FARMINGTON MUNICIPAL SCHOOL DISTRICT
REQUEST FOR PROPOSAL
RFP 2023-06
IRS SECTION 125 ADMINISTRATIVE SERVICES

DUE DATE & TIME: MARCH 1, 2023 at 2:00 pm (Local Time)

I. INTRODUCTION

A. The Farmington Municipal School District (School District) is requesting proposals from firms interested in providing Section 125 Employee Benefits Plan Administrative Services as described herein.

B. Proposals must be received by the above DUE DATE/TIME at the School District's Purchasing Department, 3401 E. 30th St., Suite A, Farmington, NM 87402

C. General inquiries regarding this solicitation may be obtained by contacting, Lisa Evans at (505) 599-0790. Respondents shall convey all other questions, in writing, via email to **levans@fms.k12.nm.us** Responses to questions shall be provided by Addendum via email to all prospective respondents to this RFP. Deadline for questions via email is February 22, 2023 at 4:30 pm (Local Time).

D. Respondents shall comply with criminal laws prohibiting bribes, gratuities, and kickbacks.

E. By responding to this request, a Respondent warrants and certifies that:
1. With the exception of any proposed marketing plan approved by the School District, it has no interest and will acquire no interest that would directly or indirectly conflict with the performance of the proposed services,
2. Proposed plan offered qualifies under all current Internal Revenue Code sections and Internal Revenue Service regulations,
3. It shall possess and maintain professional liability insurance and bonding totaling a minimum of $500,000.00.

F. Prospective respondents are informed that the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kickbacks. Respondents are required to complete and return within their proposals a completed **CAMPAIGN CONTRIBUTION FORM** enclosed within this RFP as **Attachment A**.

G. Each Respondent must attest to their status of **Certification, Debarment, Suspension and Ineligibility and Involuntary Exclusion** by completing and returning the letter enclosed as **Attachment B.**

H. Background Checks. The successful Respondent(s) (Contractor(s)) shall be responsible for complying with the provisions of NMSA 1978, Section22-10A-5, which requires two fingerprint cards from employees having unsupervised access to students. The cards shall be submitted to the School District for obtaining the employees' Federal Bureau of Investigation record. Convictions of felonies or misdemeanors contained in the Federal Bureau of Investigation record, if supported by independent evidence, may form the basis

for the employment decisions for good and just cause. Records and any related information shall be privileged and shall not be disclosed to any person not directly involved in employment decision of Contractor's employee with unsupervised access to students.

I. The School District reserves the right to cancel this RFP in whole or in part at any time if it is in its best interests. An award will not be based solely on the lowest fee; instead it will be based on several weighted criteria, as provided herein.

II. SCOPE

A. The School District employs over 1,375 employees eligible for IRS Section 125 benefits. These employees are enrolled into the School District plan by the plan administrator commencing in January and ending in mid-March each year. The first plan year under this RFP is April 1, 2023 to March 31, 2024.

B. The School District prefers that the successful Respondent be responsible for providing turnkey administrative services on a benefit plan that includes the following options:
1. Medical insurance premiums paid by employees;
2. Medical expense reimbursements;
3. Dependent care reimbursements.

C. The School District seeks to enter into an agreement for plan administration services consistent with the terms and conditions stated in the agreement enclosed as **Attachment C**.

III. REQUIRED PROPOSAL SUBMITTALS

A. Respondents may request within their response non-disclosure of confidential data. Such data must accompany the proposal and must be readily separable from the proposal in order to facilitate eventual public inspection of the non-confidential portion of the proposal.

B. Responses must consist of one (1) original and five (5) copies of the information requested in this paragraph III.B. as well as one (1) Universal Serial Bus (USB). Any deviations from the required sequence will be determined to be a reflection of the Respondent's qualifications to perform the proposed services. As such, Respondents are advised that proposals will be penalized for not providing the required submittals in the sequence presented in this section. Such penalty will range in the subtraction of from 1 to 10 points depending upon the severity of the inconsistency. ***Proposals must be submitted in a sealed envelope with the RFP number clearly indicated on envelope.*** Proposals shall include:

1. Company profile and history.
   a. Mission statement, strategic plan, or other such overall general description of the respondent's overall business objective with particular regard to customers.

2. Capacity to perform:
   a. A description of resources that will be made available to provide proposed services; include management and number of support, professional and/or para-professional staff, physical plant size, equipment, research resources, finances, etc.
3. Five (5) qualifications-based references in the form of written recommendation letters from clients preferably along border regions that include person(s) who can attest and confirm present and past performance. Do not include references from School District employees or members of the School District's Board of Education. The following contact information must also be provided:
   a. Respondent's primary and alternate staff members who will have oversight responsibility for the proposed services to the School District, including education, professional background, related work experience, and any other information to assess the qualifications of Respondent's key personnel.
4. Plan approach and strategy to delivery and execute proposed services including:
   a. Procedural description specific to each benefit option of Respondent's approach in performing the duties specified per enclosed ***Agreement and Exhibit "A"*** **ATTACHMENT C.**
   b. *Respondent's state of the art technology, e.g., web-based interface, mobile Apps, etc., for employee self-service to gain fast and easy access to important information and services, anytime and anywhere.*
   c. Any School District personnel involvement and duties that will be required for Respondent to provide services to the School District.
   d. Sign-up and tax reporting procedures with sample forms
   e. Claim procedures and relevant forms.
   f. Payment procedures and timeframe.
   g. Procedures for problem resolution and follow-up communications.
   h. Any other related services and activities undertaken in providing required services.
   i. Descriptive information of proposed products eligible for Cafeteria plan benefit, payroll deduction, and the current rating of related carrier from BEST.
   j. Respondent's billing and reporting procedures and duties and responsibilities of the School District with regard to those procedures.

IV. EVALUATION FACTORS

A. Only responses that include the required submittals as specified in Section III above will be considered for award purposes.

B. Incomplete responses will be determined as "non-responsive" and will not be accepted for award consideration

C. Responsive responses shall be evaluated based on the following weightedfactors:

WEIGHTED FACTORS	POINTS
a. Company profile Paragraph III.B.1.a	10

b.	Capacity to perform Paragraph III.B.2.a.	30
c.	Qualifications and experience Paragraph III.B.3.a	30
d.	Plan Approach and Strategy for proposed services Paragraph III.B.4.a-j.	30
	TOTAL	**100 (per rater)**

D. Respondents who submit site responses will be invited to provide oral presentations to the School District.

V. AWARD

A. Committee members will conduct the review considering evaluation factors listed in Section IV above. The committee will rank the responses according to their relative merits.
   1. Prior to award, Respondents submitting responsive proposals may be extended an opportunity to negotiate the Respondent's best and final offer:
      a. Any substantial revision will be accepted in writing from the Respondent.
      b. The process of discussion may extend up to the time of award and may require public presentation by the Respondent.

B. The School District may award a contract to more than one Respondent and nothing herein shall be construed to prevent the School District from doing so.

ATTACHMENT A

CAMPAIGN CONTRIBUTION DISCLOSURE FORM

Pursuant to NMSA 1978, § 13-1-191.1 (2006), any person seeking to enter into a contract with any state agency or local public body **for professional services, a design and build project delivery system, or the design and installation of measures the primary purpose of which is to conserve natural resources** must file this form with that state agency or local public body. This form must be filed even if the contract qualifies as a small purchase or a sole source contract. The prospective contractor must disclose whether they, a family member or a representative of the prospective contractor has made a campaign contribution to an applicable public official of the state or a local public body during the two years prior to the date on which the prospective contractor submits a proposal or, in the case of a sole source or small purchase contract, the two years prior to the date the prospective contractor signs the contract, if the aggregate total of contributions given by the prospective contractor, a family member or a representative of the prospective contractor to the public official exceeds two hundred and fifty dollars ($250) over the two year period.

Furthermore, the state agency or local public body shall void an executed contract or cancel a solicitation or proposed award for a proposed contract if: 1) a prospective contractor, a family member of the prospective contractor, or a representative of the prospective contractor gives a campaign contribution or other thing of value to an applicable public official or the applicable public official's employees during the pendency of the procurement process or 2) a prospective contractor fails to submit a fully completed disclosure statement pursuant to the law.

THIS FORM MUST BE FILED BY ANY PROSPECTIVE CONTRACTOR WHETHER OR NOT THEY, THEIR FAMILY MEMBER, OR THEIR REPRESENTATIVE HAS MADE ANY CONTRIBUTIONS SUBJECT TO DISCLOSURE.

The following definitions apply:

"**Applicable public official**" means a person elected to an office or a person appointed to complete a term of an elected office, who has the authority to award or influence the award of the contract for which the prospective contractor is submitting a competitive sealed proposal or who has the authority to negotiate a sole source or small purchase contract that may be awarded without submission of a sealed competitive proposal.

"**Campaign Contribution**" means a gift, subscription, loan, advance or deposit of money or other thing of value, including the estimated value of an in-kind contribution, that is made to or received by an applicable public official or any person authorized to raise, collect or expend contributions on that official's behalf for the purpose of electing the official to either statewide or local office. "Campaign Contribution" includes the payment of a debt incurred in an election campaign, but does not include the value of services provided without compensation their time on behalf of a candidate or political committee, nor does it include the administrative or solicitation expenses of a political committee that are paid

"**Family member**" means spouse, father, mother, child, father-in-law, mother-in-law, daughter-in-law or son-in-law.

"**Pendency of the procurement process**" means the time period commencing with the public notice of the request for proposals and ending with the award of the contract or the cancellation of the request for proposals.

Attachment A: cont.

"**Person**" means any corporation, partnership, individual, joint venture, association or any other private legal entity.

"**Prospective contractor**" means a person who is subject to the competitive sealed proposal process set forth in the Procurement Code or is not required to submit a competitive sealed proposal because that person qualifies for a sole source or a small purchase contract.

"**Representative of a prospective contractor**" means an officer or director of a corporation, a member or manager of a limited liability corporation, a partner of a partnership or a trustee of a trust of the prospective contractor.

