

**Pinal County  
Flexible Benefits Plan  
Summary Plan Description**

**Amended and Restated  
January 1, 2012**

As Amended effective December 31, 2013.

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## **INTRODUCTION**

The Employer has adopted this Plan effective January 1, 2012, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. The Plan shall be known as Pinal County Flexible Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

### **IMPORTANT INFORMATION**

**For January 1 2013- June 30, 2013:** The Plan Year will be a six (6)-month period beginning on January 1 and ending on June 30.

**For July 1, 2013-June 30, 2014 and subsequent Plan Years:** The Plan Year will be a twelve (12)-month period beginning July 1 and ending June 30.

## **SECTION I - DEFINITIONS**

### **1.1 Affiliated Employer**

The Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

### **1.2 Benefit or Benefit Options**

Any of the optional benefit choices available to a Participant as outlined in Section IV.

### **1.3 Cafeteria Plan Benefit Dollars**

The amount available to Participants to purchase Benefit Options as provided under Section IV. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

### **1.4 Code**

The Internal Revenue Code of 1986, as amended or replaced from time to time.

### **1.5 Compensation**

The amounts received by the Participant from the Employer during a Plan Year.

**1.6 Dependent**

Any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order shall be considered a Dependent under this Plan.

**Dependent** shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, as allowed by reason of the Patient Protection and Affordable Care Act of 2010.

**1.7 Effective Date**

January 1, 2012

**1.8 Eligible Employee**

All active full-time Employees scheduled to work 30 hours or more each week and elected officials, are eligible provided they occupy an authorized budgeted position, as defined by the County, and are performing all of the duties of their employment. Elected officials are also eligible to participate under the Plan under the same requirements as Employees.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law Employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

**1.9 Employee**

Any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

**1.10 Employer**

Pinal County and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

**1.11 Employer Contribution**

The contributions made by the Employer pursuant to Section III to enable a Participant to purchase Benefits. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V and as set forth in Section 3.1.

**1.12 Key Employee**

An Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

**1.13 Insurance Contract**

Any contract issued by an Insurer underwriting a Benefit.

**1.14 Insurer**

Any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits, the Employer.

**1.15 Open Enrollment Period**

The period immediately preceding the beginning of each Plan Year established by the Plan Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section V.

**1.16 Participant**

Any Eligible Employee who elects to become a Participant pursuant to Section II and has not for any reason becomes ineligible to participate further in the Plan.

**1.17 Plan**

This instrument, including all amendments thereto.

**1.18 Plan Administrator**

The individual(s) or corporation appointed by the Employer to carry out the administration of the Plan. The Employer shall be empowered to appoint and remove the plan administrator from time to time as it deems necessary for the proper administration of the Plan. In the event the plan administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the plan administrator.

**1.19 Plan Year**

**For January 1, 2012 – December 31, 2012:** The twelve (12)-month period beginning January 1 and ending December 31.

**For January 1 2013- June 30, 2013:** The Plan Year will be a six (6)-month period beginning on January 1 and ending on June 30.

**For July 1, 2013-June 30, 2014 and subsequent Plan Years:** The Plan Year will be a twelve (12)-month period beginning July 1 and ending June 30.

The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year then the initial coverage period shall be that portion of the Plan Year-commencing on such Participant's date of entry and ending on the last day of such Plan Year.

**1.20 Premium Expenses or Premiums**

The Participant's cost for the self-funded Benefits described in Section IV.

**1.21 Premium Expense Reimbursement Account**

The account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

**1.22 Salary Redirection**

The contributions made by the Employer on behalf of Participants Pursuant to Section III. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Section V.

**1.23 Salary Redirection Agreement**

An agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

**1.24 Spouse**

The legally married husband or wife of a Participant, unless legally separated by court decree.

## **SECTION II - PARTICIPATION**

### **2.1 Eligibility**

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference.

### **2.2 Effective Date of Participation**

An Eligible Employee shall become a Participant effective as of the date on which he satisfies the requirements pursuant to Section II.

