expenses Incurred during your period of participation. You may make new elections and participate in the Plan after you return from your leave of absence under the Change Event rules.

Special Enrollment Period

You may enroll in the Premium-Only Plan Program and Health Care FSA Programs other than during the annual Open Enrollment Period in two different circumstances ("**Special Enrollment Period**").

First, you declined coverage under any one of these Benefit Programs when first available because you and/or your Eligible Dependents were enrolled in other health coverage, but have since lost that coverage on account of:

- having exhausted COBRA Continuation Coverage;
- having lost eligibility for the other coverage; or
- termination of employer contributions towards the other coverage.

In this circumstance, you may enroll yourself and your Eligible Dependents in the Plan on or before the 30th calendar day following the date the other coverage was exhausted or terminated. If you or your Eligible Dependents were not provided with a Certificate of Creditable Coverage on or before the date the other coverage was exhausted or terminated, the Special Enrollment Period will end 30 calendar days after the earlier of the date a Certificate of Creditable Coverage is provided for the previous exhausted or terminated coverage or the date that is 44 days after that coverage ceases.

Second, you initially declined enrollment and you later have a new Eligible Dependent as a result of marriage. You may then enroll yourself and your Eligible Dependent in the Plan on or before the 30th calendar day following the date of the marriage. Any oral or written request to the Plan or Claims Administrator will be treated as a request for Special Enrollment. Election changes related to your marriage will take effect as of the first day of the month following receipt of a written notice of the marriage. Benefit Contributions will take effect accordingly.

In this second circumstance, the Special Enrollment Period may be extended if you are making reasonable efforts to obtain the necessary enrollment information. For example, if you are in the process of obtaining a Social Security number for your newborn Child, and receipt is delayed beyond the 30-day period, the Special Enrollment Period is extended.

Failure to Timely Enroll

If you do not deliver completed Enrollment Forms to the Employer's office or department designated in the Employer-Specific Information Section for this purpose during your Initial Enrollment Period or an Open Enrollment Period, you will be deemed to have elected the choices set forth in the Employer-Specific Information Section entitled "Failure to Timely Enroll."

Participation during a Leave of Absence

Paid and FMLA Leaves

For any paid leave, and for any leave, paid or unpaid, that qualifies under the FMLA, the Employer intends to allow you to continue all Plan benefits, to the extent possible. When you return from your leave, you will be entitled to receive the same benefits as you were receiving immediately before the start of your leave, without having to complete any Waiting Period.

- If you do not wish to receive some or all of the coverage during your leave that you were receiving just prior to your leave, you must inform the Employer's office or department designated in the Employer-Specific Information Section for this purpose before the start of your leave, or as close to the beginning of your leave as possible.

- If you wish to continue your participation in the Plan during your leave, and you are currently required to make Benefit Contributions, you must make arrangements with the Employer's office or department designated in the Employer-Specific Information Section for this purpose to pay for the coverage you wish to maintain during the course of your leave. If your leave is a paid leave, you may continue having your compensation reduced as it was before your leave. If your leave is unpaid, you can pay your Benefit Contributions:

    - in advance of your leave;

    - during your leave by sending a check monthly to the Employer's office or department designated in the Employer-Specific Information Section for this purpose; or

    - when you return from your leave either by increasing your payroll deductions or by submitting a check to the Employer's office or department designated in the Employer-Specific Information Section for this purpose.

- Your eligibility to continue any coverage that requires payments from you may be cancelled if you do not make the required Benefit Contributions during the period of your leave, unless you have made other arrangements with the Employer's office or department designated in the Employer-Specific Information Section for this purpose.

- If the Employer advances money by making these payments for you, in whole or in part, it can recoup the amounts advanced through payroll deductions upon your return to employment following your leave.

- If you have paid Benefit Contributions in advance of your leave and you terminate employment when you have not exhausted the pre-funded amount of your Benefit Contributions, any remaining unused balance of your pre-funded payments will be returned to you.

Special rules apply to the Dependent Care FSA and Health Care FSA Programs, which are described in those sections.

Other Leaves

If you take an unpaid leave of absence that does not qualify under the FMLA, or extends beyond the FMLA leave period, your benefits under the Plan will end, unless you arrange to pay for the Benefit Programs by sending a check to the Employer's office or department designated in the Employer-Specific Information Section for this purpose. You should consult with the Employer's office or department designated in the Employer-Specific Information Section for this purpose before taking an unpaid leave.

End of Plan Participation

Your participation (and your Covered Dependents' participation) in the Plan and your pay period reductions will end on the earliest of:

- your termination of employment (unless you have elected COBRA Continuation Coverage for a Benefit Program for which COBRA is available);

- a Change Event (as defined below) that leads you to revoke your participation;

- your (or your dependent's) failure to meet the eligibility requirements or conditions described in the Plan (unless you have elected COBRA Continuation Coverage for a Benefit Program for which COBRA is available);

- your failure to make a contribution under this Plan;

- for Covered Dependents, pursuant to the terms of the Qualified Medical Child Support Order under which he or she participates in the Plan; or

- the termination of the Plan by the Employer.

Once your participation in the Plan ends, your elections will be automatically revoked. Any money remaining in your Benefit Program accounts when your participation in the Plan ends will be forfeited.

Elections May Not Defer Compensation

No election that you make under the Plan or any Benefit Program available through the Plan can serve to defer compensation you have earned in one Plan Year to the next. Nevertheless, (i) compensation reductions in the final month of a Plan Year that satisfy premium obligations for coverage in the first month of the immediately following Plan Year, (ii) reimbursement for advanced payments required for orthodontia procedures extending from one Plan Year to the next, (iii) payment or reimbursement for durable medical equipment with a useful life beyond a single Plan Year, (iv) vision or dental insurance that requires a two-year coverage period, if

premiums are paid annually and no part of the first year's payments go towards the second year's premiums, and (v) disability payments under a long term disability policy, if applicable, are treated as not improperly deferring compensation under this Plan.

CHANGE IN STATUS EVENTS

You cannot change your benefit elections during the Plan Year outside an enrollment period, unless you experience a "**Change Event**" and the change you want to make is consistent with the Change Event.

Change Events for All Benefit Programs

You may change your Benefit Program selections if you or your Covered Dependent becomes eligible or ineligible for coverage under either this Plan or another plan on account of a change in:

- legal marital status (for example, marriage, divorce, legal separation, annulment);
- number of dependents (for example, birth, death, adoption, placement for adoption);
- employment status (for example, strike or lockout, termination or commencement of employment, leave of absence, including those protected under the FMLA);
- work schedule (for example, a change from Full-time to part-time (if part-time employees are not eligible to participate), or a change from employee to independent contractor);
- residence or worksite;
- a Covered Dependent's status (that is, a dependent becomes eligible or ineligible for benefits under the Plan);
- coverage made by your Spouse or other Covered Dependent permitted under the Spouse's or Covered Dependent's employer's benefit plan due to a Change Event (***not available for the Dependent Care FSA or Health Care FSA Programs***);
- the availability of benefit options or coverage under any of the Benefit Programs under the Plan (***not available for the Dependent Care FSA or Health Care FSA Programs***);
- an election made by your Spouse or other Covered Dependent during an open enrollment period under your Spouse's or other Covered Dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan (for example, your Spouse's open enrollment period is in December and your Spouse changes coverage) (***not available for the Dependent Care FSA or Health Care FSA Programs***);
- the cost of coverage during the Plan Year, but only if it is a significant increase or decrease (***not available for the Dependent Care FSA or Health Care FSA Programs***); or
- your dependent care provider or cost of dependent care (a significant increase or decrease) (***available for the Dependent Care FSA Program only***).

Additional Change Events for the Health Care FSA Program

In addition to the above Change Events, you may also change elections for the Health Care FSA Program if:

- you, your Spouse, or other Covered Dependent become eligible for continuation coverage under COBRA;

- a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your Child;

- you, your Spouse, or other Covered Dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or

- you, your Spouse, or other Covered Dependent become eligible for a Special Open Enrollment Period.

Special Rule for Election Changes for HSAs

If the Employer sponsors a high deductible health plan and you are eligible to contribute to an HSA on a tax-favored basis, the following applies:

If you have established an HSA and are making monthly contributions to your HSA through the HSA Contribution Program, you will be able to change your compensation reduction election on a monthly basis (or more frequently, if necessary) so that you are only making contributions at a time when you are eligible for the tax-advantages of the HSA – *i.e.*, you are an HSA Eligible Individual. Should you lose coverage under an HDHP and become ineligible to make HSA contributions on a tax-advantaged basis, you may revoke your compensation reduction election for your HSA contributions. Conversely, if you were not an HSA Eligible Individual, and you enroll in an HDHP and became an HSA Eligible Individual, you could elect to begin salary reduction contributions to your HSA mid-year. All changes with respect to your HSA contributions under this special rule must be made prospectively with respect to compensation that is not currently available to you at the time of the election. No changes can be made retroactively, and all changes will become effective as of the payroll period next following the date on which you inform the Plan Administrator of the change or revocation to your HSA contribution election.

Consistency Rule

Your election change must be consistent with the Change Event that affects your coverage under a Benefit Program. Examples:

- If your dependent care provider changes, you could not change your coverage elective in the Underlying Plan(s), but you could change your elections relating to the Dependent Care FSA Program.

- If one of your dependents no longer qualifies as a Covered Dependent, you could cancel coverage for that dependent, but you could *not* cancel coverage for your other Covered Dependents.

- If you have single coverage and you marry, you may elect family coverage.

Some of the Change Events may allow you the option of either increasing or decreasing coverage, for example, your Spouse changing an election under his or her employer's plan may allow you either to increase or decrease your benefits under the Plan so long as your choice is consistent with your Spouse's election. If you are not sure the election change you would like to make is consistent with the Change Event, you should contact the Employer's office or department designated in the Employer-Specific Information Section for this purpose.

Significant Cost or Coverage Changes

If your Benefit Contributions required under an Underlying Plan increase or decrease during a Plan Year, your election under the Premium-Only Plan Program will be automatically adjusted. If the cost significantly increases or decreases, you will also be permitted to make a corresponding election change, which may include selecting an alternative benefit option under an Underlying Plan consistent with the significant change in cost, or even opting out of an Underlying Plan if no consistent option exists. Whether a cost change is "significant" will be determined by the Plan Administrator on a reasonable and consistent basis.

If there is a significant curtailment in coverage under an Underlying Plan or benefit option under an Underlying Plan, including but not limited to a significant increase in the deductible, the copayment or the out-of-pocket cost sharing limit, you will be permitted to revoke your election of that Benefit Program or benefit option and be allowed to elect, on a prospective basis, another benefit option or Benefit Program providing similar coverage. Coverage will be deemed to be "significantly curtailed" only if there is an overall general reduction in coverage. If a new benefit option or Benefit Program is added during the Plan year, or an existing one is significantly improved, you will also be able to revoke your then existing election and make a new election.

Similarly, if there is a new benefit or other coverage option added to the Plan, or an existing benefit option or coverage is significantly improved during the Plan Year, you may revoke your current selections and elect, on a prospective basis, the newly added or significantly improved option or coverage.

Enrollment Opportunity for Adult Children

Your dependent Child may enroll in the Plan by the end of the calendar year in which he or she attains the age of 26, if your Dependent Child lost coverage under the Plan because he or she (i) had previously turned 19 years of age, (ii) had not reached the age of 25 and was not a Full-time Student, or (iii) had never enrolled in the Plan because they did not meet either of the Plan's age requirements at the time you enrolled. This enrollment opportunity will be considered to be a Change Event.

NOTE – This provision addresses an enrollment opportunity for your adult Children. Once enrolled, their coverage will be determined by the terms of the Plan, and will end for any of the reasons provided for under the Plan. For example, their coverage will terminate at the end of the calendar year in which they attain the age of 26, subject to their right to elect continuation coverage under COBRA.

Procedures for Changing Elections Mid-Year

If you want to change an election because of a Change Event, you must submit a written request to the Employer's office or department designated in the Employer-Specific Information Section for this purpose and identify the event that resulted in the change. The change request must be filed on or before the date that is 30 calendar days after the date of the Change Event. The change in coverage generally will be effective as of the first payroll period following notification. If the Change Event is the birth or adoption of a dependent Child, for example, the change in coverage will be retroactively effective to the date of the birth or adoption. If one or more payroll periods have passed since the birth or adoption, additional Benefit Contributions will be withheld from subsequent paychecks to place you in the position you would have been in had your new election been in effect at the date of the birth or adoption.

If you file a request for a change in coverage more than 30 days after the date of the Change Event, the requested change will not take effect, and you will have to wait until the next Open Enrollment Period, a Special Enrollment Period, or until you experience another consistent Change Event to make the change.