DISCLOSURE OF CONTRIBUTIONS:

Contribution Made By: _____

Relation to Prospective Contractor: _____

Name of Applicable Public Official: _____

Date Contribution(s) Made: _____

Amount(s) of Contribution(s) _____

Nature of Contribution(s) _____

Purpose of Contribution(s) _____

(Attach extra pages if necessary)

_____ _____
Signature Date

_____
Title (position)

--OR—

NO CONTRIBUTIONS IN THE AGGREGATE TOTAL OVER TWO HUNDRED FIFTY DOLLARS ($250) WERE MADE to an applicable public official by me, a family member or representative.

_____ _____
Signature Date

_____
Title (Position)

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ATTACHMENT B

As a potential vendor/contractor awardee to Farmington Municipal School District you are required to provide debarment/suspension certification indicating that you are in compliance with the below Federal Executive Order. Certification can be done by completing and signing this form. Please return the completed form with our solicitation submittal.

DEBARMENT

Federal Executive Order (E.O.) 12549 "Debarment and Suspension" required that all vendors/contractors receiving individual awards, using federal funds, and all sub-recipients certify that the organization and its principals are not debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency from doing business with the Federal Government.

I hereby certify that my company listed below and its principals have not been debarred, suspended, proposed for debarment, declared ineligible, are not in the process of being debarred, or are voluntarily excluded from conduction business with a federal department, an agency of the federal government, or the State of New Mexico.

Company Name:_____

Company Address:_____

Company City/State/Zip:_____

Company Phone:_____

Company Fax:_____

Email Address:_____

Company DUNS Identification No:_____

NAME AND SIGNATURE OF COMPANY REPRESENTATIVE AUTHORIZED TO CERTIFY TO THE ABOVE:

Printed Name of Representative:_____

Signature of Representative:_____
Date

ATTACHMENT C

ADMINISTRATIVE SERVICES AGREEMENT FOR IRS SECTION 125 FLEXIBLE BENEFITS PLAN

AGREEMENT made this_____day of_____, 20____, by and between the Board of Education of the Farmington Municipal School District (Employer or School District) and_____ _____(Contractor)

WHEREAS, Employer has determined that it is in the best interest of Employer and its eligible employees to provide an IRA Section 125 cafeteria plan for the benefit of such eligible employees, to be known as the Farmington Municipal Schools Plan; and

WHEREAS, in furtherance of such determination and in accordance with applicable provisions of the Plan, Employer deems it advisable to delegate certain ministerial duties and functions for purposes of accounting claims processing and record keeping to Contractor and does hereby delegate such ministerial duties and functions to Contractor; and

WHEREAS, the parties desire to set forth their agreement concerning the respective rights, duties and responsibilities of such parties relative to such delegation,

NOW, THEREFORE, for and in consideration of the mutual covenants and agreements hereinafter set forth, the Employer and Contractor agree as follows:

1. **Service**
The Employer appoints Contractor to assist it in the performance of its administrative duties under the plan. Contractor accepts such appointment subject to the terms and conditions of this agreement.

2. **Duties of Contractor**
Contractor shall perform the following duties:
   A. Contractor shall conduct annual enrollment of all eligible employees.
      1. Any payroll deductible products marketed by Contractor during enrollment must be educationally oriented presentations only and without sales pressure. Products presented must have been approved in writing by authorized School District representatives.
         a. Plan participants who have pre-existing conditions already covered by disability and/or medical insurance shall be guaranteed in writing by Contractor that the conditions will, likewise, be covered by Contractor's products prior to changing.
      2. Contractor shall conduct enrollment that includes participant education of plan benefits to all eligible participants.
         a. Premium Conversion
         b. Medical Reimbursement
         c. Dependent Care Reimbursement
   B. Contractor shall obtain and process for the Employer vouchers, claim forms or other documentation necessary for the administration of the Plan.
   C. Contractor shall provide accounting services to the Plan, as follows:
      1. Maintain a list of participating employees, including but not limited to full names and social

security numbers;

2. Maintain records of contributions by, payments of benefits to, and resulting account balances of participating employees;
3. Prepare and mail to participating employees quarterly and year-end reports of contributions made by and benefits paid to or on behalf of participating employees under the Plan.
4. Maintain records of all transactions under the Agreement during the term of the Agreement and for a period of five years thereafter.
5. Provide enrollment/changes file via Secure File Transfer Protocol.

D. Services relating to processing claims for reimbursing medical and child care expenses include but are not limited to:
   1. Communicating voucher procedures to each employee;
   2. Collecting vouchers from employees; certifying expenses as eligible and accurate; examining expense vouchers to assure participants are requesting funds from correct accounts, listing claims onto claims affidavit, obtaining approval from Employer:
   3. Maintaining copies of expense vouchers and claims affidavit lists along with documentation for expenses, all of which to be maintained on a plan-year basis;
   4. Maintaining copies of expense account reports;
   5. Verifying accuracy and then distributing reimbursement checks within days via mail directly to participants unless Contractor receives written request from individual participants to hold checks for pick up by that participant;
   6. Responding to all inquiries or resolving problems being experienced by participants;
   7. If Contractor determines that a given application for benefits is not eligible under the Plan, for whatever reason, Contractor shall promptly notify the participant with reason for denial and description of any additional information that might be necessary to perfect or complete the application.

E. Contractor's Ministerial Responsibilities
   1. Contractor is vested only with ministerial authority to process claims for benefits under the Plan in accordance with the terms of the Plan.
   2. Contractor shall have no discretionary authority to make decisions as to Plan policy, interpretations, practices or procedures, but shall perform its duties and functions within the framework of the terms of the Plan and policies, interpretations, rules, practices and procedures made by the Employer.
   3. Contractor shall make employee benefit eligibility determinations on behalf of the Employer in accordance with the claims procedures set forth in the Plan based upon information provided to Contractor by the employee and by the Employer.
   4. It is understood that Contractor is acting on behalf of the Employer in a ministerial, administrative capacity only and shall have no responsibility to investigate the truthfulness of any information provided to Contractor.

F. Services relating to Employer's tax reporting
   1. Contractor shall provide the Employer with the information in its custody for use in the preparation of all returns and reports that are required by the Internal Revenue Service, the Department of Labor and any other federal or state agency.
   2. Contractor shall assist in the timely preparation of such returns and reports whenever called upon to do so by the Employer, provided, however, that the employer shall bear responsibility for the filing and content of all such returns and reports, and the payment of any taxes that may be due.

G. Assignment of Duties
   1. Contractor shall obtain approval by the Employer to retain service from third parties to assist it in performing the duties delegated to it under this Agreement. All such third-party services shall be provided at the expense of Contractor and shall be subject to the supervision, control and

responsibility of Contractor. Contractor shall have the right to retain the services of accountants, attorneys, actuaries and any other professionals whose services are reasonably necessary or desirable to aid in the performance of its duties under this Agreement, for the benefit of the Employer. The expenses for those professional services shall be payable by Contractor.

H. Bonding Requirements
   1. Contractor shall obtain and maintain such fiduciary bonds as are required under applicable law.

3. Duties of Employer

A. Employer warrants that it has validly adopted the Plan and any component plans of the Plan. A sample of the Plan and any component plans are attached hereto as Exhibit B.
B. The Employer shall notify Contractor of the following:
   1. A reduction of participating employee hours of service resulting in loss of benefit eligibility of a participating employee.
   2. Termination of the employment of a participating employee and whether such termination was due to gross misconduct.
   3. A participating employee becoming eligible for Medicare.
C. Employer shall be responsible for the Plan's qualification with the Internal Revenue Code and any component plans under the Code, ERISA, or any other applicable federal, state or local law or ordinance.

4. Term of Agreement

This agreement shall be effective April 1, 2023, and shall remain in effect through March 31, 2024, unless terminated earlier as provided herein.

Pending satisfactory performance and mutual agreement between the parties, appointment may be extended annually for up to three additional years through March 31, 2024. In the event either one of the parties intends not to renew the agreement, written notice of intent to terminate must be provided to the other at least ninety (90) days prior to the end of the term.

During any term hereof, and on ninety (90) days' written notice, either party may terminate the Agreement with or without cause.

Upon termination of this Agreement, copies of all pertinent information from the files of Contractor shall be made available to the Employer at its request.

5. Compensation

Services described herein shall be provided to the Employer and participants at no cost. If only one Contractor is awarded a contract pursuant to this RFP, in exchange for Contractor's service, the Employer shall grant Contractor exclusive marketing rights at all the Employer's sites, subject to Employer's policies for Contractor's products qualified under the Plan and approved in writing by the Employer and attached herein as Exhibit A. If more than one Contractor is awarded a contract pursuant to this RFP, in exchange for Contractors' services, the Employer shall grant Contractors marketing rights at all the Employer's sites, subject to Employer's policies for Contractors' products qualified under the Plan and approved in writing by the Employer and attached herein as Exhibit A.

6. Independent Contractor Status

Contractor is retained as an independent contractor and not as an employee or agent of the School District. Contractor and the School District are not in a partnership or joint venture, nor are they or shall they be deemed to be partners or joint ventures of any kind for any purposes. Neither Contractor nor any of its employees shall accrue leave, insurance benefits, retirement contributions, use of school

equipment or vehicles or other benefits of employment with the School District.

7. Criminal Background Check

Contractor's employees, agents, subcontractors, subcontractor employees, or representatives who will or may have unsupervised access to students, which means performing services at any School District site, shall be required to undergo a criminal background check. Such background check shall comply with the requirements of NMSA 1978, Section 22-10A-58. Contractor agrees to provide fingerprint cards for any such individuals and shall pay for the School District to conduct such background checks.

Should the background check disclose a conviction of any of the individuals listed above for a felony or misdemeanor involving moral turpitude, such individual shall be prohibited by Contractor from entering any District building or site in connection with the Services contract under this Agreement.

8. Taxes

Contractor shall pay all federal, state, and local taxes, including but not limited to income taxes, payroll and FICA taxes, as may be imposed or levied upon the revenues earned or derived by its efforts under the Agreement. It is expressly understood and agreed that the School District shall not withhold or be responsible in any way for the payment of such taxes.