### **2.3 Application to Participate**

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application and election-of-benefits form which the Plan Administrator shall furnish to the Employee. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section V.

An Eligible Employee shall also be required to execute a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section II.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-funded Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

### **2.4 Termination of Participation**

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- a. **Termination of employment.** The participant's termination of employment, subject to the provisions of Section 2.5.
- b. **Death.** The Participant's death, subject to the provisions of Section 2.6; or
- c. **Termination of this Plan.** The termination of this Plan, subject to the provisions in Section X.

### **2.5 Termination of Employment**

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Plan shall be governed in accordance with the following:

- a. **Insurance Benefit.** With regard to Benefits provided under Section IV, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract or self-funded benefit for which premiums have already been paid.

- b. **Dependent Care Assistance Program.** With regard to the Dependent Care Assistance Program, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred up to the date of termination and submitted within 90 days after termination, based on the level of the Participant's Dependent Care Assistance Account as of the date of termination.
- c. **COBRA Applicability.** With regard to the Health Care Reimbursement Plan, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Care Reimbursement Plan have already been made. Thereafter, the health benefits under this Plan including the Health Care Reimbursement Plan shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section XI of the Plan.

## **2.6 Death**

If a Participant dies, his participation in the Plan shall cease. However, such Participant's Spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a Spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Care Reimbursement Plan.

## **SECTION III - CONTRIBUTIONS TO THE PLAN**

### **3.1 Employer Contribution**

The Employer shall make available to each Participant an Employer Contribution to be used for any Benefit under the Plan in an amount to be determined annual by the Employer. Each Participant's Employer Contribution shall be converted to Cafeteria Plan Benefit Dollars and be available to purchase Benefits as set forth above. The Employer's Contribution shall be made on a pro rata basis for each pay period of the Participant. If no Benefits are selected, there shall be no Employer Contribution.

### **3.2 Salary Redirection**

If a Participant's Employer Contribution is not sufficient to cover the cost of Benefits or Premium Expenses he elects pursuant to Section 4.1, his Compensation will be reduced in an amount equal to the difference between the cost of Benefits he elected and the amount of Employer Contribution available to him. Such reduction shall be his Salary Redirection, which the Employer will use on his behalf, together with his Employer Contribution, to pay for the Benefits he elected. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Section V and as set forth in Section 3.1.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section V) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Section V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

### **3.3 Application of Contributions**

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Care Reimbursement Fund or Dependent Care Assistance Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

### **3.4 Periodic Contributions**

Notwithstanding the requirement provided above and in other Sections of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Plan Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Care Reimbursement Plan, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

## SECTION IV - BENEFITS

### **4.1 Benefit Options**

Each Participant may elect one or more of the following optional Benefits:

1. Health Care Reimbursement Plan
2. Dependent Care Assistance Program

In addition, each Participant shall have a sufficient portion of his Employer Contributions and Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

3. Health Insurance Benefit
4. Dental Insurance Benefit
5. Basic Group-Term Life Insurance Benefit
6. Vision Insurance Benefit

### **4.2 Health Care Reimbursement Plan Benefit**

Each Participant may elect to participate in the Health Care Reimbursement Plan, in which case Section VI shall apply.

### **4.3 Dependent Care Assistance Program Benefits**

Each Participant may elect to participate in the Dependent Care Assistance Program, in which case Section VI shall apply.

### **4.4 Health Insurance Benefit**

- a. **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Contract for the Participant and his or her eligible Dependents.
- b. **Employer selects contracts.** The Employer may select suitable health Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.
- c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Contract shall be determined therefrom, and such Contract shall be incorporated herein by reference.

### **4.5 Dental Insurance Benefit**

- a. **Coverage for Participant and Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.
- b. **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

- c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

#### 4.6 **Group Term Voluntary Pre-Tax Life Insurance Benefits**

- a. **Coverage for Participant only.** Each Participant may elect to be covered under the Employer's group-term life Insurance Contract.
- b. **Employer selects contracts.** The Employer may select suitable group-term life Insurance Contracts for use in providing this group-term life insurance benefit, which policies will provide benefits for all Participants electing this Benefit on a uniform basis.
- c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such group-term life Insurance Contract shall be determined therefrom, and such group-term life Insurance Contract shall be incorporated herein by reference.