BENEFIT PROGRAMS

HSA CONTRIBUTION PROGRAM

If you are enrolled in an Underlying Plan that is an HDHP, are an Eligible Individual and have established an HSA, the HSA Contribution Program allows you to have contributions made to your HSA under the Plan either through salary reductions or by direct Employer contributions, if your Employer makes such direct Employer contributions. To find out if your Employer has elected to make such direct contributions, *see*, the Employer-Specific Information Section. Contributions under this HSA Contribution Program are in addition to any amounts you choose to pay through the Premium-Only Plan Program.

PREMIUM-ONLY PLAN PROGRAM (Premium Contribution)

The Premium-Only Plan Program is designed to help you pay your Benefit Contributions, on a pre-tax basis, for any Benefit Program. You may also pay COBRA premiums on a pre-tax basis under this Program for yourself or your tax dependents should you or they become COBRA Qualified Beneficiaries, even if the COBRA coverage is under the plan of a former employer. Your coverage under the Underlying Plans will be the same whether or not you participate in the Premium-Only Payment Program, but if you participate, your taxes will be lower because your Benefit Contributions will not be subject to federal, state, most municipal, or Social Security taxes. Because your compensation is reduced, however, choosing this option may reduce other benefits that are based on your compensation, such as Social Security, life insurance, and disability insurance. For most employees, these benefit reductions are fairly small, particularly compared to the tax savings. In some cases, benefits might not be reduced at all. You should review your own situation carefully before making a choice.

If, for any reason, you are eligible for the Underlying Plans at a time when you are not eligible to participate in the Premium-Only Payment Program, you may enroll in the Underlying Plans and pay any Benefit Contributions on an after-tax basis until you can begin to participate in the Premium-Only Plan Program.

Benefit Options

Under the Premium-Only Plan Program, you have a choice under the Plan to either:

- make an election between Cash and a range of qualified benefits. For this purpose, "**Cash**" includes your regular compensation (including bonuses and overtime), paid time-off, severance payments, but it does not include any distributions from a tax-qualified retirement plan. If you elect Cash, you will receive your full taxable compensation for a Plan Year through the Employer's normal payroll system and make your Benefit Contributions to the Benefit Programs on an after-tax basis through payroll deduction; or

- have a portion of your taxable compensation reduced and have the Employer apply that amount to pay for your Benefit Contributions on a *pre-tax basis*. If you choose to have your compensation reduced, this will, under current law, reduce your federal, state, most municipal and Social Security taxes.

Reduction of Compensation

The amount by which the Employer will reduce your compensation to make the Benefit Contributions will be stated in the Enrollment Forms. The Employer will set the Benefit Contributions and communicate them to you during the Open Enrollment Period for the upcoming Plan Year.

Treatment of Benefit Contributions While On Leave

If you take an unpaid leave of absence, you will not be able to participate in the Premium-Only Plan Program as you will not be receiving compensation that can be reduced. If you remain eligible to continue your participation in the other Benefit Programs or the Underlying Plans during the period of your unpaid leave, you will have to make your Benefit Contributions on an after-tax basis. This is true whether or not your leave qualifies under the FMLA.

On the other hand, if you are on a paid leave (whether or not FMLA-qualified), you can continue to participate in the Premium-Only Plan Program by having the compensation you receive be reduced during the leave as you elected in your Enrollment Forms, so long as you are still eligible to participate in the Benefit Programs.

CASH IN LIEU OF BENEFITS PROGRAM

General

The Cash in Lieu of Benefits Program allows you to waive medical coverage for a Plan Year and receive instead a cash payment in the dollar amount listed in the Employer-Specific Information Section. This Benefit Program is only available, however, if you have coverage under another medical plan, including Medicare, Medicaid or Tricare. You will be asked to certify that you have other medical coverage when you sign up for the Cash in Lieu of Benefits Program during Open Enrollment. The cash payment will be made payable as set forth in the Employer-Specific Information Section and may be applied towards your Benefit Contributions for the Underlying Plans or either of the FSA Programs on a pre-tax basis, if your Employer has elected this option. Of course, money received directly in your paycheck as a cash bonus will be taxable income to you.

Loss of Other Coverage

If, during the course of the Plan year, you lose your other coverage (for example, you chose to opt-out because you were covered under your wife's medical plan, but your wife subsequently is laid-off and loses coverage under her employer's medical plan), you will no longer be eligible to receive the cash payments, but you will be able to elect coverage under any Employer-provided medical coverage for which you are otherwise eligible, if you enroll within 30 days of the event that caused you to lose that other coverage. If you do not enroll within this time frame, you may not enroll until the next Open Enrollment Period. Your loss of coverage also will qualify as a Change Event, so that if you timely enroll for medical coverage, you can make any Required Contributions on a pre-tax basis.

DEPENDENT CARE FSA PROGRAM

The Dependent Care FSA Program is designed to help you pay your Eligible Dependent Care Expenses with pre-tax dollars. This lowers your income that is subject to federal, state, most

municipal, and Social Security taxes. In effect, the money saved on taxes helps pay part of the Eligible Dependent Care Expenses normally paid with after-tax dollars.

Dependent Care Account

If you enroll in the Dependent Care FSA Program for a Plan Year, the Plan Administrator will establish a Dependent Care Spending Account ("**Dependent Care Account**") for the Plan Year. Your Dependent Care Account will be credited each pay period with the Benefit Contribution amount you authorized. The Dependent Care Account is for bookkeeping purposes only. The amounts credited to your Dependent Care Account are not assets that belong to you.

Annual Contribution Amount

The maximum amount you may contribute to your Dependent Care Account each Plan Year is the least of:

- your earned income from employment,
- your Spouse's earned income from employment, or
- $5,000 annually ($2,500 if married filing separately).

If your Spouse has not earned any income from employment, but is a Full-Time Student or disabled and unable to care for himself or herself, your Spouse will be assumed to have earned $250 a month if you claim reimbursement for the care of one Qualifying Individual, or $500 a month if you claim reimbursement for the care of two or more Qualifying Individuals. A "**Full-time Student**" is someone who enrolls during each of at least five months during the taxable year for what is considered a full-time course of study, carrying a minimum of 12 credit hours, at an educational organization.

If the amount of your or your Spouse's earned income changes during the Plan Year, so that your authorized contribution amount exceeds the maximum amount as stated above, you should immediately notify the Plan Administrator so that your authorized contribution amount can be reduced.

The Plan Administrator may also reduce your contribution to the extent necessary to comply with the Code's nondiscrimination requirements.

Amount That Can Be Reimbursed To Participants

The Dependent Care FSA Program reimburses you for a Claim only to the extent of the balance in your Dependent Care Account. If the balance in your Dependent Care Account is insufficient to pay a Claim in full, the remainder of the Claim will be carried over and paid when the balance in your Dependent Care Account is sufficient. You cannot, however, carry over unpaid amounts to a subsequent Plan Year, plus any Grace Period, if applicable – *see*, Employer-Specific Information Section.

Eligible Dependent Care Expenses

The amount credited to your Dependent Care Account may only be used to pay for the Eligible Dependent Care Expenses of a Qualifying Individual. A "**Qualifying Individual**" is defined as:

- your Child under the age of 13 for whom you are allowed a personal exemption deduction for federal income tax purposes; or

- your mentally or physically disabled Spouse or tax dependent (regardless of age) who is physically or mentally incapable to care for himself or herself and resides with you for at least one-half of your tax year.

If you are a parent who is divorced, legally separated, separated under a written separation agreement, or who lived apart from your spouse at all times during the last six months of the calendar year, your Child will be considered a Qualifying Individual if:

- the Child is under the age of 13 or is physically or mentally incapable of caring for himself;

- the Child is in the custody of one or both parents for more than one-half of the calendar year; and

- you have custody of the Child for more of the calendar year than your spouse or former spouse, as the case may be.

"**Eligible Dependent Care Expenses**" are expenses Incurred for household services or care of a Qualifying Individual necessary to enable you to be gainfully employed. Eligible Dependent Care Expenses also include Social Security and unemployment taxes paid by you on behalf of the person who cares for your Qualifying Individual.

Expenses for care at a dependent care center may be claimed only if the center: provides care for more than six individuals, other than those who reside at the facility; receives a fee, payment, or grant for providing the services, regardless of whether the center is operated for profit; and complies with all applicable state and local laws and regulations.

Expenses for care provided outside of your home may be claimed only for dependents under age 13 or a disabled Spouse or disabled dependent over age 13 who regularly spends at least eight hours each day in your home.

Eligible Expenses are those Incurred during the Plan Year for which you elected to be covered under the Dependent Care FSA Program, unless they were Incurred during the two and one-half month period following the close of the Plan Year, provided you were covered on the last day of the Plan Year (the "**Grace Period**"). The Grace Period is optional, however, and you can check the Employer-Specific Information Section to see if your Employer elected to have a Grace Period for the Dependent Care FSA Program. If the Employer elects to have a Grace Period, it will uniformly apply to all participants. Reimbursements for expenses Incurred during the Grace Period will be limited to any amounts that remain in your Dependent Care Account, and any amounts remaining in your Dependent Care Account at the end of the Grace Period will be forfeited. Amounts in your Dependent Care Account can only be used to pay for Eligible Dependent Care Expenses and not for Eligible Health Care Expenses.

Ineligible Dependent Care Expenses

There are certain kinds of dependent care expenses that do not qualify for dependent care reimbursement. These "**Ineligible Dependent Care Expenses**" include:

- expenses paid on behalf of an individual who is not a Qualifying Individual;
- expenses paid to your Spouse, a parent of a Qualifying Individual Child, your or your Spouse's tax dependent, or your Child under age 19, to care for a Qualifying Individual;
- expenses for which you have received or will receive federal dependent care tax credits;
- expenses in excess of your annual elected amount or the maximum amount under the Dependent Care FSA Program;
- expenses paid to an ineligible provider (for example, expenses paid to send a dependent to an overnight camp);
- expenses Incurred during a period of time you were not covered by the Dependent Care FSA Program, unless they were Incurred during the Grace Period, if applicable;
- expenses Incurred for food, clothing, or education, unless incidental to and inseparable from the care provided (for example, nursery school expenses are considered Eligible Dependent Care Expenses even if lunch and some educational services are provided);
- educational expenses for a Child in kindergarten or a higher grade level;
- generally, expenses for transportation between your home and the place where the dependent care is provided, except that transportation to a day camp or an after-school program not on school premises furnished by a dependent care provider may be reimbursable if the expenses are otherwise Eligible Dependent Care Expenses;
- expenses for which you have not provided satisfactory proof of payment, *i.e.*, you have not provided complete third-party substantiation as to the nature of the expense and the amount of your payment;
- expenses for which the name, address and Social Security number of the dependent care provider has not been reported to the Claims Administrator;
- expenses claimed later than the date set forth in the Employer-Specific Information Section following the end of the Plan Year or Grace Period; if applicable, and
- expenses Incurred under any other FSA Program under this Plan.

Any reimbursement paid for an Ineligible Dependent Care Expense will be subject to applicable income taxes.

Example of How the Dependent Care FSA Program Saves Taxes

You are married and you and your Spouse each earn $30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Dependent Care Expenses will be $3,000. So, you choose to contribute $3,000 to your Dependent Care FSA. Your tax savings will be:

	Using Dependent Care FSA Program	**Not Using Dependent Care FSA Program**
Your Gross Pay (You and Your Spouse)	$60,000	$60,000
Your Pre Tax Dependent Care Expenses	3,000	N/A
Your Taxable Income	57,000	60,000
Your Income Taxes (25%)	14,250	15,000
Your Post Tax Dependent Care Expenses	0	3,000
Your Net Take Home Pay	$42,750	$42,000
Your Tax Savings	**$750**	N/A

Federal Dependent Care Tax Credit

You are not eligible to receive both the federal dependent care tax credit and reimbursement under the Dependent Care FSA Program for the same expense. Before enrolling in the Dependent Care FSA Program, you should determine that reimbursement under the Dependent Care FSA Program is more advantageous to you than the $6,000 maximum federal dependent care tax credit.

The federal dependent care tax credit is reduced by the amount that the Dependent Care FSA Program reimburses you for child care expenses. For example, if you have two Qualifying Individuals for whose care you incur $7,000 in dependent care expenses, and you pay $5,000 on a tax-free basis through the Program, you cannot take a tax credit with respect to the entire remaining $2,000; you can only take a tax credit of $1,000. If you paid only $4,000 on a tax-free basis through the Dependent Care FSA Program, you could take the tax credit with respect to $2,000.

Provider Information

When you submit your first Claim of each year, you must provide the Claims Administrator with information about the dependent care provider including the provider's name, address and Social Security number or employer identification number. If this information changes at any time, you are required to provide the new information with your next Claim. This information must also be provided to the IRS on your income tax return. You may obtain this information from your dependent care provider on IRS Form W-10 "Dependent Care Provider's Identification and Certification."