9. Insurance: Liability

Contractor shall purchase and provide the School District with a copy of a liability insurance policy, including but not limited to general, professional liability and employment practices liability insurance, in relation to the services provided under this Agreement during the term of this Agreement with limits at least equivalent to those specified in the New Mexico Tort Claims Act which policy shall name the District as an additional insured. Any claim of liability made against the School District shall be governed by the limitations and immunities specified in the New Mexico Tort Claims Act and the coverage under such Act provided by NMPSIA.

10. Confidentiality

Contractor agrees to abide by the rules and regulations regarding the confidentiality of personal medical records as mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. In addition, reports, work papers and records, including information and data prepared or assembled by Contractor under this Agreement, shall be confidential and shall not be made available or otherwise disclosed to any person, except the School District, without prior written approval of the School District, provided the information and data are not public records under the New Mexico Inspection of Public Records Act.

11. Dispute Resolution

(a) If a dispute arises as to the terms or interpretation of this Agreement, the parties shall promptly attempt in good faith to resolve the dispute by mediation. The parties shall mutually agree upon the selection of the mediator within ten (10) work days of a request for mediation. The mediation shall occur in Farmington, New Mexico and the parties shall share the costs of the mediation equally. If the parties cannot reach agreement on selection of a mediator, or if the mediation session cannot be held within sixty (60) days after the request, unless the parties consent to a longer period, the parties shall proceed to arbitration as set forth below.

(b) All disputes not resolved by negotiation and mediation shall be resolved by arbitration in accordance with the New Mexico Uniform Arbitration Act, NMSA 1978, Sections 44-7A-1 to 44-7A-32.. The arbitrator shall issue a scheduling order that shall not be modified except by the mutual agreement of

the parties. Judgment may be entered upon the award in accordance with the New Mexico Uniform Arbitration Act. The arbitrator shall have the authority to include in the arbitration award a provision that the prevailing party shall recover all of its costs, expenses and attorneys' fees incurred as a result of the dispute.

12. **Indemnification**

Contractor agrees to indemnify, defend, and hold harmless the School District and its Board of Education, members, employees, and agents from and against any and all third- party claims, demands, costs, damages, settlements, and liabilities (including reasonable attorneys' fees and court costs) of any kind whatsoever, arising from Contractor's performance of Services under this Agreement.

13. **Ownership of Material**

Any and all original reports, correspondence, notes or other documents of whatever kind or description and in whatever medium, including but not limited to electronic storage and photographic materials, generated or acquired by Contractor in the course of Contractor's performance of Services hereunder shall be and remain the property of the School District and shall be available to the School District at any time. At the termination of this Agreement, all such documents shall be turned over to the School District or to such other person or entity as the School District shall specify.

14. **Power to Bind the School District**

Contractor has no authority to obligate the School District to any contract or agreement of any kind, character or nature. Contractor shall have no authority to borrow funds for the School District for any purpose whatsoever. Contractor shall not bring any legal proceedings on behalf of the School District nor have the authority to engage or, hire, any consult and or legal counsel for the benefit of the School District without written approval of the School District.

15. **Time of the Essence**

Time is agreed to be of the essence in the performance of each of the terms and conditions of this Agreement. This provision is a bargained for consideration and not a mere recital.

16. **Entire Agreement; Modification**

This agreement constitutes the final and entire agreement between the parties, and there is no agreement or promise on the part of either party to do or omit to do any act or thing not herein mentioned. This Agreement is intended as a complete and exclusive statement of the terms and conditions of the parties' agreement and may not be amended, changed, modified or altered without the written consent of both parties.

17. **Assignment**

No assignment of the obligations of this Agreement in whole or in part shall be made without prior written consent of the School District. Any assignment of the obligation of this Agreement and/or assignment or encumbrance of any interest in the compensation agreed to be paid shall operate to terminate the Agreement immediately and without notice and, in such event, Contractor shall not be entitled to receive any compensation whatsoever for any Services rendered after the date of termination.

18. **Governing Law and Venue**

This Agreement shall be governed and construed in accordance with the laws of the State of New

Mexico. Except as specified in the Dispute Resolution provisions set forth above, Contractor agrees and consents to the exclusive jurisdiction of the courts of San Juan County, State of New Mexico for all purposes regarding this Agreement. Both parties shall comply with all applicable laws and regulations in the performance of this Agreement.

19. **Consents; Reasonableness; Good Faith**

Neither party shall unreasonably deny, withhold or delay any consent or approval required or contemplated for any action or transaction proposed to be taken or made hereunder. The parties agree to cooperate fully with each other and to act reasonably and in good faith and in a timely manner in all matters hereunder so that both of them may obtain the benefits to which they are entitled hereunder and for which they have negotiated. Both parties agree to negotiate in good faith and without delay as to all matters requiring negotiation.

20. **Binding Provisions**

The provisions of this Agreement shall be binding on the heirs, personal representatives, successors and assigns of the parties in like manner as to the original parties unless modified by mutual written agreement of the parties.

21. **Severability**

In the event that any provision in this Agreement shall be held invalid or unenforceable by a court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision of this Agreement.

22. **Delay or Omission**

No delay or omission to exercise any right, power, or remedy accruing under this Agreement shall impair such right, power or remedy, nor shall it be construed to be a waiver of or acquiescence in a breach of or default under this Agreement. Both parties specifically and affirmatively agree not to construe the conduct, delay or omission of the other party as altering in any way the parties' agreements as defined in this Agreement. Any waiver, permit, or approval of any breach or default under this Agreement must be in writing, and, because the language of this Section was negotiated and intended by both parties to be binding and is not a mere recital, both parties hereby agree that they will not raise waiver or estoppel as affirmative defenses so as to limit or negate the clear language and intent of this Section. All remedies, either under this Agreement, by law or otherwise, afforded to either party shall be cumulative, not alternative.

23. **Notice**

Any instruction, notice or demand (individually or together, "Notice") required or permitted by this Agreement to be given must be in writing and (i) delivered by certified mail by the Postal Service of the United States of America, postage pre-paid or (ii) hand-delivered by courier or by a nationally recognized and reputable overnight delivery service. Each Notice shall, for all purposes, be deemed given and received: (i) if given by certified mail, return receipt requested, postage pre-paid, when the return receipt is signed; or (ii) if given by a nationally recognized and reputable overnight delivery service, when the Notice is actually received by the party. The Notice shall be given *to* the party at its address first set forth below, or at such other address as the party may later specify for that purpose by Notice to the other party. The provisions in this Section governing the day in which a Notice is deemed to have been received shall mean the date on which the intended party, and not its counsel or other recipient to which a copy of the Notice may be sent, is

deemed to have received the Notice. If the Notice is tendered under the provisions of this paragraph and is refused by the intended recipient of the Notice, the Notice shall nonetheless be considered to have been given and shall be effective as of the date tendered. Notice given in a manner other than that provided above, but actually received by the party, shall be effective upon receipt.

Employer Notice Address:3401 E. 30th St. Suite A Farmington, NM 87402. Contractor Notice address:

_____

_____

24. No Discrimination

Contractor shall not discriminate or retaliate against any employee of Contractor or the School District, or against any student, parent or school patron on the basis of race, age, religion, color, national origin, ancestry, sex, sexual orientation, gender, identity, physical or mental disability or serious medical condition. Contractor agrees to comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and all implementing regulations and executive orders. No person shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination in relation to activities carried out under this contract on the basis of race, color, age, religion, sex, disability or national origin. This includes the provision of language assistance services to individuals of limited English proficiency seeking and/or eligible for services under this contract.

24. Titles, Headings and Groupings

The titles and headings to the various Sections of this Agreement are inserted only for convenience of reference and are not intended, nor shall they be construed, to modify, define, limit or expand the intent of the parties as expressed in this Agreement. The grouping of the Sections in this Agreement and the School District's specifications under the various headings is solely for the purpose of convenient organization and in no event shall the grouping of provisions, the use of Sections or the use of headings be construed to limit or alter the meaning of any provisions.

25. Non-Appropriation

The terms of this Agreement are contingent upon sufficient authorizations and appropriations being or having been made by the New Mexico State Legislature for performance of this Agreement. If sufficient appropriations and authorizations are not made or have not been made by the New Mexico State Legislature in any fiscal year, this Agreement shall terminate upon thirty (30) days written notice from School District to Contractor, provided that such termination shall not nullify the School District's obligation *to* pay Contractor for such sums as have been previously approved for payment. The School District's decision as to whether sufficient authorizations and appropriations are or have been made in any fiscal year shall be final.

26. Rights and Remedies

The parties' rights, liabilities, responsibilities and remedies with respect to this Agreement, whether in contract, tort or negligence, or otherwise, shall be exclusively those expressly set forth in this Agreement. No provision in this Agreement is intended or shall create any rights with respect *to* the subject matter of this Agreement in any third party.

27. Conflict of Interest; Procurement Compliance

Contractor represents and warrants that it did not participate in the preparation of any specifications, qualifications or evaluation criteria for any procurement process upon which the

Agreement is based and will not acquire any interest which would constitute a conflict of interest with the duties to be performed under this Agreement. The Procurement Code and New Mexico law prohibit conflicts of interest and impose penalties for bribes, gratuities or kickbacks. Further, Contractor agrees that it shall not perform any services hereunder other than those authorized by a properly issued and approved purchase order from the School District.

EXECUTED the day and year first mentioned above.

FARMINGTON MUNICIPAL SCHOOL DISTRICT	**CONTRACTOR**
BY:_____	BY:_____
TITLE:_____	TITLE:_____
DATE:_____	DATE:_____

EXHIBIT A

ADMINISTRATIVE SERVICES AGREEMENT FOR IRS
SECTION 125 FLEXIBLE BENEFITS PLAN

[If one Contractor is selected pursuant to this RFP, use the following:] Pursuant to Section V. of Administrative Services Agreement between the Employer and Contractor, the employer hereby grants exclusive marketing rights at all employer sites for the following products:

[If more than one Contractor is selected pursuant to this RFP, use the following:] Pursuant to Section V. of Administrative Services Agreement between the Employerand Contractor, the employer hereby grants marketing rights at all employer sites for the following products:

1. Cancer Insurance
2. Long Term Care Insurance
3. Accident Insurance
4. Unreimbursed Medical Expense Benefit

FARMINGTON MUNICIPAL SCHOOL DISTRICT
EMPLOYER

_____
SIGNATURE

_____
PRINT NAME

_____
TITLE

_____
DATE

Exhibit B

SAMPLE PLAN DOCUMENT
SECTION 125
FLEXIBLE BENEFIT PLAN

Version 05/11 of the Sample Plan Document includes the following changes:

Section 8.04 (a)- Amended the Eligible Medical Expenses information to comply with Health Care Reform law restrictions

Section 8.0 5 -Amended the Use of Debit Card information to comply with Health Care Reform law restrictions

The attached plan document and adoption agreement are being provided for illustrative purposes only. Because of differences in facts, circumstances, and the laws of the various states, interested parties should consult their own attorneys. This document is intended as a guide only, for use by local counsel.