#### 4.7 **Vision Insurance Benefit**

- a. **Coverage for Participant and Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.
- b. **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.
- c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

#### 4.8 **Nondiscrimination of Requirements**

- a. **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.
- b. **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.
- c. **Adjustment to avoid test failure.** If the Plan Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected

Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Care Reimbursement Plan Benefits and Dependent Care Assistance Program Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

## SECTION V - PARTICIPANT ELECTIONS

### **5.1 Initial Elections**

An Employee who meets the eligibility requirements of this Plan on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided the employee elects to do so on or before the employee's effective date of participation pursuant to Section II.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-funded benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

### **5.2 Subsequent Annual Elections**

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Plan Administrator, which Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

- a. A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;
- b. A Participant may terminate his participation in the Plan by notifying the Plan Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;
- c. An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section V.

### **5.3 Failure to Elect**

Any Participant failing to complete an election-of-benefits form pursuant to Section V by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

With regard to Benefits available under the Plan for which Premium Expenses apply, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

### **5.4 Change in Status**

- a. **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are

incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation. Any new election shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Plan Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

- i. **Legal Marital Status:** events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;
- ii. **Number of Dependents:** Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
- iii. **Employment Status:** Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;
- iv. **Dependent satisfies or ceases to satisfy the eligibility requirements:** An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstance; and
- v. **Residency:** A change in the place of residence of the Participant, Spouse or Dependent that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Assistance Program, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the attainment of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

- b. **Special Enrollment Rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.
- c. **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order ) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

- a. **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.
- b. **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.  
  
A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.
- c. **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.
- d. **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an

option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

- e. **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.
- f. **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.
- g. **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Assistance Program only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).
- h. **Health FSA cannot Change due to insurance change.** A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a cost or coverage change under any health insurance benefits.
- i. **Health FSA amount can increase or decrease.** A Participant may increase or decrease his Benefit elections under the Health Flexible Spending Account in the event of a change in status, but never below the amount that has already been reimbursed.

## SECTION VI - HEALTH CARE REIMBURSEMENT PLAN

### 6.1 Establishment of Plan

This Health Care Reimbursement Plan is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Reimbursement Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed under this Health Care Reimbursement Plan shall be periodically paid from amounts allocated to the Health Care Reimbursement Fund. Periodic payments reimbursing Participants from the Health Care Reimbursement Fund shall in no event occur less frequently than monthly.

### 6.2 Definitions

For the purposes of this Section and the Cafeteria Plan, the terms below have the following meaning:

- a. **"Health Care Reimbursement Fund"** means the fund established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a participant, his or her Spouse and his or her Dependents may be reimbursed.
- b. **"Highly Compensated Participant"** means, for the purposes of this Section and determining discrimination under Code Section 105(h), a Participant who is:
  - i. one of the five (5) highest paid officers;
  - ii. a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than ten percent (10%) in value of the stock of the Employer; or
  - iii. among the highest paid twenty-five percent (25%) of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).
- c. **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

Effective January 1, 2011, a Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

- d. The definitions of Section I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Plan.

### **6.3 Carry-over and Forfeitures**

Beginning with the July 1, 2013 to June 30, 2014 Plan Year, up to \$500.00 of unused amounts remaining in your Health Care Reimbursement Fund at the end of the applicable Plan Year, may be carried over to the next Plan Year, to pay for qualifying expenses in addition to the amount you elect for the next Plan Year. This applies only to the Health Care Reimbursement Fund Benefits under the Plan. Any funds remaining that exceed this \$500.00 carryover limit will be forfeited. Qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first, then up to \$500.00 may be carried over to the next Plan Year, before any amount is forfeited. Pursuant to subsection 6.7(d) and Section VIII., Health Care Reimbursement Fund claims must be submitted no later than ninety(90) days from the end of the applicable Plan Year. The carryover amount will not be available to you until ninety (90) days after the Plan Year when your previous Plan Year's run out period has ended. All claims submitted for expenses incurred in a Plan Year, must be reimbursed first from that Plan Year's contributions before being reimbursed from previous Plan Year's carryover amounts.