Expenses Eligible under More Than One Dependent Care Spending Account Program

If a dependent care benefit is payable under two or more dependent care spending account programs, you may submit a Claim for the expense to either program, but this Dependent Care FSA Program will not pay an expense paid by another program. At the Claims Administrator's request, you are obligated to supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments.

Forfeiture of Amounts Remaining at the End of the Plan Year

Because of Code requirements, if you do not use the total amount in your Dependent Care Account for reimbursement of Eligible Dependent Care Expenses Incurred during a Plan Year or its Grace Period, the amount remaining will be forfeited on the number of days following the end of the Plan Year that are designated in the Employer-Specific Information Section. Forfeited amounts may be: (i) used to pay the administration expenses of the Dependent Care FSA Program, (ii) returned to employees on a reasonable and uniform basis, or (iii) retained by the employer.

Termination of the Dependent Care FSA Program

In the event the Dependent Care FSA Program is terminated, any amounts in your Dependent Care Account will remain available for reimbursement of expenses Incurred during the Plan Year while the Program was in effect until 90 calendar days after the date of termination of the Program.

Participation during an Unpaid Leave of Absence

If you take an unpaid leave of absence that is not short-term or temporary, based on the particular facts and circumstances of your leave, whether or not FMLA-qualified, you may not be able to participate in the Dependent Care FSA Program during the period of your leave. If you are not eligible to participate during your leave, you will not be entitled to receive reimbursement for Claims Incurred during the period of your leave. Upon your return to work, you may resume your participation in the Dependent Care FSA Program and make a new Benefit Contribution election.

You should contact the Employer's office or department designated in the Employer-Specific Information Section for this purpose before taking a leave of absence to determine whether you will be eligible to participate in the Dependent Care FSA Program during your leave.

HEALTH CARE FSA PROGRAM

The Health Care FSA Program is designed to help you pay for Eligible Health Care expenses with pre-tax dollars. This lowers your income that is subject to federal, state, and most municipal and Social Security Taxes. There are two varieties of health care FSAs. The one which is described immediately following this paragraph is the "**General Purpose FSA**," and is available to all Plan participants except those who are enrolled in the Employer's HDHP. For those enrolled in the Employer's HDHP, a Plan participant is eligible to enroll in the Limited Purpose FSA if it has been established by your Employer. The Limited Purpose FSA is described at the end of the section describing the General Purpose FSA. Generally, you will

make your election as to which type of Health Care FSA you wish to enroll in during the annual Open Enrollment Period.

Health Care Account

If you enroll in the Health Care FSA Program for a Plan Year, the Plan Administrator will establish a health care spending account ("**Health Care Account**") for you for that Plan Year. Your Health Care Account will be credited each pay period with the Benefit Contribution amount you authorized. Your Health Care Account is for bookkeeping purposes only. The amounts credited to your Health Care Account are not assets that belong to you.

Annual Contribution Amount

Each year you may contribute to your Health Care Account the maximum amount designated in the Employer-Specific Information Section. The Plan Administrator, however, may reduce your contribution amount to the extent necessary to comply with certain non-discrimination requirements under the Code. Effective for Plan Years beginning on or after January 1, 2024, the maximum amount you may contribute to our Health Care Account will be $3,200; provided, however, that if this limitation, required under the federal Affordable Care Act ("**ACA**"), is changed because the ACA has been amended, this limitation will be changed accordingly. If the ACA is amended to eliminate this limitation, then the maximum contribution amount set forth in the Employer-Specific Information Section will apply. For Plan Years beginning after December 31, 2013, this limit will be indexed for inflation.

Amount That Can Be Reimbursed To Participants

Immediately upon your participation in the Health Care FSA Program, the full annualized value of the amount you elected to contribute will be available to reimburse you for Eligible Health Care Expenses. For example, if you have chosen to have your wages reduced by $5,000, (assuming that is the annual maximum) under the Health Care FSA Program, you may be reimbursed in full for a $5,000 Claim Incurred on your first day of participation in the Health Care FSA Program.

If you leave employment before the end of the Plan Year and cease to be a participant in the Health Care FSA Program, you must be refunded any amount you previously contributed to the extent that amount relates to the period from the date you ceased to be a participant through the end of the Plan Year.

Eligible Health Care Expenses

The amount credited to your Health Care Account can only be used to pay for your or a Qualified Dependent's Eligible Health Care Expenses Incurred while you were covered under the Health Care FSA Program, or during the Grace Period, if applicable – *see*, the Employer-Specific Information Section.

A "**Qualified Dependent**" is:

- your Spouse;
- your adult Children until the end of the calendar year in which they turn 26; or

- any individual that you can claim as a dependent on your federal income tax return under Code Section 152.

"**Eligible Health Care Expenses**" are expenses that qualify as medical care under Sections 213(d)(1)(A) and (B) of the Code and are for the benefit of a Qualified Dependent. These generally include expenses Incurred for diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation essential to obtaining related services. Eligible Health Care Expenses do not include payment for long-term care services or insurance premiums.

For example, Eligible Health Care Expenses include amounts paid for:

- hospital expenses;

- medical, dental, or vision expenses;

- over-the-counter medications or drugs purchased for medical care, but only if they are obtained through a written prescription, from a licensed health care provider;

- prescription drugs; and

- insurance deductibles and copayments that are not reimbursed by another insurance plan or reimbursement account.

Expenses Incurred during the Plan Year for which you elected to be covered under the Health Care FSA Program, unless they were Incurred during the Grace Period, if applicable. The Grace Period will uniformly apply to all participants, reimbursements for expenses Incurred during the Grace Period will be limited to any amounts that remain in your Health Care Account, and any amounts remaining in your Health Care Account at the end of the Grace Period will be forfeited. Amounts in your Health Care Account can only be used to pay for Eligible Health Care Expenses and not for Eligible Dependent Care Expenses.

Ineligible Health Care Expenses

There are certain kinds of "**Ineligible Health Care Expenses**" that do ***not*** qualify for reimbursement. These include:

- expenses paid on behalf of an individual who is not a Qualified Dependent;

- expenses that are payable under any other insurance plan or group health plan (including one sponsored by the Employer) or that were paid under another employer's health care spending account program (at the Claims Administrator's request, you are obligated to supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments);

- expenses for which you have received, or will receive, an itemized deduction on your federal tax return;

- expenses for premiums for insurance not provided by your employer (for example, premiums paid for your Spouse's insurance);

- expenses for over-the-counter drugs or medications for which you do not have a written prescription;
- expenses in excess of the annualized elected amount;
- expenses Incurred during a time you were not covered by the Health Care FSA Program;
- expenses Incurred after the end of the Plan Year, unless they were Incurred during the Grace Period, if applicable;
- expenses for which you have not provided satisfactory proof of payment; and
- expenses claimed later than the number of days listed in the Employer-Specific Information Section for filing claims following the end of a Plan Year, or applicable Grace Period.

Any reimbursement paid for an Ineligible Expense under the Health Care FSA Program will be subject to income taxes as applicable.

Special Eligible Expense Rule for Qualified Reservist Distributions

Notwithstanding the regular rules for amounts credited to an Employee's Health Care Account, the Plan will permit Qualified Reservist Distributions. Qualified Reservist Distributions are an exception to the rule that the amounts credited to an Employee's Health Care Account may not be distributed other than for reimbursements of substantiated Eligible Health Care Expenses.

A "**Qualified Reservist Distribution**" is a distribution to an Employee of all or a portion of the balance in the Employee's Health Care Account if:

- the employee is a member of a Reserve Component who is ordered or called to active duty for a period of 180 calendar days or more or for an indefinite period, regardless of the period of active duty that is actually served by the employee under such order or call; and
- the employee requests the distribution during the period beginning with the order or call to active duty and ending on the last day of the Plan Year, or applicable Grace Period, that includes the date of the order or call to active duty.

If the period specified in the order or call is less than 180 calendar days, a Qualified Reservist Distribution is not available; however, subsequent calls or orders that increase the total period of active duty to 180 calendar days or more will qualify the employee for a Qualified Reservist Distribution.

A "**Reserve Component**" of the armed forces of the United States includes: the Army or Air National Guard of the United States; the Army, Navy, Marine Corps, Air Force, or Coast Guard Reserve of the United States; or the Reserve Corps of the Public Health Service of the United States.

The amount available as a Qualified Reservist Distribution will be the entire amount of the balance remaining in the employee's Health Care Account as of the date of the Qualified Reservist Distribution request, minus all claims for reimbursement from the employee's Health Care Account that have been received as of the date of the request for the Qualified Reservist Distribution, but not yet distributed, if any.

Remember -- you still have the right to submit claims for Eligible Expenses incurred before the date you request a Qualified Reservist Distribution, and those substantiated claims will be reimbursed.

You will not be able to submit a claim for reimbursement for Eligible Health Care Expenses that are Incurred after the date you request a Qualified Reservist Distribution. In other words, your Qualified Reservist Distribution stops your participation in the Health Care FSA Program for the remainder of the Plan Year.

If you are eligible for a Qualified Reservist Distribution, you may request such a distribution as follows:

- Provide the Claims Administrator with a copy of your order or call to active duty and indicate in writing that you want a Qualified Reservist Distribution of your Health Care Account balance. You must make this request by the last day of the Plan Year, or applicable Grace Period, in which you received the order or call to active duty.

- The Claims Administrator will then determine the balance of your Health Care Account and issue you a check for that balance no later than 60 calendar days after the date you made your Qualified Reservist Distribution request.

If you take a Qualified Reservist Distribution, the distribution amount will be included in your gross income and wages for the tax year of the distribution. This means the distribution amount will be reported as taxable pay on your Form W-2 for that year. The amount reported as taxable pay, however, will be reduced by any amount in your Health Care Account that represents after-tax contributions you may have made for COBRA Continuation Coverage.

Qualified Reservist Distributions are uniformly available to all Participants, and amounts distributed as Qualified Reservist Distributions will be disregarded for purposes of assessing the Plan's compliance with the nondiscrimination rules under IRC § 125.

Example of How the Health Care FSA Program Saves on Taxes

You earn $30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Health Care Expenses will be $1,500. So, you choose to contribute $1,500 to your Health Care FSA. Your tax savings will be:

	Using Health Care FSA Program	**Not Using Health Care FSA Program**
Your Gross Pay	$30,000	$30,000
Your Pre-tax Health Care Expenses	1,500	N/A
Your Taxable Income	28,500	30,000
Your Income Taxes (25%)	7,125	7,500
Your Post-tax Health Care Expenses	0	1,500
Your Net Take Home Pay	$21,375	$21,000
Your Tax Savings	**$375**	N/A

Federal Itemized Deduction

You are not entitled to receive both a federal itemized deduction for medical expenses and a reimbursement under the Health Care FSA Program for the same expense. Before enrolling in the Health Care FSA Program, you should determine whether reimbursement of Eligible Health Care Expenses under the Health Care FSA Program is more advantageous than the federal itemized deduction. For those employees whose Eligible Health Care Expenses never exceed 7.5% of their adjusted gross income, reimbursement under the Health Care FSA Program will likely be more advantageous.

Expenses Eligible under More Than One Health Care Spending Account Program

If a health care benefit is payable under two or more health care spending account programs, you may submit a Claim for the expense to either program, but this Health Care FSA Program will not pay an expense paid by another program. At the Claims Administrator's request, you are obligated to supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments.

Forfeiture of Amounts Remaining at the End of the Plan Year

Because of Code requirements, if you do not use the total amount in your Health Care Account for reimbursement of Eligible Health Care Expenses Incurred during a Plan Year or its Grace Period and your Employer has not elected the Carryover Provision, the amount remaining will be forfeited on the number of days following the end of the Plan Year that are designated in the Employer-Specific Information Section. Forfeited amounts may be: (i) used to pay the administration expenses of the Health Care FSA Program, (ii) returned to employees on a reasonable and uniform basis, or (iii) retained by the employer.

Termination of the Health Care FSA Program

In the event the Health Care FSA Program is terminated, any amounts in your Health Care Account will remain available for reimbursement of expenses Incurred during the Plan Year while the Health Care FSA Program was in effect until 90 calendar days after the date of termination of the Health Care FSA Program.

Participation during an Unpaid Leave of Absence

If you take an unpaid leave of absence that qualifies under the FMLA, you have the following options under the Health Care FSA Program:

- Revoke your coverage under the Health Care FSA Program and discontinue making contributions to your Health Care Account. You are not entitled to receive reimbursements for Claims Incurred during the period your Health Care FSA Program coverage is terminated. Upon your return from your leave during the same Plan Year, you resume participation in the Health Care FSA Program and your Health Care Account is reinstated. When you begin again to participate in the Health Care FSA Program, you may either:

    - resume coverage at the level in effect before your leave started and increase your before-tax salary reductions for the remaining portion of the Plan Year to make up the unpaid before-tax contributions; or

- resume coverage under the Health Care FSA Program at a reduced level (the level of coverage is pro-rated for the period during which no contributions were made) and keep your Benefit Contributions at the same level in effect before your leave.