SECTION 125 FLEXIBLE BENEFIT PLAN
ADOPTION AGREEMENT

The undersigned Employer hereby adopts the Section 125 Flexible Benefit Plan for /hose Employees who shall qualify as Participants hereunder. The Employer hereby selects the following Plan specifications:

A. EMPLOYER INFORMATION

Name of Employer:	FARMINGTON MUNICIPAL SCHOOLS
Address:	3401 E. 30th St.Suite A FARMINGTON, NM 87402
Employer Identification Number:	85-6000130
Nature of Business:	PUBLIC EDUCATION
Name of Plan:	FARMINGTON MUNICIPAL SCHOOLS Flexible Benefit Plan
Plan Number:	501

B. EFFECTIVE DATE

Original Effective Date of Plan	
If Amendment to existing plan, effective date of amendment:	**APRIL 1, 2023**

C. ELIGIBILJTY REQUIREMENT FOR PARTICIPATION

Eligibility requirements for each component plan under this Section 125 document will be applicable and, if different, will be listed in Item tf.

Length of Service:	First of month following employment
Minimum Hours:	All employees with 20 hours of service or more each week. An hour of service is each hour for which an employee receives, or is entitled to receive, payment for performance of duties for the Employer.
Age:	Minimum age of 18 years.

D. PLAN YEAR

The current plan year will begin April 1, 2023, and end on March 31, 2024. Each subsequent plan year will begin April 1 and end on March 31.

E. *EMPLOYER CONTRIBUTIONS*

Non-Elective Contributions:

The Employer may at its sole discretion provide a non-elective contribution to provide benefits for each Participant under the Plan. This amount will be set by the Employer each Plan Year in a uniform and non-discriminatory manner. If this non-elective contribution amount exceeds the cost of benefits elected by the Participant, excess amounts may not be paid to the Participant as taxable cash.

Elective Contributions (Salary Reduction):

The maximum amount available to each Participant for the purchase of elected benefits through salary reduction will be:

$20,000

Each Participant may authorize the Employer to reduce his or her compensation by the amount needed for the purchase of benefits elected, less the amount of non-elective contributions. An election for salary reduction will be made on the benefit election form.

F. AVAILABLE BENEFITS: **Each of the following components should be considered a plan that comprises this Plan.**

1. **Group Mcdjcal Insurance -- The terms, conditions, and limitations for the Group Medical Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)**

NMPSIA (BCBS/Pres)
AMERICAN FIDELITY ASSURANCE -ACCIDENT
AFLAC - ACCIDENT

Eligibilitv Requirements ror PnrticipaLion. if difl'crcnt than Item C.

2. **Pisa1>ili!Y Inc;onr n Insur;rncc -- The terms, conditions, and limitations for the Disability Income Insurance will be as set forth in the insurance policy or policies described below: (See Section VI of the Plan Document)**

UNUM
AFLAC
NMPSIA

Eligibility Requirements for Participation, if different than Item C.

3. **Cancer Coverage -- The terms, conditions, and limitations for the Cancer Coverage will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)**

AFLAC
AMERICAN FIDELITY ASSURANCE COMPANY

Eligibilitv Requirements for Pai·ticip,tion, if different than 11:em C.

4. **Dcntal(Yjsjon Insuranee -- The terms, conditions, and limitations for the Dental/Vision Insurance will be as set forth in the insurance policy or policies described below: (See Section V of the Plan Document)**

NMPSIA (UNITED CONCORDIA DENTAL)
NMPSIA (DAVIS VISION)

Eligibility Requirements for Participation. if different than Item

5. **Group Ljfe Insurance which will be comprised of Group term life insurance and Individual term life insurance under Section 79 of the Code.**

The terms, conditions, and limitations for the Group Life Insurance will be as set forth in the insurance policy or policies described below: (See Section VII of the Plan Document)

Individual life coverage under Section 79 is available as a benefit, and the face amount when combined with the group-term life, if any, may not exceed $50,000.

NMPSIA (THE STANDARD)

F,ligihiljty Requirements for Participntion, if different than Item C.

6. **Dcprndcnt Care Assjstancc Pion --The terms, conditions, and limitations for the Dependent Care Assistance Plan will be as set fo1th in Section IX of the Plan Document and described below:**

Minimum Contribution - $ -0- per Plan Year

Maximum Contribution-$ 5,000 **per Plan Year**

Recordkeeper:

Eligibility Requirements for Participation, if different than Item C.

7. Medical Expense Rcimburscmcnl Plan **--The tenns, conditions, and limitations for the Medical Expense Reimbursement Plan will be as set forth in Section VIII of the Plan Document and described below:**

Minimum Coverage - $ -0- per Plan Year or a Prorated Amount for a Short Plan Year

Maximum Coverage - $ 2,550 **per Plan Year or a Prorated Amount for a Short Plan Year**

Recordkeeper:

Grace Period: The Provisions in Section 8.06 of the Plan to permit a Grace P eriod of 2Y, months with respect to the Medical Expense Reimbursement Plan is elected.

Eligibility Requirements for Participation. i r different tlrnn Item C.

The Plan shall be construed, en forced, administered, and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, (as amended) if applicable, the Internal Revenue Code of 1986 (as amended), and the laws of the State of New Mexico. Should any provision be determined to be void, in valid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void. ·

This Plan is hereby adopted this _____ day of_____,,20_□

FARMINGTON MUNICIPAL SCHOOLS

Witness: _____ By: _____ _____

Title: _____ Title: _____

SECTION 125 FLEXIBLE BENEFIT PLAN

SECTION I

PURPOSE

The Employer is establishing this Flexible Benefit Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

In establishing this Plan, the Employer desires to attract, reward, and retain highly qualified, competent Employees, and believes this Plan will help achieve that goal.

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of I986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

SECTION II

DEFINITIONS

The following words and phrases appear in this Plan and will have the meaning indicated below unless a different meaning is plainly required by the context:

2.01 Administrator The Employer unless another has been designated in writing by the Employer as Administrator within the meaning of Section 3(I6) of ERISA (if applicable).

2.02 Beneficiary Any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death.

2.03 Code Internal Revenue Code of I 986, as amended.

2.04 **Dependent** Any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section I05, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(I), (b)(2), and (d)(I)(B) thereof, and (ii) includes any child of the Participant to whom Code Section I52(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Student on a Medically Necessary Leave of Absence: With respect to any plan that is considered a group health plan under Michelle's Law (and not a HIPAA excepted benefit under Code Sections 983l(b), (c) and 9832(c)) and to the extent the Employer is required by Michelle's Law to provide continuation coverage, a Dependent includes a child who qualifies as a Tax Dependent (defined in Section 2.04(a)) because of his or her full- time student status, is enrolled in a group health plan, and is on a medically necessary leave of absence from school. The child will continue to be a Dependent if the medically necessary leave of absence commences

. while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the group health plan's benefits coverage. Written physician certification that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary is required at the Administrator's request. The child will no longer be considered a Dependent as of the earliest date that the child is no longer on a medically necessary leave of absence, the date that is one year after the first day of the medically necessary leave of absence, or the date benefits would otherwise terminate under either the group health plan or this Plan. Terms related to Michelle's Law, and not otherwise defined, will have the meaning provided under the Michelle's Law provisions of Code Section 9813.

(c) Adult Children: With respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A 'child' for purpose of this Section 2.04(c) means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adult child described in this Section 2.04(c) is only a Dependent with respect to benefits provided after March 30,2010 (subject to any other limitations of the Plan).

Dependent for purposes of the Dependent Care Reimbursement Plan is defined in Section 9.04(a).

2.05 Effective Date

The effective date of this Plan as shown in Item B of the Adoption Agreement.

2.06 Elective Contribution

The amount the Participant authorizes the Employer to reduce compensation for the purchase of benefits elected.

2.07 Eligible Employee

Employee meeting the eligibility requirements for participation as shown in Item C of the Adoption Agreement.

2.08 Employee

Any person employed by the Employer on or after the Effective Date.

2.09	Employer	The entity shown in Item A of the Adoption Agreement, and any Related Employers authorized to participate in the Plan with the approval of the Employer. Related Employers who participate in this Plan are listed in Appendix A to the Adoption Agreement. For the purposes of Section 11.01 and 11.02, only the Employer as shown in Item A of the Adoption Agreement may amend or terminate the Plan.
2.10	Employer Contributions	Amounts that have not been actually received by the Paiiicipant and are available to the Participant for the purpose of selecting benefits under the Plan. This term includes Non-Elective Contributions and Elective Contributions through salary reduction.
2.11	Entry Date	The date that an Employee is eligible to participate in the Plan.
2.12	ERISA	The Employee Retirement Income Security Act of 1974, Public Law 93-406 and all regulations and rulings issued thereunder, as amended (if applicable).
2.13	Fiduciary	The named fiduciary shall mean the Employer, the Administrator and other parties designated as such, but only with respect to any specific duties of each for the Plan as may be set forth in a written agreement.
2.14	Health Savings Account	A "health savings account" as defined in Section 223(d) of the Internal Revenue Code of 1986, as amended established by the Participant with the HSA Trustee.
2.15	HSA Trustee	The Trustee of the Health Savings Account which is designated in Section F.8 of the Adoption Agreement.
2.16	Highly Compensated	Any Employee who at any time during the Plan Year is a "highly compensated employee" as defined in Section 414(q) of the Code.
2.17	High Deductible Health Plan	A health plan that meets the statutory requirements for annual deductibles and out-of-pocket expenses set fo1ih in Code section 223(c)(2).
2.18	HJPAA	The Health Insurance Portability and Accountability Act of 1996, as amended.
2.19	Insurer	Any insurance company that has issued a policy pursuant to the terms of this Plan.
2.20	Key Employee	Any Participant who is a "key employee" as defined in Section 416(i) of the Code.
2.21	Non-Elective Contribution	A contribution amount made available by the Employer for the purchase of benefits elected by the Participant.
2.22	Participant	An Employee who has qualified for Plan pa1iicipation as provided in Item C of the Adoption Agreement.