### **6.4 Limitation on Allocations**

Notwithstanding any provision contained in this Health Care Reimbursement Plan to the contrary, the maximum amount that may be allocated to the Health Care Reimbursement Plan by a Participant in or on account for the 2012 Plan Year is \$2,650.

**For January 1 2013- June 30, 2013:** The maximum amount that may be allocated to the Health Care Reimbursement Plan by a Participant will be \$1,250.

**For July 1, 2013-June 30, 2014 and subsequent Plan Years** The maximum amount that may be allocated to the Health Care Reimbursement Plan by a Participant for subsequent Plan Years will be \$2,500.

### **6.5 Nondiscrimination Requirements**

- a. **Intent to be nondiscriminatory.** It is the intent of this Health Care Reimbursement Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.
- b. **Adjustment to avoid test failure.** If the Plan Administrator deems it necessary to avoid discrimination under this Health Care Reimbursement Plan, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Care Reimbursement Fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Care Reimbursement Fund for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan.

## **6.6 Coordination with Cafeteria Plan**

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Care Reimbursement Plan. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Care Reimbursement Plan. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

## **6.7 Health Care Reimbursement Plan Claims**

- a. **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her spouse and his or her dependents during the plan year shall be reimbursed during the Plan Year subject to Section II, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.
- b. **Reimbursement available throughout Plan Year.** The Plan Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Reimbursement Plan for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.
- c. **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Plan Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Plan Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Reimbursement Fund, such amount will not be claimed as a tax deduction. The Plan Administrator shall retain a file of all such applications.
- d. **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within the 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Plan Administrator.

## **6.8 Debit and Credit Cards**

Participants may, subject to a procedure established by the Plan Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Plan Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

- a. **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical

Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

- b. **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and is valid for 5 years so long as the Participant remains a Participant in the Health Care Reimbursement Plan. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Care Reimbursement Plan.
- c. **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.
- d. **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Plan Administrator.
- e. **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:
  - i. Co-payments for doctor and other medical care;
  - ii. Purchase of prescription drugs;
  - iii. Purchase of medical items such as eyeglasses, syringes, crutches, etc.
- f. **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Plan Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Plan Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.
- g. **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Plan Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Plan Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.
  - i. Repayment of the improper amount by the Participant;
  - ii. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
  - iii. Claims substitution or offset of future claims until the amount is repaid; and
  - iv. If items (i.) through (iii.) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

## 6.9 Qualified Reservist Distribution

- a. **Qualified Reservist Distribution.** A Participant may request a Qualified Reservist Distribution, provided the following provisions are satisfied. "Qualified Reservist Distribution" means any distribution to a Participant of all or a portion of the balance in the Participant's Health Care Reimbursement Plan if:

- i. Such Participant was an individual who was (by reason of being a member of a reserve component (as defined in Section 101 of Title 37, United States Code)) ordered or called to active duty for a period of 180 days or more or for an indefinite period.
  - ii. A Participant may have been called prior to June 18, 2008, provided the individual's active duty continues after June 18, 2008 and the period of duty complies with subsection (a).
  - iii. The distribution is made during the period beginning on the date of the order or call that applies to the Participant and ending on the last day of the Plan Year which includes the date of such order or call.
  - iv. The Qualified Reservist Distribution option is offered to all Participants who qualify under this Article.
  - v. Qualified Reservist Distributions may only be made if the Participant is ordered or called to active duty, not the Participant's spouse or dependents.
  - vi. Under Section 101 of the Title 37 of the United States Code, "reserve component" means: (1) the Army National Guard, (2) the Army Reserve, (3) the Navy Reserve, (4) the Marine Corps Reserve, (5) the Air National Guard, (6) the Air Force Reserve, (7) the Coast Guard Reserve, or (8) the Reserve Corps of the Public Health Service.
- b. **Conditions:** The following conditions apply:
- i. The Employer must receive a copy of the order or call to active duty and may rely on the order or call to determine the period that the Participant has been ordered or called to duty.
  - ii. Eligibility for a Qualified Reservist Distribution is not affected if the order or call is for 180 days or more or is indefinite, but the actual period of active duty is less than 180 days or is changed otherwise from the order or call.
  - iii. If the original order is less than 180 days, then no Qualified Reservist Distribution is allowed. However, if subsequent calls or orders increase the total days of active duty to 180 or more, then a Qualified Reservist Distribution will be allowed.
- c. **Amount:** The amount a Participant may be reimbursed from the Health Care Reimbursement Plan is the amount contributed by the Participant to the Health Care Reimbursement Plan as of the date of the distribution request, less any reimbursements received as of the date of the distribution request.
- d. **Procedure.** The Employer must specify a process for requesting the distribution. The Employer may limit the number of distributions processed for a Participant to 2 per Plan Year. The distribution request must be made on or after the call or order and before the last day of the Grace Period. The QRD shall be paid within a reasonable time but in no event more than 60 days after the date of the request.
- e. **Claims.** Claims incurred prior to the date of the request of the distribution shall be paid as any other claim. Claims incurred after the date of the distribution shall be paid on submission as any other claim.

## **SECTION VII - DEPENDENT CARE ASSISTANCE PROGRAM**

### **7.1 Establishment of Program**

This Dependent Care Assistance Program is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Assistance Account.

### **7.2 Definitions**

For the purposes of this section and the Cafeteria Plan the terms below shall have the following meaning:

- a. **"Dependent Care Assistance Account"** means the account established for a Participant pursuant to this Section to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the qualifying Dependents of Participants.
- b. **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.
- c. **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:
  - i. If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least eight 8 hours per day in the Participant's household;
  - ii. If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and
  - iii. Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of nineteen 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

- d. **"Qualifying Dependent"** means, for Dependent Care Assistance Account purposes,
- i. a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;
  - ii. a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or
  - iii. a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).
- e. The definitions of Section I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Account.

### **7.3 Dependent Care Assistance Accounts**

The Plan Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Assistance Program benefits.

### **7.4 Increases in Dependent Care Assistance Accounts**

A Participant's Dependent Care Assistance Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Assistance Account pursuant to elections made under Section V hereof.

### **7.5 Decreases in Dependent Care Assistance Accounts**

A Participant's Dependent Care Assistance Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section VII.

### **7.6 Allowable Dependent Care Assistance Reimbursement**

Subject to limitations contained in Section VII of this Program, and to the extent of the amount contained in the Participant's Dependent Care Assistance Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

### **7.7 Annual Statement of Benefits**

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section VII during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's form W-2.

## **7.8 Forfeitures**

The amount in a Participant's Dependent Care Assistance Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section VII) shall be forfeited and credited to the benefit plan. In such event, the Participant shall have no further claim to such amount for any reason.

## **7.9 Limitation on Payments**

### **Code Limits.**

**For January 1 2013- June 30, 2013:** Notwithstanding any provision contained in this Section to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or \$2,500 (\$1,250 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

**For July 1, 2013-June 30, 2014 and subsequent Plan Years:** Notwithstanding any provision contained in this Section to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or \$5,000 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

## **7.10 Nondiscrimination Requirements**

- a. **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Assistance Program that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).
- b. **25% test for shareholders.** It is the intent of this Dependent Care Assistance Program that not more than twenty-five 25% of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than five 5% of the stock or of the capital or profits interest in the Employer.
- c. **Adjustment to avoid test failure.** If the Plan Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Assistance Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Assistance Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

### 7.11 Coordination with Cafeteria Plan

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Assistance Program. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Assistance Program. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