In both cases, the coverage level is reduced by prior reimbursements.

- Continue your coverage under the Health Care FSA Program during your leave, but discontinue contributions. The full annualized value of the amount you have elected to contribute to the Health Care FSA Program, less any prior reimbursements, will be available to reimburse you for Eligible Health Care Expenses Incurred during your leave. Upon your return from leave, your pre-tax Benefit Contributions automatically will resume and be increased for the remaining portion of the Plan Year to catch-up on the contributions missed during your leave.

- Continue your coverage under the Health Care FSA Program during your leave and make contributions on an after-tax basis. The full annualized value of the amount you have elected to contribute to the Health Care FSA Program, less any prior reimbursements, will be available to reimburse you for Eligible Health Care Expenses Incurred during your leave. Upon your return from your leave, your pre-tax Benefit Contributions will resume at the same level as was in effect before your leave started.

If you take an unpaid leave of absence that does not qualify under the FMLA, coverage under the Health Care FSA Program will end as of the last day of the calendar month during which your leave began. You are not entitled to receive reimbursement for Claims Incurred during your leave. Upon your return to work, you may resume your participation in the Health Care FSA Program and make a new Benefit Contribution election in accordance with the Plan enrollment and Change Event rules.

You should contact the Employer's office or department designated in the Employer-Specific Information Section for this purpose before taking a leave of absence.

Limited Purpose Health Care FSA (If Established by Your Employer)

If your only medical coverage is under an HDHP, you are an Eligible Individual, and if you have established an HSA, then the health care expenses which you will be eligible to have reimbursed from your Health Care Account will be limited to IRC §213(d)(1)(A) and (B) medical expenses that are for your vision are, dental care and/or preventive care. Items listed as Eligible Health Care Expenses under the sub-section with that title under this SPD that do not come within those limited categories are not Eligible Health Care Expenses under this Limited Purpose Health Care FSA. If you are reimbursed for health care expenses that are not within this limitation, you will not be an Eligible Individual able to obtain the tax benefits of having an HSA.

FOR ALL BENEFIT PROGRAMS

An expense is "**Incurred**" on the date the service that gives rise to the expense takes place.

IMPORTANT INFORMATION ABOUT THE PLAN

CLAIM FILING AND REVIEW PROCEDURES

Whenever you wish to receive benefits under the Plan, you must file a Claim for benefits with the Plan. Only those Claims that are for covered benefits under the Plan will be paid to you or a health care provider on your behalf. A "**Claim**" is any request for a Plan benefit made by a claimant in accordance with the Plan's reasonable procedures for filing benefit Claims, or an allegation by a claimant that the Plan Administrator or the Employer has violated the Code. If your Claim is denied, you have a right to an appeal of that denial by the Claims Administrator. The Plan's procedures for filing a Claim and for requesting an appeal of a denied Claim are explained below and may differ depending on the kind of Claim that is filed.

Time limits apply to you for filing a Claim, providing more information to complete a Claim, and appealing a denied Claim. The Claims Administrator also must comply with time limits for notifying you of an improper or incomplete Claim, deciding your initial Claim, and reviewing your appeal of denied Claim. At the end of this section, a Claim Procedures Time Limits Chart lists all these time limits.

For purposes of these Claim filing and appeal procedures, the entity or individual that is responsible for determining your Claim under a particular Benefit Program is always referred to as the "**Claims Administrator**." This reference applies to the Plan Administrator or a third party hired by the Plan Administrator for the Self-funded Benefit Programs. Refer to the Benefit Program Information Chart for the Claims Administrator for each Benefit Program. The Claims Administrator who reviews a denied Claim may be different than the Claims Administrator who reviews the initial Claim.

To be properly payable all benefit Claims must be substantiated by information from a third-party that is independent of you, your Spouse or your dependents. This information must include, (i) a description of the service, treatment, supply or product, (ii) the date on which you received or underwent the service, treatment, procedure or supply, or the date on which you purchased the product, and (iii) the amount for charged. No Claim will be paid or reimbursed prior to the date on which the expense was Incurred.

General Procedures for All Benefit Programs

Authorized Representatives

You may appoint an authorized representative to deal with the Plan on your behalf with respect to any benefit Claim that you file or any appeal of a denied Claim that you choose to pursue. The Employer's office or department designated in the Employer-Specific Information Section for this purpose and the Claims Administrator have forms that you may fill out at any time, identifying for the Plan the person you wish to appoint as your authorized representative. The Plan will only recognize the person you have authorized on the last dated form you filed with the Plan. For the Health Care FSA Program, your health care provider with knowledge of your condition will also be treated as your authorized representative. Once you have appointed an authorized representative, the Claims Administrator will communicate directly with your representative, and will not also inform you of the status or outcome of your Claim; you will have to seek that information from your representative. If you have not appointed a

representative, the Claims Administrator will communicate with you directly. Claims may be filed and an appeal of any denied Claim may be sought by any employee participating in the Plan, any Covered Dependent, or any properly authorized representative.

Notice of Initial Claim Denial

If your initial Claim under any Benefit Program is denied in whole or in part, the Claims Administrator will provide to you in writing or electronically (for example, by e-mail) an explanatory notice ("**Notice of Initial Claim Denial**"). Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, is a Claim denial. This includes any determination based on the eligibility of the person on whose behalf the expense was Incurred or whether the expense itself is eligible for reimbursement. Any Notice of Initial Claim Denial must:

- inform you of the specific reasons(s) for the denial of your initial Claim;
- inform you of the pertinent Plan provisions on which the denial is based;
- provide an explanation of the Plan's appeal procedures, including applicable time limits; and
- contain a description of any additional materials necessary to perfect your Claim, and an explanation of why this material is necessary.

Notice of Denial on Appeal

If you appeal the initial denial of your Claim, and your Claim is denied in whole or in part on appeal, the Claims Administrator will provide to you in writing or electronically (for example, by e-mail) an explanatory notice ("**Notice of Denial on Appeal**"). Any Notice of Denial on Appeal must:

- inform you of the specific reasons(s) for the denial; and
- inform you of the pertinent Plan provision(s) on which the denial is based.

The decision of the Claims Administrator following the decision on appeal is final and binding.

Claims for Premium-Only Plan, Cash in Lieu of Benefits, HSA Contribution and Dependent Care FSA Programs

Filing a Claim

<u>*Premium-Only Plan and Cash in Lieu of Benefits Programs*</u>

For the Premium-Only Plan, Cash in Lieu of Benefits and HSA Contribution Programs, you do not need to file a specific Claim for benefits. Once you enroll in the Programs, the benefits automatically follow. If for any reason, however, you believe you have been improperly excluded from participation in the Premium-Only Plan, Cash in Lieu of Benefits and HSA Contribution Programs or if you believe your compensation does not accurately reflect the elections you made under these Programs, you may file a formal Claim in writing to the Claims Administrator. Be sure to state:

- why you think you should receive the benefits available under the Premium-Only Plan, Cash in Lieu of Benefits and HSA Contribution Programs,

- why you think you have not been getting the benefits, and
- your name and Social Security number.

Notice of the decision on your Claim under the Premium-Only Plan, Cash in Lieu of Benefits and HSA Contribution Programs will be issued within a reasonable time period, but no later than the time periods specified in the Claims Procedures Time Limits Chart.

Dependent Care FSA Program

You must file a proper Claim to receive reimbursement of Eligible Dependent Care Expenses under the Dependent Care FSA Program. Claims for reimbursement must be submitted on Claim forms available from the Employer's office or department designated in the Employer-Specific Information Section for this purpose. You can file a Claim at any time during the Plan Year, or up to the number of days following the end of the Plan Year or applicable Grace Period as explained in the Employer-Specific Information Section.

If you submit a proper Claim, the Claims Administrator will reimburse you out of your Dependent Care Account for Eligible Dependent Care Expenses. All Claims must meet each of the requirements described in the Dependent Care FSA Program section of this Plan and each of the following additional important requirements.

- The Claim must be for a paid expense that was Incurred during the Plan Year, or during the applicable Grace Period, if any;
- The Claim must be submitted before the end of the Claim submission period set forth in the Employer-Specific Information Section;
- The Claim must be made on a form available from the Claims Administrator listed in the Benefit Program Information Chart, and must include:
  - the amount, date, and nature of the expense;
  - the name, address, and the federal taxpayer identification number or employer identification number of the person, organization, or entity to which the expense was or is to be paid;
  - the name of the person for whom the expense was Incurred, and the relationship of that person to you;
  - the amount recovered or recoverable from any other source with respect to the expense; and
  - written evidence from an independent third party stating that the expense has been Incurred, the amount of the expense (for example, bills, invoices, receipts, or other writings showing the amount of the expense).

If you discontinue participation in the Dependent Care FSA Program during the Plan Year, dependent care expenses Incurred after discontinuation in the Program will *not* be eligible for reimbursement, regardless of whether funds remain in your Dependent Care Account. If you

terminate your employment with the Employer before the end of the Plan Year for which you have established a Dependent Care Account, any amounts remaining in your Account will remain available for reimbursement of Eligible Dependent Care Expenses Incurred while you were a Participant in the Dependent Care FSA Program for the number of days following your date of termination designated in the Employer-Specific Information Section.

The Claims Administrator will review all Dependent Care FSA Program Claims that are submitted and reserves the right to deny ineligible or improperly documented expenses and require additional verification of expenses. Deliberate submission of ineligible expenses may result in your removal from the Dependent Care FSA Program.

Decision on Your Initial Claim

Notice of the decision on your Claim will be issued within a reasonable time period, but no later than the time periods specified in the Claims Procedures Time Limits Chart.

Claim Review Procedures

If your Claim for benefits under the Premium-Only Plan, Cash in Lieu of Benefits, HSA Contribution and Dependent Care FSA Programs is denied, in whole or in part, and you disagree with this decision, you must make a written appeal to the Benefit Program's Claims Administrator for a review of the denial of your Claim. Your appeal must be submitted to the Claims Administrator at the address listed in the Benefit Program Information Chart.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your appeal to the Claims Administrator. You may also request an opportunity to have a meeting to present your case to the Claim Administrator. You may elect to be represented by counsel at this meeting.

The review on your appeal will take into account all comments, documents, records, and other information submitted by you relating to your appeal, even if that information was not submitted or considered in the initial decision of your Claim. The Claims Administrator will make its decision on your appeal within a reasonable time, but no later than the time periods indicated in the Claims Procedures Time Limits Chart.

Dependent Care FSA Claims will generally be payable on a monthly basis, unless there is an issue involving the Claim that would trigger the review process. Small claims may be cumulated until they reach a modest and reasonable threshold amount of $100, and then all the small claims will be paid together in that month.

Claims for the Health Care FSA Program

Filing a Claim

You must file a proper Claim to receive reimbursement of Eligible Health Care Expenses under the Health Care FSA Program. A paper Claim that is not made through a debit card must be submitted on the Claim forms available from the Claim Administrator listed in the Benefit Program Information Chart. You can file a Claim at any time during the Plan Year, or up to the number of days following the end of the Plan Year, or applicable Grace Period, set forth in the Employer-Specific Information Section.

If you submit a proper Claim, the Claims Administrator will reimburse you out of your Health Care Account for Eligible Health Care Expenses. All Claims, whether through a debit card or on paper, must meet each of the requirements described in the Health Care FSA Program section of this Plan and must be for an expense that was Incurred during the Plan Year, or during the Grace Period, if applicable.

If you discontinue participation in the Health Care FSA Program during the Plan Year, and you subsequently Incur additional expenses, then these new Claims will *not* be eligible for reimbursement, regardless of whether or not funds remain in your Health Care Account. If you terminate your employment with the Employer before the end of the Plan Year for which you have established a Health Care Account, any amounts remaining in your Health Care Account will remain available for reimbursement of Claims Incurred while you were a Participant until the number of days following your termination date designated in the Employer-Specific Information Section.

The Claims Administrator will review all Claims submitted and reserves the right to deny ineligible or improperly documented expenses and require additional verification of expenses. Deliberate submission of ineligible Claims may result in your removal from the Health Care FSA Program.

Decision on Your Initial Claim

Notice of the decision on your Claim will be issued within a reasonable time period, but no later than the time period specified in the Claims Procedures Time Limits Chart.

Claim Review Procedures

If your initial Claim for benefits is denied and you disagree with this decision, you must make an appeal to the Claims Administrator for a review of that decision.

Your appeal must be in writing, and transmitted either by mail or any reasonably available electronic media to the Claims Administrator listed in the Benefit Program Information Chart. Your appeal must include an explanation of why you think your Claim should not have been denied. You must include any additional information, materials or documentation that you believe supports your Claim.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your appeal to the Claims Administrator. You may also request an opportunity to have a meeting to present your case to the Claim Administrator. You may elect to be represented by counsel at this meeting.