2.23	Plan	**The Plan referred to in Item A of the Adoption Agreement as may be amended from time to time.**
2.24	Plan Year	**The Plan Year as specified in Item D of the Adoption Agreement.**
2.25	Policy	**An insurance policy issued as a part of this Plan.**
2.26	Preventative Care	**Medical expenses which meet the safe harbor definition of "preventative care" set fo1ih in IRS Notice 2004-23, which includes, but is not limited to, the following: (i) periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations); (ii) well-baby and/or well-child care; (iii) immunizations for adults and children; (iv) tobacco cessation and obesity weight-loss programs; and (v) screening devices. However, preventative care does not generally include any service or benefit intended to treat an existing illness, injury or condition.**
2.27	Recordkeeper	**The person designated by the Employer to perform recordkeeping and other ministerial duties with respect to the Medical Expense Reimbursement Plan and/or the Dependent Care Reimbursement Plan.**
2.28	Related Employer	**Any employer that is a member of a related group of organizations with the Employer shown in Item A of the Adoption Agreement, and as specified under Code Section 414(b), (c) or (m).**

SECTION III

ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

3.01 ELIGIBILITY: **Each Employee of the Employer who has met the eligibility requirements of Item C of the Adoption Agreement will be eligible to participate in the Plan on the Entry Date specified or the Effective Date of the Plan, whichever is later. Dependent eligibility to receive benefits under any of the plans listed in Item F of the Adoption Agreement will be described in the documents governing those benefit plans. To the extent a Dependent is eligible to receive benefits under a plan listed in Item F, an Eligible Employee may elect coverage under this Plan with respect to such Dependent. Notwithstanding the foregoing, life insurance coverage on the life of a Dependent may not be elected under this Plan.**

3.02 **ENROLLMENT: An eligible Employee may enroll (or re-enroll) in the Plan by submitting to the Employer, during an enrollment period, an Election Form which specifies his or her benefit elections for the Plan Year and which meets such standards for completeness and accuracy as the Employer may establish. A Participant's Election Form shall be completed prior to the beginning of the Plan Year, and shall not be effective prior to the date such form is submitted to the Employer. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form.**

A Participant's right to elect certain benefit coverage shall be limited hereunder to the extent such rights are limited in the Policy. Furthermore, a Participant will not be entitled to revoke an election after a period of coverage has commenced and to make a new election with respect to the remainder of the period of coverage unless both the revocation and the new election are on account of and consistent with a change in status, or other allowable events, as determined by Section 125 of the Internal Revenue Code and the regulations thereunder.

3.03 **TERMINATION OF PARTICIPATION:** A Participant shall continue to participate in the Plan until the earlier of the following dates:

a. The date the Participant terminates employment by death, disability, retirement or other separation from service; or

b. The date the Participant ceases to work for the Employer as an eligible Employee; or

c The date of termination of the Plan; or

d. The first date a Participant fails to pay required contributions while on a leave of absence.

3.04 **SEPARATION FROM SERVICE:** The existing elections of an Employee who separates from the employment service of the Employer shall be deemed to be automatically terminated and the Employee will not receive benefits for the remaining portion of the Plan Year.

3.05 **QUA IFYING LEAVE UNDER FAMIL LEAVE ACT:** Notwithstanding any prov1s1on to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's existing coverage under the Plan with respect to benefits under Section V and Section VIII of the Plan on the same terms and conditions as though he were still an active Employee. If the Employee opts to continue his coverage, the Employee may pay his Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his Elective Contribution for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave compensation (including unused sick days or vacation) by making a special election to that effect prior to the date such compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

SECTION IV

CONTRIBUTIONS

4.01 **EMPLOYER CONTRIBUTIONS:** The Employer may pay the costs of the benefits elected under the Plan with funds from the sources indicated in Item E of the Adoption Agreement. The Employer Contribution may be made up of Non-Elective Contributions and/or Elective Contributions authorized by each Participant on a salary.reduction basis.

4.02 **IRREVOCABILITY OF ELECTIONS:** A Participant may file a written election form with the Administrator before the end of the current Plan Year revising the rate of his contributions or discontinuing such contributions effective as of the first day of the next following Plan Year. The

Participant's Elective Contributions will automatically terminate as of the date his employment terminates. Except as provided in this Section 4.02 and Section 4.03, a Participant's election under the Plan is irrevocable for the duration of the plan year to which it relates. The exceptions to the irrevocability requirement which would permit a mid-year election change in benefits and the salary reduction amount elected are set out in the Treasury regulations promulgated under Code Section 125, which include the following:

(a) Change in Status. A Participant may change or revoke his election under the Plan upon the occurrence of a valid change in status, but only if such change or termination is made on account of, and is consistent with, the change in status in accordance with the Treasury regulations promulgated under Section 125. The Employer, in its sole discretion as Administrator, shall determine whether a requested change is on account of and consistent with a change in status, as follows:

(!) Change in Employee's legal marital status, including marriage, divorce, death of spouse, legal separation, and annulment;

(2) Change in number of Dependents, including birth, adoption, placement for adoption, and death;

(3) Change in employment status, including any employment status change affecting benefit eligibility of the Employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from an unpaid leave of absence, and a change in work site. If the eligibility for either the cafeteria Plan or any underlying benefit plans of the Employer of the Employee, spouse or Dependent relies on the employment status of that individual, and there is a change in that individual's employment status resulting in gaining or losing eligibility under the Plan, this constitutes a valid change in status. This category only applies if benefit eligibility is lost or gained as a result of the event. If an Employee terminates and is rehired within 30 days, the Employee is required to step back into his previous election. If the Employee terminates and is rehired after 30 days, the Employee may either step back into the previous election or make a new election;

(4) Dependent satisfies, or ceases to satisfy, Dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and

(5) Residence change of Employee, spouse or Dependent, affecting the Employee's eligibility for coverage.

(b) Special Enrollment Right. If a Participant or his or her spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(±), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances: (i) a Participant or his or her spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted, or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; (ii) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; (iii) the Participant's or his or her spouse's or Dependent's coverage under a Medicaid plan or under a children's health insurance program (CHIP) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage; or (iv) the Participant, his or her spouse or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than 60 days after the date the

Participant, his or her spouse or Dependent is determined to be eligible for such assistance. An election change under (iii) or (iv) of this provision must be requested within 60 days after the termination of Medicaid or state health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable. Special enrollment rights under the health insurance plan will be determined by the terms of the health insurance plan.

(c) Certain Judgments, Dccrc1::s or Orders. If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO]) requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, the Participant may have a mid-year election change to add or drop coverage consistent with the Order.

(d) EntiUcmcnt to Medicare or Medicaid. If a Participant, Participant's spouse or Participant's Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may cancel or reduce health coverage under the Employer's Plan. Loss of Medicare or Medicaid entitlement would allow the Participant to add health coverage under the Employer's Plan.

(e) Family Medical Leave Act. If an Employee is taking leave under the rules of the Family Medical Leave Act, the Employee may revoke previous elections and re-elect benefits upon return to work.

(f) COBRA OuoJirving Event. If an Employee has a COBRA qualifying event (a reduction in hours of the Employee, or a Dependent ceases eligibility), the Employee may increase his pre-tax contributions for coverage under the Employer's Plan if a COBRA event occurs with respect to the Employee, the Employee's spouse or Dependent. The COBRA rule does not apply to COBRA coverage under another Employer's Plan.

(g) Changes in Eligibility for Adult Children. To the extent the Employer amends a plan listed in Item F of the Adoption Agreement that provides benefits that are excluded from an Employee's income under Code Section 105 to provide that Adult Children (as defined in Section 2.04(c)) are eligible to receive benefits under the plan, an Eligible Employee may make or change an election under this Plan *to* add coverage for the Adult Child and *to* make any corresponding change to the Eligible Employee's coverage that is consistent with adding coverage for the Adult Child.

Notwithstanding anything to the contrary in this Section 4.02, the change in election rules in this Section 4.02 do not apply to the Medical Expense Reimbursement Plan, or may not be modified with respect to the Medical Expense Reimbursement Plan if the Plan is being administered by a Recordkeeper other than the Employer, unless the Employer and the Recordkeeper otherwise agree in writing.

4.03 OTHER EXCEPTIO N S TO IRREVOCABILITY OF ELECTIONS. Other exceptions to the irrevocability of election requirement permit mid-year election changes and apply to all qualified benefits except for Medical Expense Reimbursement Plans, as follows:

(a) Change in Co,l. If the cost of a benefit package option under the Plan significantly increases during *the* plan year, Participants may (i) make a corresponding increase in their salary reduction amount, (ii) revoke their elections and make a prospective election under another benefit option offering similar coverage, or (iii) revoke election completely if no similar coverage is available, including in spouse or dependent's plan. If the cost significantly decreases, employees may elect coverage even if they had not previously participated and may drop their previous election for a similar coverage

option in order to elect the benefit package option that has decreased in .cost during the year. If the increased or decreased cost of a benefit package option under the Plan is insignificant, the participant's salary reduction amount shall be automatically adjusted.

(b) Significant curtailment of coverage.

(i) With no lo of coverage. If the coverage under a benefit package option is significantly curtailed or ceases during the Plan Year, affected Participants may revoke their elections for the curtailed coverage and make a new prospective election for coverage under another benefit package option providing simiJar coverage.

(ii) With loss of coverage. If there is a significant curtailment of coverage with loss of coverage, affected Participants may revoke election for curtailed coverage and make a new prospective election for coverage under another benefit package option providing similar coverage, or drop coverage if no similar benefit package option is available.

(c) Additi n or Significant Improvement of Benefit Package Option. If during the Plan Year a new benefit package option is added or significantly improved, eligible employees, whether currently participating or not, may revoke their existing election and elect the newly added or newly improved option.