### 7.12 Dependent Care Assistance Program Claims

The Plan Administrator shall direct the payment of all such Dependent Care Assistance claims to the Participant upon the presentation to the Plan Administrator of documentation of such expenses in a form satisfactory to the Plan Administrator. In its discretion in administering the Plan, the Plan Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Plan Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- a. The Dependent or Dependents for whom the services were performed;
- b. The nature of the services performed for the Participant, the cost of which he wishes reimbursement;
- c. The relationship, if any, of the person performing the services to the Participant;
- d. If the services are being performed by a child of the Participant, the age of the child;
- e. A statement as to where the services were performed;
- f. If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least eight (8) hours a day in the Participant's household;
- g. If the services were being performed in a day care center, a statement:
  - i. that the day care center complies with all applicable laws and regulations of the state of residence,
  - ii. that the day care center provides care for more than six (6) individuals (other than individuals residing at the center), and
  - iii. of the amount of fee paid to the provider.
- h. If the Participant is married, a statement containing the following:
  - i. the Spouse's salary or wages if he or she is employed, or
  - ii. if the Participant's Spouse is not employed, that
    - (1) he or she is incapacitated, or
    - (2) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.
- i. **Claims for Reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Plan

Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted with 90 days after termination of employment.

### 7.13 Debit and Credit Cards

Participants may, subject to a procedure established by the Plan Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Plan Administrator and the Plan for payment of Employment-Related Dependent Care Expenses, subject to the following terms:

- a. **Card only for dependent care expenses.** Each Participant issued a card shall certify that such card shall only be used for Employment-Related Dependent Care Expenses. The Participant shall also certify that any Employment-Related Dependent Care Expense paid with the card has not already been reimbursed by any other plan covering dependent care benefits and that the Participant will not seek reimbursement from any other plan covering dependent care benefits.
- b. **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and is valid for 5 years so long as the Participant remains a Participant in the Dependent Care Assistance Program. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Dependent Care Assistance Program.
- c. **Only available for use with certain service providers.** The cards shall only be accepted by such service providers as have been approved by the Plan Administrator. The cards shall only be used for Employment-Related Dependent Care Expenses from these providers.
- d. **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Plan Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Plan Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.
- e. **Correction methods.** If such purchase is later determined by the Plan Administrator to not qualify as an Employment-Related Dependent Care Expense, the Plan Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Plan Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.
  - i. Repayment of the improper amount by the Participant;
  - ii. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
  - iii. Claims substitution or offset of future claims until the amount is repaid; and
  - iv. If items (i.) through (iii.) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

## SECTION VIII - BENEFITS & RIGHTS

### 8.1 Claim for Benefits

- a. **Insurance Claims.** Any claim for Benefits underwritten by the self-funded plan shall be made to the Employer. If the Employer denies any claim, the Participant or beneficiary shall follow the Employer's claims review procedure.
- b. **Dependent Care Assistance Program Claims.** Any claim for Dependent Care Assistance Program Benefits shall be made to the Plan Administrator. For the Dependent Care Assistance Program, if a participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Plan Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment. If the Plan Administrator denies a claim, the Plan Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:
  - i. specific references to the pertinent Plan provisions on which the denial is based;
  - ii. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and
  - iii. an explanation of the Plan's claim procedure.
- c. **Appeal.** Within sixty 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Plan Administrator for a full and fair review. The claimant or his duly authorized representative may:
  - i. request a review upon written notice to the Plan Administrator;
  - ii. review pertinent documents; and
  - iii. submit issues and comments in writing.
- d. **Review of appeal.** A decision on the review by the Plan Administrator will be made not later than sixty 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Plan Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.
- e. **Health FSA claims.** If a Participant fails to submit a claim under the Health Care Reimbursement Plan within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Plan Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment. Once a claim is submitted, the following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
<b>Insufficient information on the Claim:</b>	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- i. The specific reason or reasons for the denial.
- ii. Reference to the specific Plan provisions on which the denial was based.
- iii. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- iv. A description of the Plan's review procedures and the time limits applicable to such procedures.
- v. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- vi. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- i. was relied upon in making the claim determination;
- ii. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- iii. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