The Health Care FSA Program has only one level of appeal. The Claims Administrator will make its decision on your appeal within a reasonable time, but no later than the time periods indicated in the Claims Procedures Time Limits Chart. There are no time extensions permitted for making appeal decisions.

Health Care FSA Claims will generally be payable on a monthly basis, unless this is an issue involving a Claim that would trigger the review process. Small Claims may be cumulated until they reach a modest and reasonable threshold amount of $100, and then all the small claims will be paid together in that month.

Claims Procedure Time Limits

Time Limits for the Health Care FSA Program

Claims Administrator's Notice of Initial Claim Denial	**30 days** after receiving the initial Claim. **45 days** after receiving the Claim if the Claims Administrator needs more information and if Claims Administrator provides an extension notice during initial 30-day period.
Participant Deadline to Appeal Decision	**180 days** after receiving the Claim denial.
Claims Administrator's Notice of Appeal Decision	**60** days after receiving the request for appeal. **30 days** after receiving the request for appeal if Claims Administrator requires two levels of appeal. No extension for decisions on appeal.

Time Limits for the Premium-Only Plan, Cash in Lieu of Benefits, HSA Contribution and Dependent Care FSA Programs

Claims Administrator's Notice of Initial Claim Denial	**90 days** after receiving the initial Claim. **60 days** after receiving the Claim if the Claims Administrator needs extension for special circumstances and if Claims Administrator provides an extension notice during initial 90-day period.
Participant Deadline to Appeal Decision	**60 days** after receiving the Claim denial.
Claims Administrator's Notice of Appeal Decision	**60** days after receiving the request for appeal. **120 days** after receiving the request for appeal if Claims Administrator needs an extension (*e.g.*, because of the need to hold a hearing).

SPECIAL RULES FOR THE HEALTH CARE FSA PROGRAM

Facility of Payment

If an expense or benefit that should have been paid by the Plan is paid by another person or entity, the Plan may pay to that person or entity any amount that it considers necessary to satisfy the intent of the Plan's coordination provisions. The Plan will then have no further liability for those expenses or benefits.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("**COBRA**") gives you and your Covered Dependents the right to continue coverage under the Health Care FSA Program beyond the time the coverage would normally end ("**Continuation Coverage**"), under certain circumstances. COBRA Continuation Coverage can become available to you and your Covered Dependents when you or they would otherwise lose group health coverage. This section generally explains COBRA Continuation Coverage, when it may become available to you and your Covered Dependents, and what you need to protect your right to receive it, but since the only Benefit Program available to you is the Health Care FSA Program, your rights to COBRA are limited to those described in the Section entitled "Special Rule for the Health Care FSA Program."

Continuation Coverage is the same coverage that you and your dependents were entitled to under the Plan, and should you elect Continuation Coverage, will be the same coverage available to other participants or beneficiaries who are not receiving Continuation Coverage. Upon the occurrence of one of the Qualifying Events listed below, you will have the opportunity

to continue the coverage you had under the Plan(s) immediately prior to the occurrence of the event. Each person who is qualified and who elects Continuation Coverage will have the same rights under the Plan as other participants and beneficiaries, with respect to whom none of these events occurred, including open and special enrollment rights.

COBRA Continuation Coverage for the Plan is administered by the Plan Administrator, whose address and phone number can be found in the Employer-Specific Information Section.

Qualifying Events

COBRA Continuation Coverage is a continuation of coverage under the Health Care FSA Program when coverage would otherwise end on account of a life event known as a "**Qualifying Event**." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a Qualified Beneficiary. A "**Qualified Beneficiary**" is someone who will lose coverage under the Plan because of a Qualifying Event.

You will become a Qualified Beneficiary if you will lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of work are reduced or you move to a position with the Employer where you are not eligible to participate in the Plan.
- Your employment ends for any reason other than your gross misconduct.

Your Spouse will become a Qualified Beneficiary if coverage is lost because any one or more of the following Qualifying Events happens:

- You die.
- You are divorced or legally separated from your Spouse.
- Your hours of work are reduced or you move to a position with the Employer where you are not eligible to participate in the Plan.
- Your employment ends for any reason other than your gross misconduct.
- You become entitled to Medicare benefits (under Part A, Part B, or both).

Your Covered Dependent Child will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

- You die.
- You are divorced or legally separated from your Spouse.
- Your hours of work are reduced or you move to a position with the Employer where you are not eligible to participate in the Plan.
- Your employment ends for any reason other than your gross misconduct.
- You become entitled to Medicare benefits (under Part A, Part B, or both).

- Your Child stops being eligible for coverage under the Plan as a dependent Child.

Notice of Qualifying Event Required

The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the reduction of your hours or end of your employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

For the other Qualifying Events (your divorce or legal separation, or your Child's losing eligibility for coverage as a dependent Child), you must notify the Plan Administrator within 60 calendar days after the Qualifying Event occurs. You must provide written notice of the Qualifying Event to the Plan Administrator. Your notice must include: the name of the employee or former employee who is or was a Plan Participant, a description of the Qualifying Event, the date of the Qualifying Event, any documents or materials relevant to the Qualifying Event, and the name(s), address(es), and Social Security number(s) of the Covered Dependent(s) affected by the Qualifying Event. Failure to notify the Plan Administrator in a timely manner will mean that neither you nor your Covered Dependents will be able to elect COBRA Continuation Coverage for these Qualifying Events.

Electing COBRA Continuation Coverage

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. To elect Continuation Coverage, you must complete the election form and send it in according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, your Spouse may elect coverage even if you do not. COBRA Continuation Coverage may be elected for only one, several, or for all dependent Children who are Qualified Beneficiaries. A parent may elect or reject Continuation Coverage for any minor Children. You and your Spouse may elect Continuation Coverage for each other, but cannot reject coverage for the other person. After you have submitted your election forms, if it is determined that you or a Covered Dependent is not entitled to Continuation Coverage, you will be provided with a written explanation of why the election of Continuation Coverage could not be honored.

In considering whether to elect COBRA Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, other group health plans can apply pre-existing conditions exclusions to you if you have more than a 63-day gap in health coverage; election of COBRA Continuation Coverage may help you avoid a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies without pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another Group Health Plan for which you are otherwise eligible, such as a plan sponsored by your Spouse's employer, on or before the 30th calendar day after your group health plan coverage ends because of the Qualifying Events listed above. You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you elect COBRA Continuation Coverage for the maximum time available to you.

Cost of COBRA Continuation Coverage

Generally, each Qualified Beneficiary must pay the entire cost of COBRA Continuation Coverage. The cost cannot exceed 102% (or in the case of an extension due to a disability, 150%) of the cost to the Plan for coverage of a similarly-situated Plan Participant and/or beneficiary who is not receiving COBRA Continuation Coverage. The cost for a similarly-situated Plan Participant or beneficiary includes both the employer and employee contributions for coverage. The required payment for each COBRA Continuation period for each option will be described in the notice sent to you.

Paying for COBRA Continuation Coverage

First Payment for COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment with the election form. You must, however, make your first payment no later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) If you miss this first payment date, you will lose all COBRA Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your payment.

Periodic Payments for COBRA Continuation Coverage

After your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent coverage period. Each monthly payment for COBRA Continuation Coverage is due on the dates stated in the COBRA election forms sent to you. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace Periods for Monthly Payments

Although monthly payments are due on the dates stated in the COBRA election forms, you will be given a grace period of 30 days after the first day of each coverage period to make each periodic payment. Your COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan retroactive to the date payment was due. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and either the amount paid will be deemed payment in full for that period or you will be asked to pay the shortfall. If the notice says the shortfall must be paid and you do not pay within 30 days after the date the notice is received, COBRA Continuation Coverage will end retroactive to the date the shortfall payment was due.

Duration of Coverage

COBRA Continuation Coverage for you and/or your Covered Dependents may continue:

- for 18 months when the Qualifying Event is the end of your employment or reduction in your hours of employment;
- 29 months when the Qualifying Event is your end of employment or reduction of your work hours and you or a Covered Dependent qualify for a disability extension (refer to "Disability" below) during the 18-month COBRA Continuation Coverage period;

- for your Covered Dependents for 36 months when the Qualifying Event is your divorce or legal separation, your death, your enrollment in Medicare (Part A or Part B) or a Child's loss of Eligible Dependent status; or

- for your Covered Dependents, when the Qualifying Event is your end of employment or reduction in your work hours, and you enrolled in Medicare fewer than 18 months before the Qualifying Event, for 36 months after the date you enrolled in Medicare. For example, if you enrolled in Medicare eight months before you terminated employment, Continuation Coverage for your Covered Dependents could last up to 36 months from the date you enrolled in Medicare, which is 28 months after the date of the Qualifying Event.

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

- any required premium payment was due but not timely paid;

- after electing COBRA Continuation Coverage, a Qualified Beneficiary:

  - becomes covered under another employer's group health plan that does not impose any pre-existing condition exclusion for a Qualified Beneficiary's pre-existing condition; or

  - becomes enrolled in Medicare benefits, under Part A or Part B, or both; or

- the Employer ceases to provide any group health plan for its employees.

COBRA Continuation Coverage also may be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Continuation Coverage, such as fraud. If your period of COBRA Continuation Coverage is terminated for any reason before the end of your maximum period, you will be notified of the termination and provided with an explanation of why it was terminated.

At the end of the 18-month or 36-month COBRA Continuation Coverage period, you must be allowed to enroll for individual conversion coverage, but only if this opportunity is provided under the specific Benefit Program for which you elected COBRA Continuation Coverage.

Extending the Length of COBRA Continuation Coverage

There are two ways in which a COBRA Continuation Coverage period of less than 36 months may be extended: if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Plan Administrator in writing of a disability or second Qualifying Event in order to extend the period of COBRA Continuation Coverage. Your failure to provide notice of a disability or second Qualifying Event may affect the right to extend the period of COBRA Continuation Coverage.

Disability

If you or any Covered Dependent is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th

calendar day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage.

You or a Covered Dependent must notify the Plan Administrator in writing on or before the 60th calendar day after the latest of: (a) the date of the Social Security Administration's disability determination, (b) the date on which the employment-related Qualifying Event occurred, or (c) the date on which the Qualified Beneficiary lost Plan coverage as a result of the Qualifying Event. This disability notice must include the name of the disabled person, the effective date of the Social Security Administration's disability determination, and any other relevant documentation.

Each Qualified Beneficiary who has elected COBRA Continuation Coverage on account of your employment-related Qualifying Event will be entitled to the 11-month disability extension as long as one of them qualifies for it. If the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact in writing on or before the 30th calendar day following the Social Security Administration's determination. Coverage due to your initial employment-related Qualifying Event, or any subsequent Qualifying Event, may still be available if the maximum period for that COBRA Continuation Coverage has not expired as of the date a determination of "no longer disabled" is made.

Second Qualifying Event

If your Covered Dependents experience another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, your Covered Dependents can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the COBRA Administrator. This extension may be available to your Covered Dependents receiving COBRA Continuation Coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced or legally separated from your Spouse, or your dependent Child stops being eligible under the Plan as a dependent Child, but only if the event would have caused your Covered Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

You must notify the Plan Administrator within 60 calendar days after a second Qualifying Event occurs if you want to extend COBRA Continuation Coverage. Your notice must include: the name of the employee or former employee who is or was a Plan Participant; a description of the second Qualifying Event; and the name(s), address(es), and Social Security number(s) of the Covered Dependents involved in the second Qualifying Event. Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, *etc.*

Special Rule for Health Care FSA Program

The COBRA Continuation Coverage you may elect with respect to the Health Care FSA Program is different from the COBRA Continuation Coverage you may elect with respect to other COBRA-eligible Benefit Programs offered by the Employer.

First, COBRA Continuation Coverage for the Health Care FSA Program is only available until the end of the Plan Year in which the Qualifying Event occurs and may not be extended beyond that date.

Second, if you elect to receive COBRA Continuation Coverage under the Health Care FSA Program, you must pay the applicable premium, and the Employer is entitled to add a 2% administration charge. If you will not be receiving any compensation that can be reduced under the Health Care FSA Program, you will be paying 102% premium on an after-tax basis for only 100% coverage. Thus, even though COBRA Continuation Coverage is available, you must decide if it is a justifiable option for you based on its cost to you.

Third, the Plan does not have to offer you COBRA Continuation Coverage for the Health Care FSA Program if, at the time of the Qualifying Event, the contribution you must pay for this coverage exceeds the maximum coverage remaining available to you for the Plan Year under the Health Care FSA Program. For example, if you terminate employment in March after electing to contribute $1,800 to the Health Care FSA Program and you have already submitted Claims totaling $1,000, then your remaining coverage would be $800, but your cost to keep this coverage would be $1,377 ($1,800 X 102% = $1,836/12 = $153/month X the 9 months remaining in Plan Year). In this case, you would ***not*** be entitled to COBRA Continuation Coverage under the Health Care FSA Program.