(d) Change in Coverage of a Spouse or Dependent Under Another Employer's Plan. If there is a change in coverage of a spouse, former spouse, or Dependent under another employer's plan, a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse or Dependent. This rule applies if (1) mandatory changes in coverage are initiated· by either the insurer of spouse's plan or by the spouse's employer, or (2) optional changes are initiated by the spouse's employer or by the spouse through open enrollment.

(e) Loss of coverage under other group hea.lth coverage. If during the Plan Year coverage is lost under any group health coverage sponsored by a governmental or educational institution, a Participant may prospectively change his or her election to add group health coverage for the affected Participant or his or her spouse or dependent.

4.04 CASH BENEFIT: Available amounts not used for the purchase of benefits under this Plan may be considered a cash benefit under the Plan payable to the Participant as taxable income to the extent indicated in Item E of the Adoption Agreement.

4.05 PAYMENT tfROM EMPLOYER'S GENERAL ASSETS: Payment of benefits under this Plan shall be made by the Employer from Elective Contributions which shall be held as a part of its general assets.

4.06 EMPLOYER MAY HOLD ELECTIVE CONTRIBUTIONS: Pending payment of benefits in accordance with the terms of this Plan, Elective Contributions may be retained by the Employer in a separate account or, if elected by the Employer and as permitted or required by regulations of the Internal Revenue Service, Department of Labor or other governmental agency, such amounts of Elective Contributions may be held in a trust pending payment.

4.07 MAXIMUM EMPLOYER CONTRIBUTIONS: With respect to each Participant, the maximum amount made available to pay benefits for any Plan Year shall not exceed the Employer's Contribution specified in the Adoption Agreement and as provided in this Plan.

SECTIONV

GROUP MEDICAL INSURANCE BENEFIT PLAN

5.01 **PURPOSE:** These benefits provide the group medical insurance benefits to Participants.

5.02 **EL!GIBI !TY:** Eligibility will be as required in Items F(I), F(3), and F(4) ofthe Adoption Agreement.

5.03 **D8: CR[PTIO QF BENEFITS:** The benefits available under this Plan will be as defined in Items F(I), F(3), and F(4) ofthe Adoption Agreement.

5.04 **TERMS, CONDITIONS AND LIMITATIONS:** The terms, conditions and limitations of the benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

5.05 **COBRA:** To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA, Participants and Dependents shall be entitled to continued participation in this Group Medical Insurance Benefit Plan by contributing monthly (from their personal assets previously subject to taxation) 102% of the amount of the premium for the desired benefit during the period that such individual is entitled to elect continuation coverage, provided, however, in the event the continuation period is extended to 29 months due to disability, the premium to be paid for continuation coverage for the 11 month extension period shall be 150% ofthe applicable premium.

5.06 **SECTION 105 AND 106 PLAN:** It is the intention ofthe Employer that these benefits shall be eligible for exclusion from the gross income ofthe Participants covered by this benefit plan, as provided in Code Sections 105 and 106, and all provisions ofthis benefit plan shall be construed in a manner consistent with that intention. It is also the intention of the Employer to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 as outlined in the policies identified in the Adoption Agreement.

5.07 **CONTRfBUTrON :** Contributions for these benefits will be provided by the Employer on behalfofa Participant as provided for in Item E ofthe Adoption Agreement.

5.08 **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT:** Notwithstanding anything to the contrary herein, the Group Medical Insurance Benefit·Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

SECTION VI

DISABILITY INCOME BENEFIT PLAN

6.01 **PURPOSE:** This benefit provides disability insurance designated to provide income to Participants during periods ofabsence from employment because ofdisability.

6.02 **ELLG18[LITY:** Eligibility will be as required in Item F(2) ofthe Adoption Agreement.

6.03 **DESCRIPTION OF BENEFITS:** The benefits available under this Plan will be as defined in Item F(2) ofthe Adoption Agreement.

6.04 . TERMS, CONDITION AND LIMITATIONS: The terms, conditions and limitations of the Disability Income Benefits offered shall be as specifically described in the Policy identified in the Adoption Agreement.

6.05 SECTION I04 AND I06 PLAN: It is the intention of the Employer that the premiums paid for these benefits shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan, as provided in Code Sections !04 and 106, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

6.06 CONTRIBUTIONS: Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement.

SECTION VII

GROUP AND INDIVIDUAL LIFE INSURANCE PLAN

7.0 I PURPOSE: This benefit provides group life insurance benefits to Participants and may provide certain individual policies as provided for in Item F(5) of the Adoption Agreement.

7.02 ELIGIBILITY: Eligibility will be as required in Item F(5) of the Adoption Agreement.

7.03 DESCRIPTION OP BE1 EPITS: The benefits available under this Plan will be as defined in Item F(5) of the Adoption Agreement.

7.04 TERMS CONDIT!ONS. A D LIMITATIONS: The terms, conditions, and limitations of the group life insurance are specifically described in the Policy identified in the Adoption Agreement.

7.05 SECTION 79 PLAN: It is the intention of the Employer that the premiums paid for the benefits described in Item F(5) of the Adoption Agreement shall be eligible for exclusion from the gross income of the Participants covered by this benefit plan to the extent provided in Code Section 79, and all provisions of this benefit plan shall be construed in a manner consistent with that intention.

7.06 CONTRIBUTION :S Contributions for this benefit will be provided by the Employer on behalf of a Participant as provided for in Item E of the Adoption Agreement. Any individual policies purchased by the Employer for the Participant will be owned by the Participant.

SECTION VIII

MEDICAL EXPENSE REIMBURSEMENT PLAN

8.0 I PURPOSE: The Medical Expense Reimbursement Plan is designed to provide for reimbursement of Eligible Medical Expenses (as defined in Section 8.04) that are not reimbursed under an insurance plan, through damages, or from any other source. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Sections I05 and 106, for Participants who elect this benefit and all provisions of this Section VIII shall be construed in a manner consistent with that intention.

8.02 ELIO! BILfTY: The eligibility provisions are set forth in Item F(7) of the Adoption Agreement.

8.03 TERMS, CONDITIONS, AND LIMITATIONS:

a. **Accounts.** The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Medical Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. **Maximum benefit.** The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's Elective Contribution allocated to the program during the Plan Year, not to exceed the maximum amount set forth in Item F(7) of the Adoption Agreement.

c. **Claim Procedure.** In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Reimbursement Recordkeeper. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the ninetieth (90th) day following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set forth in Section XII.

d. **Funding.** The funding of the Medical Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administrative expenses become due and payable under this Medical Expense Reimbursement Plan.

e. **Forfeiture.** Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Medical Expenses incurred during the Participant's participation during the Plan Year shall be forfeited and shall remain assets of the Plan. With respect to a Participant who terminates employment with the Employer and who has not elected to continue coverage under this Plan pursuant to COBRA rights referenced under Section 8.03(f) herein, such Participant shall not be entitled to reimbursement for Eligible Medical Expenses incurred after his termination date regardless if such Participant has any amounts of Employer Contributions remaining to his credit. Upon the death of any Participant who has any amounts of Employer Contributions remaining to his credit, a dependent of the Participant may elect to continue to claim reimbursement for Eligible Medical Expenses in the same manner as the Participant could have for the balance of the Plan Year.

f. **COBRA.** To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ("COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of

desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date o(the qualifying event. Participants who have a deficit. balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

g. Nondiscrimination. Benefits provided under this Medical Expense Reimbursement Plan shall not be provided in a manner that discriminates in favor of Employees or Dependents who are highly compensated individuals, as provided under Section I 05(h) of the Code and regulations promulgated thereunder.

h. Uniform Coverage Rule. Notwithstanding that a Participant has not had withheld and credited to his account all of his contributions elected with respect to a particular Plan Year, the entire aggregate annual amount elected with respect to this Medical Expense Reimbursement Plan, shall be available at all times during such Plan Year to reimburse the participant for Eligible Medical Expenses with respect to this Medical Expense Reimbursement Plan. To the extent contributions with respect to this Medical Expense Reimbursement Plan are insufficient to pay such Eligible Medical Expenses, it shall be the Employer's obligation to provide adequate funds to cover any short fall for such Eligible Medical Expenses for a Participant; provided subsequent contributions with respect to this Medical Expense Reimbursement Plan by the Paiticipant shall be available to reimburse the Employer for funds advanced to cover a previous short fall.

i. Unirormed Services Employment and Reemploymen t Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law I 03-353).

j. Proration of Limit. In the event that the Employer has purchased a uniform coverage risk policy from the Recordkeeper, then the Maximum Coverage amount specified in Section F.7 of the Adoption Agreement shall be pro rated with respect to (i) an Employee who becomes a Participant and enters the Plan during the Plan Year, and (ii) short plan years initiated by the Employer. Such Maximum Coverage amount will be pro rated by dividing the annual Maximum Coverage amount by 12, and multiplying the quotient by the number of remaining months in the Plan Year for the new Participant or the number of months in the short Plan Year, as applicable.

k. Continuation Coverage ror Certain Dependent Children. In the event that benefits under the Medical Expense Reimbursement Plan does not qualify for the exception from the portability rules of HIPAA, then, effective for Plan Years beginning on or after October 9, 2009, notwithstanding the foregoing provisions, coverage for a Dependent child who is enrolled in the Medical Expense Reimbursement Plan as a student at a post-secondary educational institution will not terminate due to a medically necessary leave of absence before a date that is the earlier of:

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For purposes of this paragraph, "medically necessary leave of absence" means a leave of absence of the child from a post-seconda1y educational institution, or any other change in enrollment of

the child at the institution, that: (i) commences while the child is suffering from a serious illness or injury; (ii) is medically necessary; and (iii) causes the child to lose student status for purposes of coverage under the terms of the Plan. A written certification must be provided by a treating physician of the dependent child to the Plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

8.04 **ELIGIBLE MEDICAL EXPENSES:**

(a) **Eligible Medical Expense in General.** The phrase 'Eligible Medical Expense' means any expense incurred by a Participant or any of his Dependents (subject to the restrictions in Sections 8.04(b) and (c)) during a Plan Year that (i) qualifies as an expense incurred by the Participant or Dependents for medical care as defined in Code Section 213(d) and meets the requirements outlined in Code Section 125, (ii) is excluded from gross income of the Participant under Code Section 105(b), and (iii) has not been and will not be paid or reimbursed by any other insurance plan, through damages, or from any other source. Notwithstanding the above, capital expenditures are not Eligible Medical Expenses under this Plan. Further, notwithstanding the above, effective January I, 2011, only the following drugs or medicines will constitute Eligible Medical Expenses:

(i.) Drugs or medicines that require a prescription;

(ii.) Drugs or medicines that are available without a prescription ("over-the-counter drugs or medicines") and the Participant or Dependent obtains a prescription; and

(iii.) Insulin.