- iv. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

- f. **Forfeitures.** Any balance remaining in the Participant's Dependent Care Assistance Program or Health Care Reimbursement Plan as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan of the Employer pursuant to Section VI or Section VII, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

## **8.2 Application of Forfeitures**

Any forfeited amounts credited to the benefit plan by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan shall first be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

## **8.3 Non-Assignability of Rights**

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

## SECTION IX - ADMINISTRATION

### **9.1 Plan Administration**

The Employer shall be the Plan Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, an Employee of the Employer, to perform the duties of the Plan Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Plan Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Plan Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as a Plan Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. A Plan Administrator may resign by delivering a written resignation to the Employer or be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery to the Plan Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Plan Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Act, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Plan Administrator shall have full power to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Plan Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Plan Administrator shall have all powers necessary or appropriate to accomplish the Plan Administrator's duties under the Plan. The Plan Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to the following authority, in addition to all other powers provided by this Plan.

- a. To make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plan;
- b. To interpret the Plan, the Plan Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- d. To reject elections or to limit contributions or Benefits for certain highly compensated Participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
- e. To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan.
- f. To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;
- g. To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Plan Administrator determines such shall be paid if

the Plan Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Plan Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

- h. To establish and communicate procedures to determine whether a medical child support order is qualified; and
- i. To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Plan Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

## **9.2 Examination of Records**

The Plan Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

## **9.3 Payment of Expenses**

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Plan Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

## **9.4 Insurance Control Clause**

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

## **9.5 Indemnification of Plan Administrator**

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any Employee or former Employee who previously served as Plan Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

## **SECTION X - AMENDMENT OR TERMINATION OF PLAN**

### **10.1 Amendment**

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

### **10.2 Termination**

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Contract shall be paid in accordance with the terms of the Contract.

No further additions shall be made to the Health Care Reimbursement Fund or Dependent Care Assistance Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

## **SECTION XI - MISCELLANEOUS**

### **11.1 Plan Interpretation**

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section XI.

### **11.2 Gender and Number**

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

### **11.3 Written Document**

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

### **11.4 Exclusive Benefit**

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

### **11.5 Participant's Rights**

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

### **11.6 Action by the Employer**

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

### **11.7 No Guarantee of Tax Consequences**

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such

payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

#### **11.8 Indemnification of Employer by Participants**

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

#### **11.9 Funding**

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

#### **11.10 Governing Law**

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Arizona.

#### **11.11 Severability**

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

#### **11.12 Captions**

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

#### **11.13 Continuation of Coverage (COBRA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This

Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

#### **11.14 Family and Medical Leave Act**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

#### **11.15 Health Insurance Portability and Accountability Act (HIPAA)**

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

#### **11.16 Uniform Services Employment and Reemployment Rights Act USERRA**

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Employment And Reemployment Rights Act USERRA and the regulations thereunder.

#### **11.17 Compliance With HIPAA Privacy Standards**

- a. **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.
- b. **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- c. **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information will not be used or disclosed for underwriting purposes.
- d. **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

- i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- ii. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
- iii. mitigation of any harm caused by the breach, to the extent practicable; and
- iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

e. **Certification.** The Employer must provide certification to the Plan that it agrees to:

- i. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- ii. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- iii. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- iv. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
- v. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- vi. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- vii. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- viii. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- ix. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and

disclosures to those purposes that make the return or destruction of the information infeasible; and

- x. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d.) above.

**11.18 Compliance with HIPAA Electronic Security Standards** Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

- a. **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- b. **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- c. **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.17.

**11.20 Genetic Information Nondiscrimination Act (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

**11.21 Women's Health and Cancer Rights Act**

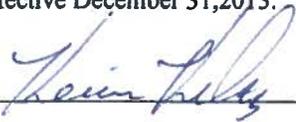
Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

**11.22 Newborns' and Mothers' Health Protection Act**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

**SECTION XII - ADOPTION**

Pinal County hereby adopts the provisions of this plan, and its duly authorized officer has executed this plan document and summary plan description effective the first day of January, 2012 and as amended to be effective December 31, 2013.

By: 

Date: 6-12-14

Title: Trust Chairperson