Questions about COBRA Continuation Coverage

If you have questions concerning the Plan or your COBRA Continuation Coverage rights, you should contact the COBRA Administrator. For more information about your rights under ERISA (including COBRA), HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("**EBSA**") in your area or visit the EBSA website at *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan Informed of Any Changes of Address

In order to protect your family's rights to COBRA Continuation Coverage, you should keep the Plan Administrator informed of any changes in the addresses of family members.

HIPAA Privacy Rule

The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and the Standards for Privacy of Individually Identifiable Health Information (the "**Privacy Rule**") (available at *www.hhs.gov/ocr/hipaa/finalreg.html*) require health plans to protect the confidentiality of your Protected Health Information. The Privacy Rule applies to the Health Care FSA Program under the Plan. The Plan has also required its service providers that create, receive or maintain your Protected Health Information ("**Business Associates**") to agree to protect your Protected Health Information. The Plan may use and disclose your Protected Health Information as permitted or required by the Privacy Rule or when you authorize the use or disclosure. The Privacy Rule is summarized here and is more fully described in the Plan's Notice of Privacy Practices that was provided to you. Please contact the Plan Administrator or the Plan's Privacy Officer if you would like another copy.

"**Protected Health Information**" ("**PHI**") includes any information, whether oral or recorded, in any form or medium, that is created or received by the Plan that relates to your past, present, or future physical or mental health, including the provision of and payment for care, that identifies you or provides a reasonable basis for your identification. PHI does not include de-identified health information or health information that the Employer is entitled to under

applicable law (for example, the FMLA, Occupational Safety Health Act, the Americans with Disabilities Act, workers' compensation, and other state and federal laws), or health information that the Employer obtains through sources other than the Plan and retains as part of your employment records (for example, drug screening tests, fitness for duty examination results, or other similar information). This type of information is not subject to the Privacy Rule.

As part of its efforts to comply with the HIPAA Privacy Rule, the Plan has appointed a "**Privacy Officer**." The Privacy Officer is the person with whom you should lodge any complaints if you believe that the confidentiality of your PHI has been compromised in the course of administering your benefit Claims. The HIPAA Privacy Officer for the Plan is designated in the Employer-Specific Information Section:

Required Disclosures of PHI by the Plan

The Plan must disclose your PHI under the following three conditions:

- to you, with respect to your own PHI;
- to the Secretary of the Department of Health and Human Services to determine whether the Plan is in compliance with the Privacy Rule; and
- where required by law. This means that the Plan will make the disclosure only when the law requires it do so, but not if the law would just allow it to do so.

Permitted Uses and Disclosures of PHI by the Plan

The Plan may use or disclose your PHI as necessary for the operation of the Plan as described in this document and under the following conditions:

- for treatment purposes, when necessary;
- for payment and healthcare operations, as defined in the Privacy Rule;
- to Business Associates that enter into Business Associate agreements with the Employer;
- under certain circumstances expressly permitted by the Privacy Rule (see the Plan's Notice of Privacy Practices;
- to you about treatment alternatives or other health-related benefits or services that may be of interest to you; or
- with a proper authorization from you.

Even if a use or disclosure of PHI is permitted above, the Plan will comply with any special protections, under state or federal law, which are more protective of your privacy.

Disclosure of PHI by the Plan to the Employer

The Plan may disclose your PHI to the Employer to carry out Plan administrative functions because the Employer agrees to:

- make these disclosures only to the Plan's Workforce;

- not use or further disclose the information other than as permitted or required by this Plan as explained in this document or the Notice of Privacy Practices or as required by law;

- ensure that any agents, including a subcontractor to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Employer with respect to that information;

- not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer, except the Employer may make disclosures with respect to workers' compensation;

- report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures permitted under the Plan;

- make available to you your PHI that is maintained by the Plan and provide you with the right to obtain a copy of your PHI disclosed to and retained by the Employer;

- permit you to amend your PHI maintained by the Plan and incorporate these amendments as required by the Privacy Rule, as described in the following section titled "Your Rights Under HIPAA And The Privacy Rule;"

- permit you to have an accounting of the disclosures of your PHI made by the Plan as described in the following section titled "Your Rights Under HIPAA And The Privacy Rule";

- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance with the Privacy Rule;

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

- ensure that adequate separation between the Plan and the Employer is established as described below.

The Plan and the Employer will take steps to provide for the adequate separation between the Plan and the Employer. Only the employees of the Employer, identified as the "**Plan's Workforce**," as so designated in the Employer-Specific Information Section, will have access to your PHI.

The Plan's Workforce will receive PHI as needed, in the ordinary course of business, to carry out the payment, health care operation, or other functions necessary for the proper operation of the Plan. The Plan will restrict the access to, and use and disclosure of, your PHI by these employees to those administrative functions that the Employer performs for the Plan. The Plan may also disclose limited health information to the Plan's Workforce in connection with enrollment or disenrollment of individuals into or out of the Plan. The Employer will handle any complaint relating to non-compliance by addressing that issue with the employee. The

Employer will also provide a mechanism for resolving issues of noncompliance, including disciplinary action up to and including discharge.

To maintain the confidentiality of your PHI, you should only communicate with one of these individuals to inquire about any aspect of the Plan, a benefit Claim, your entitlement to coverage or any other matter regarding your health care benefits under the Plan, and the matter you wish to discuss requires that you share or communicate medical information about yourself.

If the PHI of any Plan Participant is acquired, accessed, used or disclosed in a manner that constitutes a "**Breach**" as defined in Division A, Title XIII – Health Information Technology, Division B, Title IV of the American Recovery and Reinvestment Act of 2009 (the "**HITECH Act**"), that person will be notified.

Your Rights under HIPAA and the Privacy Rule

You have certain rights, under HIPAA and the Privacy Rule, relating to your PHI maintained by the Plan. All requests to exercise your individual rights must be made in writing to the Privacy Officer. The Plan's insurers or HMO's keep their own records and you must make any requests relating to your PHI in those records directly to the insurer or HMO.

Your rights include:

- *Right to Notice*. You have the right to receive a copy of the Plan's Notice of Privacy Practices. Contact the Employer's office or department designated in the Employer-Specific Information Section for this purpose for a copy of the Notice.

- *Right to Access*. You have the right to access your PHI, so long as the information is retained in the Plan's medical, billing, and Claim adjudication (the "**Designated Record Set**"). The Plan may charge a reasonable fee for copying the information you request, and the cost of any mailing. The Plan may deny your request for access, and, in certain circumstances, that decision will not be subject to appeal; while, in other circumstances, you may seek an appeal of the Plan's denial. In either case, if your request is denied, the Plan will respond in writing, explaining its reasons for the denial, whether the reason is appealable, and the procedures for seeking appeal, if applicable. Any review will be conducted by someone designated by the Plan who was not involved in the original decision.

- *Right to an Accounting*. Within a single 12-month period, you may request one accounting of disclosures of your PHI made by the Plan at no charge. If you request more than one accounting within the same 12-month period, the Plan may charge you a reasonable fee. You will be informed in advance of the proposed fee and will have an opportunity to revise or withdraw your request in order to avoid or reduce the fee. The Plan is obligated to provide you with an accounting of any disclosures of your PHI made within the 6-year period immediately prior to the date of your request, except disclosures made:

  - for purposes of treatment, payment, or healthcare operations;

  - directly to you or close family members involved in your care;

  - for purposes of national security;

- incidentally (as defined in the Privacy Rule);
- as part of a limited data set (as defined in the Privacy Rule);
- to correctional institutions or law enforcement officials; and
- pursuant to your express authorization.

- *Right to Amend*. You may request that your PHI maintained in the Designated Record Set of the Plan be amended. When requesting an amendment, you are also required to state the reason why you believe that the existing information is in error and needs to be revised. The Plan need not agree to your request. If your request is granted, the Plan will inform you of what changes or corrections it is making and how that will be done. If your request is denied, the Plan will provide you with: (a) the reasons for the denial; (b) an explanation of your right to submit a statement of disagreement and directions about how to do that; (c) a statement that even if you do not choose to submit a statement of disagreement, you may ask that your request for an amendment and the Plan's denial be provided with any future disclosures of the PHI that was the subject of your request; and (d) a description of the Plan's complaint procedures, including the name, address, and phone number of the person with whom any complaint should be lodged. If you elect to submit a statement of disagreement, the Plan may submit a rebuttal statement in response. If the Plan chooses to submit a rebuttal statement, it will provide you with a copy.

- *Right to Request Restrictions*. You may also request that the Plan restrict its uses and disclosures of your PHI for purposes that would otherwise be permissible under HIPAA and the Privacy Rule. The Plan Administrator, or the appropriate Claims Administrator, need not agree to any restriction that you may request, but if it does agree to your request, the Plan will be bound to honor the restriction, until you indicate in writing that you are withdrawing the restriction, or the Plan or Claims Administrator informs you that it is withdrawing its consent to the restriction. The Plan's withdrawal of consent, however, will only apply to PHI created or received after you have been notified of the termination.

- *Right to Request Confidential Communications*. You may also request that the Plan communicate with you in a confidential manner, for example, by sending information to an alternate address. The Plan will accommodate any reasonable request, though it will require that any alternative used still allow for payment information to be effectively communicated and for payments to be made.

- *Right to File a Complaint*. If you believe your rights have been violated, you have a right to file a complaint with the Plan's Privacy Officer or with the Secretary of the United States' Department of Health and Human Services. If you have questions about the status of your PHI or what is being done to protect its confidentiality, or if you wish to file a complaint, contact the Privacy Officer.

HIPAA Security Rule

HIPAA and the Standards for Security of Electronic Protected Health Information (the "**Security Rule**") require health plans to protect the confidentiality, integrity, and availability of your Electronic PHI ("e**PHI**") that they create, receive, transmit, or maintain about you in the course of providing health care benefits. To ensure the security of your ePHI, the Employer will

comply with the Security Rule as set out below. The Plan has also required its Business Associates to agree to protect your ePHI.

ePHI includes any PHI that is transmitted or maintained in an electronic media. "**Electronic Media**" includes media used to store ePHI such as a hard drive in a computer, as well as media used to transmit your ePHI; for example, the Internet. The Security Rule does not cover ePHI that did not exist in electronic form before being electronically transmitted. For example, ePHI transmitted paper-to-paper, by fax, telephone, video conferencing, or through messages left on voice-mail, are not covered by the Security Rule. However, telephone voice response and fax-back systems are considered ePHI (and these are covered by the Security Rule) because they are used as input and output devices for computers.

Disclosures of ePHI Expressly Permitted by the Security Rule

The Security Rule permits the Plan to disclose your ePHI to the Employer as follows:

- de-identified health information to the Employer, if the Employer requests the information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan;
- de-identified health information to the Employer, if the Employer requests the information for the purpose of modifying, amending, or terminating the Plan;
- to the Employer when you authorize the disclosure; and
- to the Employer to determine your enrollment or eligibility status in the Plan.

Disclosures of ePHI by the Plan to the Employer

The Plan may disclose your ePHI to the Employer to carry out Plan administrative functions because the Employer agrees to:

- make these disclosures only to the Plan's Workforce;
- implement "**Policies and Procedures**" that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- make any documentation related to the Policies and Procedures available to the Secretary of the United States Department of Health and Human Services for the purpose of determining the Plan's compliance with the Security Rule;
- ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the ePHI;
- report to the Plan any "**Security Incident**" of which it becomes aware, including an attempted or successful unauthorized access, use, disclosure, modification, or destruction of ePHI; and
- ensure that adequate separation between the Plan and the Employer is established and described below.

The Plan and the Employer will take steps to provide for the adequate separation between the Plan and the Employer for purposes of exposure to ePHI. Only members of the Plan's Workforce will have access to your ePHI.

Genetic Information

The Plan will be operated to comply with the requirements of the Genetic Information Nondiscrimination Act of 2008 ("**GINA**"), and guidance issued pursuant to GINA that is applicable to the Plan.

General Rule as to Premium or Contribution Costs. The Plan, or any insurer providing coverage with respect to any Benefit Program, may not adjust premium or contribution amounts for individuals covered under the Plan on the basis of Genetic Information.

General Rule as to Coverage. The Plan will not require any individual, as a condition of enrollment or continued enrollment under the Plan, to pay a premium or contribution amount which is greater than such premium or contribution amount would be for a similarly situated individual enrolled in the Plan because of a health status-related factor of that individual or that individual's Covered Dependent.