Commencement of Pn.rticipation. Only medical care expenses incurred by a Participant or the Participant's Dependent(s) on or after the date such Paiiicipant commenced participation in the Medical Expense Reimbursement Plan shall constitute an Eligible Medical Expense.

(c) **Eli'iiiblc Expenses Incurred bv Dependents.** For purposes of this Section, Eligible Medical Expenses incurred by Dependents defined in Section 2.04(c) are eligible for reimbursement if incurred after March 30, 2010; Eligible Medical Expenses incurred by Dependents defined in Sections 2.04(a) and (b) are eligible for reimbursement if incurred either before or after March 30,2010 (subject to the restrictions of Section 8.04(b)).

(d) **Health Savings Accounts.** If the Employer has elected in Item F.8 of the Adoption Agreement to allow Eligible Employees to contribute to Health Savings Accounts under the Plan, then for a Participant who is eligible for and elects to contribute to a Health Savings Accounts, Eligible Medical Expenses shall be limited as set forth in Item F.8 of the Adoption Agreement.

8.05 **USE OF DEBIT CARD:** In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses (other than over-the-counter drugs or medicines) under the (b) Medical Expense Reimbursement Plan, the provisions described in this Section shall apply. However, beginning January I, 2011, a Debit Card may not be used to purchase drugs or medicines over-the-counter.

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a. Substantiation. The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card to pay the claimed Eligible Medical Expense:

(i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or fu11her review.

(ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verity to the Recordkeeper (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.

b. Status of harges. All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (a) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.

c. Correction Procedures for Improper Payments. In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:

(i) First, upon the Recordkeeper's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld f'om the Eligible Employee's wages or other compensation to the extent consistent with applicable law.

(iii) Third, if the improper payment still remains outstanding, the Plan may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

d. Intent to comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of

such cards set forth in Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

8.06 **GRACE PERIOD:** If the Employer elects in Section tf.7 of the Adoption Agreement to permit a Grace Period with respect to the Medical Reimbursement Plan, the provisions of this Section 8.06 shall apply. Notwithstanding anything to the contrary herein and in accordance with Internal Revenue Service Notice 2005-42, a Participant who has unused contributions relating to the Medical Reimbursement Plan from the immediately preceding Plan Year, and who incurs Eligible Medical Expenses for such qualified benefit during the Grace Period, may be paid or reimbursed for those Eligible Medical Expenses from the unused contributions as if the expenses had been incurred in the immediately preceding Plan Year. tfor purposes of this Section, 'Grace Period' shall mean the period extending 2 1/2 months after the end of the immediately preceding Plan Year to which it relates. Eligible Medical Expenses incurred during the Grace Period shall be reimbursed first from unused contributions allocated to the Medical Reimbursement Plan for the prior Plan Year, and then from unused contributions for the current Plan Year, if participant is enrolled in current Plan Year.

SECTION IX

DEPENDENT CARE REIMBURSEMENT PLAN

9.01 **PURPO E:** The Dependent Care Reimbursement Plan is designed to provide for reimbursement of certain employment-related dependent care expenses of the Participant. It is the intention of the Employer that amounts allocated for this benefit shall be eligible for exclusion from gross income, as provided in Code Section 129, for Participants who elect this benefit, and all provisions of this Section IX shall be construed in a manner consistent with that intention.

9.02 **ELJGIBILfTY:** The eligibility provisions are set forth in Item tf(6) of the Adoption Agreement.

9.03 **TERMS. CONDITIONS. AND LLMITATfONS:**

a. **Accounts.** The Reimbursement Recordkeeper shall establish a recordkeeping account for each Participant. The Reimbursement Recordkeeper shall maintain a record of each account on an on-going basis, increasing the balances as contributions are credited during the year and decreasing the balances as Eligible Dependent Care Expenses are reimbursed. No interest shall be payable on amounts recorded in any Participant's account.

b. **Maximum Benefit.** The maximum amount of reimbursement for each Participant shall be limited to the amount of the Participant's allocation to the program during the Plan Year not to exceed the maximum amount set forth in Item tf(6) of the adoption agreement.

tfor purpose of this Section IX, the phrase "earned income" shall mean wages, salaries, tips and other employee compensation, but only if such amounts are includible in gross income for the taxable year. A Participant's spouse who is physically or mentally incapable of self-care as described in Section 9.04(a)(ii) or a spouse who is a full-time student within the meaning of Code Section 21(e)(7) shall be deemed to have earned income for each month in which such spouse is so disabled (or a full-time student). The amount of such deemed earned income shall be $250 per month in the case of one Dependent and $500 per month in the case of two or more Dependents.

c. **Claim Procedure. In order to be reimbursed for any dependent care expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Reimbursement Recordkeeper. The Participant shall submit the completed form to the Reimbursement Recordkeeper with an original bill or other proof of the expense from an independent third party acceptable to the Reimbursement Recordkeeper. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of the expense as determined by the Reimbursement Recordkeeper. Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the ninetieth (90th) day following the last day of the Plan Year during which the Eligible Dependent Care Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of the incapacity or death of the Participant. Forms for reimbursement shall be reviewed in accordance with the claims procedure set fo1ih in Section XII.**

d. **Punding. The funding of the Dependent Care Reimbursement Plan shall be through contributions by the Employer from its general assets to the extent of Elective Contributions directed by Participants. Such contributions shall be made by the Employer when benefit payments and account administration expenses become due and payable under this Dependent Care Expense Reimbursement Plan.**

e. **Fodeilure. Any amounts remaining to the credit of the Participant at the end of the Plan Year and not used for Eligible Dependent Care Expenses incurred during the Plan Year shall be forfeited and remain assets of the Plan.**

f. **Nondiscrimination. Benefits provided under this Dependent Care Reimbursement Plan shall not be provided in a manner that discriminates in favor of Highly Compensated Employees (as defined in Code Section 414(q)) or their dependents, as provided in Code Section 129. In addition, no more than 25 percent of the aggregate Eligible Dependent Care Expenses shall be reimbursed during a Plan Year to five percent owners, as provided in Code Section 129.**

9.04 DEFINITIONS:

a. **"Dep ndent" (for purposes of this Section IX) means any individual who is:**

(i) **a Participant's qualifying child (as defined in Code Section 152(c)) who has not attained the age of 13; or**

(ii) **a dependent (qualifying child or qualifying relative, as defined in Code Section 152(c) and (d), respectively) or the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the taxpayer for more than half of the taxable year. For purposes of this Dependent Care Reimbursement Plan, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental defect, the individual is incapable of caring for his or her hygienic or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others.**

b. **"Dependent care Center" (for purposes of this Section IX) shall be a facility which:**

(i) **provides care for more than six individuals (other than individuals who reside at the facility);**

(ii) receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit); and

(iii) satisfies all applicable laws and regulations of a state or unit of local government.

C. "Eligible Dependent Care Expenses" (for purposes of this Section IX) shall mean expenses incurred by a Participant which are:

(i) incurred for the care of a Dependent of the Participant or for related household services;

(ii) paid or payable to a Dependent Care Service Provider; and

(iii) incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

"Eligible Dependent Care Expenses" shall not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is (i) a qualifying child (as defined in Code Section 152 (c)) under the age of 13, or (ii) a dependent (qualifying child or qualifying relative, as defined in Code Section 152 (c) and (d), respectively)), who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year, or (iii) the spouse of a Participant who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the taxable year. Eligible Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

d. "Dependent Care Service Provider" (for purposes of this Section IX) means:

(i) a Dependent Care Center, or

(ii) a person who provides care or other services described in Section 9.04(b) and who is not a related individual described in Section 129(c) of the Code.

SECTION X

HEALTH SAVINGS ACCOUNTS

10.01 PURPOSE: If elected by the Employer in Section F.8 of the Adoption Agreement, the Plan will permit pre-tax contributions to the Health Savings Account, and the provisions of this Article X shall apply.

10.02 BENEFITS: A Participant can elect benefits under the Health Savings Accounts portion of this Plan by electing to pay his or her Health Savings Account contributions on a pre-tax salary reduction basis. In addition, the Employer may make contributions to the Health Savings Account for the benefit of the Participant.

10.03 TERMS.CONDITIONS AND LfMITATrON:

a. Maximum Benefit. The maximum annual contributions that may be made to a Participant's Health Savings Account under this Plan is set forth in Section F.8 of the Adoption Agreement.

b. Mid-Year Election Changes. Notwithstanding any to the contrary herein, a Participant election with respect to contributions for the Health Savings Account shall be revocable during the duration of the Plan Year to which the election relates. Consequently, a Participant may change his or her election with respect to contributions for the Health Savings Account at any time.

10.04 **RESTRICTIONS O MEDICAL REJMBURSEMENT PLAN:** If the Employer has elected in Section F.8 of the Adoption Agreement both Health Savings Accounts under this Plan and the Medical Expense Reimbursement Plan, then the Eligible Medical Expenses that may be reimbursed under the Medical Reimbursement Plan for Participants who are eligible for and elect to participate in Health Savings Accounts shall be limited as set forth in Section tf.8 of the Adoption Agreement.

10.05 **NO ESTABLISHMENT Of' ERISA PLAN:** It is the intent of the Employer that the establishment of Health Savings Accounts are completely voluntary on the part of Participants, and that, in accordance with Department of Labor tfield Assistance Bulletin 2004-1, the Health Savings Accounts are not "employee welfare benefit plans" for purposes of Title I of ERISA.