Nevertheless, nothing in the preceding paragraphs will be construed to:

- restrict the amount that an insurer may charge the Employer for Plan coverage, except as limited by the "General Rule As To Premium or Contribution Costs" noted above; or

- restrict the Plan, or any insurer providing coverage with respect to the Plan, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Neither of these general rules will be construed to limit the ability of any insurer to increase the premium charged based on the manifestation of a disease or disorder of an individual covered under the Plan in line with its standard underwriting practices. The manifestation of a disease or disorder in one individual, however, cannot also be used as Genetic Information about any other Plan Participant or Covered Dependent, nor can it be used to further increase the premium charged based on the Genetic Information of other individuals covered under the Plan who have not manifested such disease or disorder.

Neither the Employer nor any Plan insurer may require any employee or Covered Dependent to undergo a Genetic Test. The Plan, or any Plan insurer, however, may request, but not require, that an individual covered under the Plan undergo a Genetic Test in connection with research so long as the request is consistent with Code § 9802(c)(4) – *i.e.*, the request is in writing and is consistent with any state, federal or local law or regulation for the protection of human subjects in research, the results of the test not be used for underwriting purposes, and that refusal to undergo the test will have no effect on the individual's enrollment status, or the amount of the premium or contribution the individual is required to pay.

Nothing in the preceding paragraph, however, prevents a health care professional who his providing health care services to an individual to request that such individual undergo a Genetic Test.

Notwithstanding the foregoing, nothing in this Section will be construed to preclude the Plan, or any Plan insurer, from obtaining and using the results of a Genetic Test in making a determination regarding payment; as defined in HIPAA; provided, however, that the Plan, or Plan insurer, may request only the minimum amount of information necessary to accomplish this purpose.

The Plan, or any Plan insurer, may not:

- request, require or purchase Genetic Information for underwriting purposes; nor
- request, require or purchase Genetic Information with respect to any individual's enrollment in the Plan or coverage in connection with such enrollment.

If the Plan, or any Plan insurer, obtains Genetic Information incidental to the requesting, requiring or purchasing of other information concerning any individual, such request, requirement or purchase shall not be considered to violate the second bullet point immediately above if such request, requirement or purchase is not utilized for underwriting purposes.

The term "**Genetic Information**" concerning an individual means information about (i) that individual's Genetic Tests, (ii) the Genetic Tests of that individual's Family Members, and (iii) the manifestation of a disease or disorder in Family Members of that individual, including, with respect to a pregnant female, the Genetic Information of any fetus carried by that individual, and, with respect to any individual utilizing an assisted reproductive technology, the Genetic Information of any embryo legally held by the individual, (iv) the request for or receipt of Genetic Services, and (v) participation in clinical research which includes Genetic Services by the individual or the individual's family members. Genetic Information does not include any information about the age or sex of any individual.

The term "**Genetic Test**" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations or chromosomal changes, but does not include an analysis of proteins or metabolites that either (i) does not detect genotypes, mutations or chromosomal changes, or (ii) is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by an appropriately trained health care professional with expertise in the field of medicine involved.

The term "**Genetic Services**" means a Genetic Test, genetic counseling or genetic education.

With respect to Genetic Information, the term "**Family Member**" means an employee's Covered Dependent, or a person who is eligible to be a Covered Dependent of that employee, and any other person who is a first, second, third or fourth-degree relative of that employee, that employee's Covered Dependent, or a person who is eligible to be a Covered Dependent of that employee.

PLAN ADMINISTRATION

Plan Administrator

The Employer is the Plan Administrator and has sole responsibility for the administration of the Plan. The Plan Administrator has full discretionary authority to: interpret the Plan; determine eligibility for and the amount of benefits; determine the status and rights of Participants,

beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms (including Enrollment Forms); to exercise all of the power and authority necessary to properly administer the Plan and to comply with the Internal Revenue Code of 1986, as amended (the "**Code**"); employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the Plan. The discretionary authority of the Plan Administrator extends to its factual determinations, as well as its construction of Plan terms and its determination of benefit entitlements. Where the Plan Administrator has designated a Claim Administrator for any Benefit Program under the Plan, that designation is intended to grant that Claims Administrator all of the discretionary authority of the Plan Administrator needed by the Claim Administrator to carry out its designated duties under the Plan.

Discretion

Wherever it is provided in the Plan that the Employer or Plan Administrator may perform or not perform any act, or permit or consent to any action, non-action, or procedure, or wherever they are given discretionary power or authority, they have exclusive discretion; provided, however, that they may not exercise their discretion so as to violate the Code or knowingly to discriminate either for or against any employee, Participant, or covered individual or any group of these persons.

OTHER IMPORTANT PROVISIONS

Plan Name

MESSA OptionALL Plan

Plan Year

See, the Employer-Specific Information Section

Plan Sponsor

See, the Employer-Specific Information Section

Type of Plan

The Plan is a cafeteria plan intended to satisfy the requirements of Section 125 of the Code.

Funding

The Employer pays the cost of the Benefit Programs, other than any amounts you are required to pay to participate in any of the Underlying Plans. The amount you are required to pay to participate in each of the Underlying Plans (other than deductible, copayment or co-insurance amounts) are your "**Benefit Contributions**." The maximum amount of employer contributions available to any employee are the total Benefit Contributions, plus the maximum amounts you may elect to contribute to the Health Care FSA and Dependent Care FSA Programs. You will be informed of the amount of any Benefit Contributions at your Initial Enrollment Period and each Open Enrollment Period.

The benefits provided under the Plan will be paid, to the extent permitted by the Code, from the general assets of the Employer. Nothing in this Plan will be construed to require the Employer to maintain any fund for its own contributions or segregate any amount that it is

obligated to contribute for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

Amendment or Termination of the Plan

The Employer, acting through its Board or other supervisory body, or a delegate, may amend or modify the terms of the Employer-Specific Information Section, or terminate its participation in the Plan at any time in any manner. With respect to the Plan itself, MESSA, acting through its Board, or its delegate, may amend, modify or terminate the Plan at any time and in any manner with respect to any individual in its sole discretion. Any amendment may be made retroactively effective to the extent not prohibited by the Code. If the Employer's participation ceases, or the Plan is terminated or partially terminated for any reason, the benefits to which you became entitled prior to the effective date for the Employer's cessation of participation or the Plan's termination will be covered. The Employer's ceasing to participate or the termination of the Plan will not reduce or eliminate your right to reduce your compensation earned before the date of termination.

Nondiscrimination Rules

For each calendar year, the nontaxable benefits under the Plan provided to key employees, as defined in Code Section 416(i), cannot exceed 25% of the aggregate nontaxable benefits provided to all Participants under the Plan as defined in Code Section 125(e)(2), as to eligibility to participate, or in favor of "highly compensated participants," as defined in Code Section 125(e)(1), as to contributions or benefits.

If the Employer determines at any time that the Plan may not satisfy any nondiscrimination rule in the Code, the Employer may take whatever action it deems appropriate to assure compliance with the rule. Any action will be taken uniformly with respect to similarly-situated Participants. The action may include, without limitation, the modification of your Enrollment Forms, with or without your consent. If your Plan benefits are affected, you will be notified of the action to be taken.

Compliance with Tax Law

The Plan is intended to comply with all applicable law, including Section 125 of the Code. It will be considered amended to the extent necessary to comply with Section 125. However, neither the Plan, the Plan Sponsor, nor any Claims Administrator represents or guarantees that this Plan in fact meets the requirements of any provision of the Code. Any other provision of this Plan notwithstanding, individuals who are not treated as employees for purposes of the tax treatment of any contribution to any Benefit Program are not eligible to participate in the Plan. The Plan cannot be operated so as to defer the receipt of compensation in a manner that violates Section 125.

Limitation of Rights

The Plan does not constitute a contract between you and the Employer. Nothing contained in the Plan gives you the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge you at any time, with or without cause, but subject to the terms of any applicable collective bargaining agreement, regardless of the effect that the discharge will have upon you as a Participant in the Plan (subject only to the provisions of any relevant collective bargaining agreement).

Overpayments

An "**Overpayment**" occurs if the Plan pays an amount not payable under the Plan, if the Plan pays an expense or benefit more than once, or if an expense or benefit is paid by both the Plan and a third party. In addition, an Overpayment occurs if amounts which you have elected to have withheld from your compensation on a pre-tax basis are under-withheld for whatever reason. An expense or benefit is considered paid if it is paid to you or to someone else (for example, a health care provider) on your or your Covered Dependent's behalf.

If an Overpayment is made by the Plan, the Plan has the right to recover the Overpayment. If that Overpayment is made to a health care provider, the Plan may request a refund of the Overpayment from either you or the provider. If the refund is not received from either you or the provider, the Overpayment will be deducted from future Plan benefits available to you or your Covered Dependents or from your wages, but the amounts withheld may not reduce your pay below the applicable state minimum wage law to the extent permitted by law. Any Overpayment you owe due to your or your Covered Dependent's ineligibility for Plan benefits will be offset by the amount of any Benefit Contributions you paid for coverage for the person while ineligible. Any Overpayment you owe due to amounts that have been under-withheld may be corrected by a comparable pre-tax over-withholding from your future compensation. If that possibility for recovery is foreclosed (*e.g.*, for example you have terminated employment), you will be asked to correct the Overpayment by making an after-tax payment of the under-withheld amount.

Entire Representation

This document, along with any summary, schedule of benefits, or Booklet describing any Benefit Program, together are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral).

Acceptance; Cooperation

If you accept benefits under this Plan, you are considered to have accepted its terms, and agree to perform any act and to execute any documents that may be necessary or desirable to carry out this Plan or any of its provisions.

Governing Law

The Plan is to be construed and enforced in accordance with the laws of the State of Michigan, to the extent not preempted by federal law.

Construction

Words used in the masculine apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural should be read as the singular, and the singular as the plural.

Non-Assignability of Rights

No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest will be void.

Errors

An error cannot give a benefit to you if you are not actually entitled to the benefit.

Severability

The enforceability of any provision of the Plan will not affect the enforceability of the remaining provisions of the Plan.

EMPLOYER-SPECIFIC INFORMATION SECTION

This Section is an essential part of the documentation for the Plan. The information in this Section provides employer-specific details that will govern how the Plan will be administered with respect to you and your family.

NAME, ADDRESS AND PHONE NUMBER OF THE EMPLOYER

Dexter Community Schools
Employer Name

2704 Baker Rd.
Street Address

Dexter, MI 48130
City, State and Zip Code

(734) 424-4100 (734) 424-4111
Phone Number Fax Number

CONTACT INFORMATION FOR ENROLLMENT FORMS, CHANGE EVENT FORMS, PARTICIPATION DURING LEAVES OF ABSENCE AND QUESTIONS ABOUT THE PLAN

Business / Payroll Office
Department or Office to Contact

(734)424-4100 ext 1014 (734) 424-4111
Phone Number Fax Number

PLAN YEAR

The Plan Year will begin on the first day of January [insert month] and end on the last day of December [insert month].

Short Plan Year [Complete only if there is a valid business reason].
The period from the first day of _______________ [insert month] through the last day of _______________ [insert month] will constitute a short Plan Year. Contribution amounts must be prorated based on the number of months in the short Plan Year.

BENEFIT PROGRAMS [check all that apply]

[X] HSA Contribution Program

[X] Premium-Only Plan Program (Premium Contribution)

[X] Cash in Lieu of Benefits Program

[X] Dependent Care FSA Program

[X] Health Care FSA Program

ELIGIBILITY INFORMATION

➢ **Employee Eligibility**

You are eligible to participate in the Plan (an "**Eligible Employee**") if you are [check all that apply]:

[X] a Full-time employee of the Employer

[X] a Full-time member of the Employer covered under a collective bargaining agreement

[X] a Part-time employee of the Employer

[X] a Part-time member of the Employer covered under a collective bargaining agreement

To be an eligible Full-time employee, you must be scheduled to work at least [check one]:

[ ] 30 hours per week

[ ] 35 hours per week

[ ] 40 hours per week

[X] Other <u>30 hours or subject to the Collective Bargaining Agreement</u>

To be an eligible Part-time employee, you must be scheduled to work at least [check one]:

[ ] 20 hours per week

[ ] 25 hours per week

[ ] 32 hours per week

[X] Other <u>20 hours or subject to the Collective Bargaining Agreement</u>

➢ **Waiting Period**

You are eligible to participate in the Plan as of the following [check one]:

[ ] your date of hire

[X] the first day of the month immediately following your date of hire

[ ] the date on which you complete [ ] 30, [ ] 60, or [ ] 90 calendar days [check one] as a Full-time or Part- time (if applicable) employee of the Employer

[ ] the first day of the month immediately following the date on which you complete [ ] 30, [ ] 60, or [ ] 90 calendar days [check one] as a Full-time or Part-time (if applicable) employee of the Employer

PLAN ENROLLMENT AND ELECTIONS

- **Failure to Timely Enroll** [check one]

  [ ] You will be deemed to have elected to receive your full compensation during the following Plan Year through the Employer's normal payroll system, and will not be able to participate in the Plan until the next Open Enrollment Period, unless you experience a Change Event.

  [X] If you are a Plan Participant who has filed Enrollment Forms in your Initial Enrollment Period or in a prior Open Enrollment Period but you do not update your Enrollment Forms to the Employer's office or department designated in this Employer-Specific Information Section for such purposes during a subsequent Open Enrollment Period, you will be deemed to have elected to receive the same Underlying Plan benefits during the upcoming Plan Year as were in effect during the current Plan Year and to make any required Benefit Contributions for those benefits. You will have been notified of your existing election choices with the Enrollment Forms and other materials provided to you prior to or during the Open Enrollment Period. Your participation in the HSA Contribution Program, Cash in Lieu of Benefits Program, Dependent Care FSA Program, and Health Care FSA Program, however, will end as of the last day of the Plan Year, if you do not affirmatively elect to make contributions during the Open Enrollment Period. After the last day of the Plan Year you may, however, still seek reimbursement of Eligible Dependent Care Expenses and/or Eligible Health Care Expenses Incurred during your period of participation up to the deadline for applying for reimbursement for the Plan Year.

- **Participation Upon Rehire or Return From a Leave of Absence**

  If, during the same Plan Year, you terminate employment and you return to employment within 30 days, or you are on an unpaid leave of absence of 30 days or less and then return to work, [check one]

  [X] your elections under the Plan before your termination of employment will be reinstated automatically and you will not have the opportunity to make a new election.

  [ ] you can immediately reenter the Plan and may make new benefit elections for the remainder of the Plan Year.

  If, during the same Plan Year, you terminate employment and you return to employment after 30 days, or you are on an unpaid leave of absence longer than 30 days and then return to work, [check one]

  [ ] you can immediately reenter the Plan and may make new benefit elections for the remainder of the Plan Year.

[X] you will be treated as a new hire.

NOTE: If you are rehired in a later Plan Year, you will be treated as a new hire.

- **Permitted Mid-Year Election Changes**

You may prospectively revoke an election of coverage under this Plan's Benefit Programs (not available for the Dependent Care FSA or the Health Care FSA Programs) provided the following conditions are met:

[X] Conditions for Revocation due to Reduction in Hours of Service

1. You were reasonably expected to average at least 30 hours of service per week but a change in your employment status occurred such that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in you ceasing to be eligible under the Plan; and
2. The revocation of the election of coverage under the Plan corresponds to your intended enrollment in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date coverage under this Plan was revoked.

[ ] Conditions for Revocation due to Enrollment in a Qualified Health Plan

1. You are eligible to enroll in a Qualified Health Plan through a Marketplace either for a Special Enrollment Period or during a Marketplace's annual open enrollment period; and
2. The revocation of the election of coverage under this Plan corresponds to your intended enrollment through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day that coverage under this Plan was revoked.

HSA CONTRIBUTION PROGRAM

- **Health Trustee/Custodian**

[X] HealthEquity, Inc. is the preferred trustee/custodian for the Plan, but employees can establish their HSA at a trustee/custodian of their choice. Establishing your HSA with a different trustee/custodian, however, may mean that your contributions cannot be made on a pre-tax basis through this OptionALL Plan.

- **Maximum Contribution Amount**

The maximum amount you may contribute to your HSA for the 2024 Plan Year is $ 4,150/8,300 (not to exceed $4,150 for single coverage or $8,300 for family coverage; an additional $1,000 may be contributed for a calendar year if you are 55 or older and are not yet entitled to Medicare).

- **Health Contributions**

[X] All HSA contributions under this OptionALL Plan will be made by salary reduction.

[ ] All HSA contributions under this OptionALL Plan will be made by direct employer contributions and not by salary reduction. The amount of the direct employer contribution will be $ ___________ per year, payable [ ] entirely as of the first payroll period of the Plan Year, [ ] semi-annually, [ ] quarterly, [ ] monthly, [ ] ratably over each payroll period [check the one that applies].

[ ] HSA contributions under this OptionALL Plan will be made by a combination of salary reduction and direct employer contributions. The amount of the direct employer contribution will be $ ___________ per year, payable [ ] entirely as of the first payroll period of the Plan Year, [ ] semi-annually, [ ] quarterly, [ ] monthly, [ ] ratably over each payroll period [check the one that applies].

PREMIUM-ONLY PLAN PROGRAM (Premium Contribution)

[X] Benefit contributions may be made by salary reductions in order to reduce your insurance premiums on a pre-tax basis. The amount by which the Employer will reduce compensation will be stated in the Enrollment Forms.

CASH IN LIEU OF BENEFITS PROGRAM

[X] You may waive medical coverage under your Employer's Underlying Plan and instead elect to receive cash payments. The amount of the annual cash payment you will be entitled to receive is <u>$1200 Full Time DEA and DAA and Individual Contract / $600 Part Time DEA and DAA.</u>

Application of Annual Cash Payment
[check all that apply]

[ ] The amount of annual cash payment may be applied toward your Benefit Contributions for the Underlying Plans, the Dependent Care FSA Program or the Health Care FSA Program on a pre-tax basis.

[X] The amount of annual cash payment will be made payable [ ] entirely as of the first payroll period of the Plan Year, [ ] semi-annually, [ ] quarterly, [ ] monthly, [X] ratably over each payroll period [check the one that applies].

DEPENDENT CARE FSA PROGRAM

- **Grace Periods**

  There [   ] will [X] will not [check one] be a two and one-half month Grace Period, ending on _____________.

- **Number of Days Following End of Plan Year or Grace Period to File Claim**

  Claims can be filed up to [   ] 30, [   ] 60, or [X] 90 calendar days [check one] following the end of the Plan Year or Grace period, if applicable, for Eligible Dependent Care Expenses Incurred during the Plan Year or applicable Grace Period.

- **Maximum Contribution Amount**

  The maximum amount you may contribute to your Dependent Care Account for the 2024 Plan Year is $ 5,000 (not to exceed $5,000 annually or $2,500 if married filing separately).

HEALTH CARE FSA PROGRAM

- **Health Care FSA Options**

  If there is no HDHP offered as an Underlying Plan, you are eligible to enroll in [check one]:

  [X] General Purpose FSA

  [   ] No Health Care FSA

  If an HDHP is one of the options offered as an Underlying Plan, you are eligible to enroll in [check one]:

  [   ] Limited Purpose FSA

  [X] General Purpose FSA if you are not enrolled in the HDHP

  [X] No Health Care FSA if you are enrolled in the HDHP

  If an HDHP is the only option offered as an Underlying Plan, you are eligible to enroll in [check one]:

  [   ] Limited Purpose FSA

[X] No Health Care FSA

- **Maximum Contribution Amount**

  The maximum amount you may contribute to your Health Care Account for the 2024 Plan Year is $___3,200___ (not to exceed $3,200 or the amount otherwise allowed by the IRS).

- **Grace Periods**

  There [ ] will [X] will not [check one] be a two and one-half month Grace Period.

- **Number of Days Following End of Plan Year or Grace Period in Which to File Claim**

  Claims can be filed up to [ ] 30, [ ] 60, or [X] 90 calendar days [check one] following the end of the Plan Year or Grace period, if applicable, for Eligible Health Care Expenses Incurred during the Plan Year or applicable Grace Period.

- **Carryover**

  [ ] An allowance of $__________ (not to exceed $550) of any unused funds remaining as of the end of the Plan Year or any applicable run-out period shall carryover to the immediately following Plan Year for payment or reimbursement of qualified medical expenses (select this option only if a Grace Period was not elected).

  If you have NOT elected to participate in the Health Care FSA for the upcoming Plan Year, unused carryover funds will be forfeited at the beginning of the Plan Year.

If an HDHP is offered or is anticipated to be offered as an Underlying Plan [check one]:

[ ] You may waive or decline the carryover of any unused amounts provided that written notice is given to the Claims Administrator at least [ ] 30, [ ] 60, or [ ] 90 calendar days [check one] prior to the end of the Plan Year (select this option if the Employer has not elected a Limited Purpose FSA).

[ ] You may transfer the carryover amounts from the General Purpose FSA to the Limited Purpose FSA provided that written notice is given to the Claims Administrator at least [ ] 30, [ ] 60, or [ ] 90 calendar days [check one] prior to the end of the Plan Year (select this option if the Employer has elected a Limited Purpose FSA but not a General Purpose FSA).

[ ] Carryover amounts from the General Purpose FSA will automatically transfer to the Limited Purpose FSA provided that no written objection is received by the Claims Administrator at least [ ] 30, [ ] 60, or [ ] 90 calendar days [check one] prior to the end of the Plan Year (select this option if the Employer has elected both a Limited Purpose FSA and a General Purpose FSA).

HIPAA Privacy Officer for the Health Care FSA Program:

Chief Financial Officer	Dexter Community Schools
Individual’s Title	Employer’s Name

2704 Baker Rd.
Street Address

Dexter, MI 48130
City, State and Zip Code

(734) 424-4107	(734) 424-4111
Phone Number	Fax Number

Health Care FSA Program Workforce

The following persons are designated as the Health Care FSA Program’s workforce, and may, therefore, have access to your PHI for purposes of administering the Program:

- The Privacy Officer
- Chief Financial Officer
  [List Individual’s Title]
- ______________________________
  [List Individual’s Title]
- ______________________________
  [List Individual’s Title – repeat as often as needed]
- Any members of the Employer’s Human Resource Department, Benefits Office, Accounting/Payroll Department, or other work unit whose job description includes Plan administration or claims adjudication.

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BENEFIT PROGRAM INFORMATION CHART

Benefit Program	Funding and Claim Type	Insurance Employer or Claims Administrator Contact Information
Premium-Only Plan Program		**Dexter Community Schools** www.dexterschools.org
Self-funded	Filing a Claim:	2704 Baker Rd. Dexter, MI 48130 (734) 424-4100 (Phone) (734) 424-4111 (Fax)
	Appeal of Denied Claim (only one level of appeal):	____________________________ ________________ [Name of Employer] ________________ [Street Address] _____________, MI 48___ ( ) ___-____ (Phone) ( ) ___-____ (Fax)
Dependent Care FSA Program		**MESSA** www.messa.org
Self-funded	Filing a Claim:	1475 Kendale Blvd. East Lansing, MI 48823 (800) 292-4910 (Toll Free) (517) 332-2581 (Local Phone) (517) 333-6258 (Fax)
	Appeal of Denied Claim (only one level of appeal):	MESSA c/o MESSA OptionALL Plan Administrator 1475 Kendale Blvd. East Lansing, MI 48823 (800) 292-4910 (Toll Free) (517) 332-2581 (Local Phone) (517) 333-6258 (Fax)

Benefit Program	Funding and Claim Type	Insurance Employer or Claims Administrator Contact Information
Health Care FSA Program **Self-funded**	 Filing a Claim: Appeal of Denied Claim (only one level of appeal):	**MESSA** www.messa.org 1475 Kendale Blvd. East Lansing, MI 48823 (800) 292-4910 (Toll Free) (517) 332-2581 (Local Phone) (517) 333-6258 (Fax) MESSA c/o MESSA OptionALL Plan Administrator 1475 Kendale Blvd. East Lansing, MI 48823 (800) 292-4910 (Toll Free) (517) 332-2581 (Local Phone) (517) 333-6258 (Fax)

Benefit Program	Funding and Claim Type	Insurance Employer or Claims Administrator Contact Information
COBRA Claims Administration		**MESSA** www.messa.org
	<u>Filing a Claim</u>:	1475 Kendale Blvd. East Lansing, MI 48823 (800) 292-4910 (Toll Free) (517) 332-2581 (Local Phone) (517) 333-6258 (Fax)
	<u>Appeal of Denied Claim</u> (only one level of appeal):	MESSA c/o MESSA COBRA Administrator 1475 Kendale Blvd. East Lansing, MI 48823 (800) 292-4910 (Toll Free) (517) 332-2581 (Local Phone) (517) 333-6258 (Fax)
Cash in Lieu of Benefits Program		**Dexter Community Schools** www.dexterschools.org
Self-funded	<u>Filing a Claim</u>:	2704 Baker Rd. Dexter, MI 48130 (734) 424-4100 (Phone) (734) 424-4111 (Fax)
	<u>Appeal of Denied Claim</u> (only one level of appeal):	______________________________ ________________ [Name of Employer] ________________ [Street Address] _____________, MI 48___ ( ) ___-____ (Phone) ( ) ___-____ (Fax)

EXECUTION

IN WITNESS WHEREOF, the Employer hereby agrees to: (i) adopt this "MESSA OptionALL Plan" for the benefit of its eligible employees and their covered dependents, (ii) become a participating employer, and (iii) have this agreement be executed by its duly authorized officer this **4th** day of **December**, **2023**, to be effective as of the **1st** day of **January, 2024**.

Dexter Community Schools

By: Sharon Raschke

Its: Chief Financial Officer