SECTION XI AMENDMENT AND

TERMINATION

11.01 **AMENDMENT:** The Employer shall have the right at any time, and from time to time, to amend, in whole or in part, any or all of the provisions of this Plan, provided that no such amendment shall change the terms and conditions of payment of any benefits to which Participants and covered dependents otherwise have become entitled to under the provisions of the Plan, unless such amendment is made to comply with federal or local laws or regulations. The Employer also shall have the right to make any amendment retroactively which is necessary to bring the Plan into conformity with the Code. In addition, the Employer may amend any provisions or any supplements to the Plan and may merge or combine supplements or add additional supplements to the Plan, or separate existing supplements into an additional number of supplements.

11.02 **TERMINATION:** The Employer shall have the right at any time to terminate this Plan, provided that such termination shall not eliminate any obligations of the Employer which therefore have arisen under the Plan.

SECTION XII

ADMINISTRATION

12.01 **NAMED FJDUCIARIES:** The Administrator shall be the fiduciary of the Plan.

12.02 **APPOINTMENT OF RECORDKEEPER:** The Employer may appoint a Reimbursement Recordkeeper which shall have the power and responsibility of performing recordkeeping and other ministerial duties arising under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan provisions of this Plan. The Reimbursement Recordkeeper shall serve at the pleasure of, and may be removed by, the Employer without cause. The Recordkeeper shall receive reasonable compensation for its services as shall be agreed upon from time to time between the Administrator and the Recordkeeper.

12.03 **POWERS AND RESPONSIBILITIES OF ADMINISTRATOR:**

a. **General.** The Administrator shall be vested with all powers and authority necessary in order to amend and administer the Plan, and is authorized to make such rules and regulations as it may deem necessary to carry out the provisions of the Plan. The Administrator shall determine any

questions arising in the administration (including all questions of eligibility and determination of amount, *time* and manner of payments of benefits), construction, interpretation and application of the Plan, and the decision of the Administrator shall be final and binding on all persons.

b. Recordkecping. The Administrator shall keep full and complete records of the administration of the Plan. The Administrator shall prepare such repo1ts and such information concerning the Plan and the administration thereof by the Administrator as may be required under the Code or ERISA and the regulations promulgated thereunder.

c. In pection of Records. The Administrator shall, during normal business hours, make available to each Pa1ticipant for examination by the Participant at the principal office of the Administrator a copy of the Plan and such records of the Administrator as may pertain to such Participant. No Participant shall have the right to inquire as to or inspect the accounts or records with respect to other Participants.

12.04 COMPENSATION AND EXPENSES OF ADMINISTRATOR: The Administrator shall serve without compensation for services as such. All expenses of the Administrator shall be paid by the Employer. Such expenses shall include any expense incident to the functioning of the Plan, including, but not limited to, attorneys' fees, accounting and clerical charges, actuary fees and other costs of administering the Plan.

12.05 LIABILITY OF ADMINISTRATOR: Except as prohibited by law, the Administrator shall not be liable personally for any loss or damage or depreciation which may result in connection with the exercise of duties or of discretion hereunder or upon any other act or omission hereunder except when due to willful misconduct. In the event the Administrator is not covered by fiduciary liability insurance or similar insurance arrangements, the Employer shall indemnify and hold harmless the Administrator from any and all claims, losses, damages, expenses (including reasonable counsel fees approved by the Administrator) and liability (including any reasonable amounts paid in settlement with the Employer's approval) arising from any act or omission of the Administrator, except when the same is determined to be due to the willful misconduct of the Administrator by a court of competent jurisdiction.

12.06 DELEGATJONS OP RESPONSIBILITY: The Administrator shall have the authority to delegate, from time to time, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable and in the same manner to revoke any such delegation of responsibilities which shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator. The Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall report periodically to the Administrator concerning the discharge of the delegated responsibilities.

12.07 RICTHT TO RECEIVE AND RELEASE nECESSARY INFORMATTO The Administrator may release or obtain any information necessary for the application, implementation and determination of this Plan or other Plans without consent or *notice* to any person. This information may be released to or obtained from any insurance company, organization, or person subject to applicable law. Any individual claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this provision.

12.08 CLAIM FOR BENEFITS: To obtain payment of any benefits under the Plan a Participant must comply with the rules and procedures of the particular benefit program elected pursuant to *this* Plan under which the Participant claims a benefit.

12.09 **GENERAL CLAIMS REVIEW PROCEDURE:** This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan or is not governed by Section 12.10.

a. **Initial Claim For Benefit.**. Each Participant may submit a claim for benefits to the Administrator as provided in Section 12.08. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

b. **Review of Claim Denial.** If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review , unless special circumstances require an extension of time for processing the review, in which case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

c. **Exhaustion of Remedies**. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

12.10 **SPECIAL CLAIMS REVIEW PROCEDURE:** The provisions of this Section 12.10 shall be applicable to claims under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan, effective on the first day of the first Plan Year beginning on or after July 1, 2002, but in no event later than January 1, 2003, provided such plans are subject to ERISA.

a. **Benefit Denials:** The Administrator is responsible for evaluating all claims for reimbursement under the Medical Expense Reimbursement Plan and the Group Medical Insurance Plan.

The Administrator will decide a Participant's claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Participant will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Administrator is expected to be made. The Participant will be given 45 days in which to complete an incomplete claim. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

If the Administrator denies the claim, in whole or in part, the Participant will be furnished with a written notice of adverse benefit determination setting forth:

1. the specific reason or reasons for the denial;

2. reference to the specific Plan provision on which the denial is issued;

3. a description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary, and

4. appropriate information as to the steps to be taken if the Participant wishes to appeal the Administrator's determination, including the participant's right to submit written comments and have them considered, his right to review (on request and at no charge) relevant documents and other information, and his right to file suit under ERISA with respect to any adverse determination after appeal of his claim.

b. **Appealing Denied Claims:** If the Participant's claim is denied in whole or in part, he may appeal to the Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Administrator's initial notice of adverse benefit determination, or else the participant will lose the right to appeal the denial. If the Participant does not appeal on time, he will also lose his right to file suit in court, as he will have failed to exhaust his internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Participant's written appeal should state the reasons that he feels his claim should not have been denied. It should include any additional facts and/or documents that the Participant feels support his claim. The Participant may also ask additional questions and make written comments, and may review (on request and at no charge) documents and other information relevant to his appeal. The Administrator will review all written comment the Participant submits with his appeal.

c. **Review or Appeal:** The Administrator will review and decide the Participant's appeal within a reasonable time not longer than 60 days after it is submitted and will notify the Participant of its decision in writing. The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. The Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. (The

identity of a medical expert consulted in connection with the Participant's appeal will be provided.) Ifthe decision on appeal affirms the initial denial ofthe Participant's claim, the Participant will be furnished with a notice of adverse benefit determination on review setting forth:

I. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based,

3. A statement of the Participant's right to review (on request and at no charge) relevant documents and other information,

4. If the Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy ofsuch rule, guideline, protocol, or other criterion will be provided free ofcharge to the Participant upon request," and

5. A statement ofthe Participant's right to bring suit under ERISA§ 502(a).

12.11 PAYMENT TO REPRESENTATIVE: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor, and such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Administrator and the Employer.

12.12 PROTECTED HEALTH INFORMATION. The provisions of this Section will apply only to those portions of the Plan that are considered a group health plan for purposes of45 CFR Parts 160 and 164. The Plan may disclose PHI to employees ofthe Employer, or to other persons, only to the extent such disclosure is required or permitted pursuant to 45 CFR Parts 160 and 164. The Plan has implemented administrative, physical, and technical safeguards to reasonably and appropriately protect, and restrict access to and use of, electronic PHI, in accordance with Subpart C of45 CFR Part 164. The applicable claims procedures under the Plan shall be used to resolve any issues of non-compliance by such individuals. The Employer will:

- not use or disclose PHI other than as permitted or required by the plan documents and permitted or required by law;
- reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the it on behalfofthe Plan, in accordance with Subpart C of45 CFR Part 164;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalfof the Plan;
- 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 such information;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan ofthe Employer;

- report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- make available PHI in accordance with 45 CFR Section 164.524;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services or his designee upon request for purposes of determining compliance with 45 CFR Section 164.504(t);
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and,
- ensure that the adequate separation required in paragraph (t)(2)(iii) of 45 CFR Section 164.504 is established.

For purposes of this Section, "PHI" is "Protected Health Information" as defined in 45 CFR Section 160.103, which means individually identifiable health information, except as provided in paragraph (2) of the definition of "Protected Health Information" in 45 CFR Section 160.103, that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium by a covered entity, as defined in 45 CFR Section 164.104.

SECTION XUI MISCELLANEOUS PROVISIONS

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

13.02 **FORM AND PROOFS:** Each Participant or Participant's Beneficiary eligible to receive any benefit hereunder shall complete such forms and furnish such proofs, receipts, and releases as shall be required by the Administrator.

13.03 **NO GUARANTEE OF TAX CONSEQUENCES:** Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or a Dependent under the Plan will be excludable from the Participant's or Dependent's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant or Dependent.

13.04 **PLAN NOT CONTRACT OF EMPLOYMENT:** The Plan will not be deemed to constitute a contract of employment between the Employer and any Participant nor will the Plan be considered an inducement for the employment of any Participant or employee. Nothing contained in the Plan will be deemed to give any Participant or employee the right to be retained in the service of the Employer nor to

interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the Plan.

13.05 **NON-ASSIGNABILITY:** No benefit under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or his Beneficiary, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferability by operation of law.

13.06 **SEVERABILITY:** If any provision of the Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof will continue to be fully effective.

13.07 **CONSTRUCTION:**

a. Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively where appropriate.

b. Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

13.08 **NONDISCRIMINATION:** In accordance with Code Section I 2 5 (b)(I), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(I)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

13.09 **ERISA.** The Plan shall be construed, enforced, and administered and the validity determined in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974 (as amended), the Internal Revenue Code of 1986 (as amended), and the laws of the State indicated in the Adoption Agreement. Notwithstanding anything to the contrary herein, the provisions of ERISA will not apply to this Plan if the Plan is exempt from coverage under ERTSA. Should any provisions be determined to be void, invalid, or unenforceable by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of the court only will be deemed not to include the provision determined to be void.