Jefferson City Public Schools Flexible Benefit Plan for the Employees of Jefferson City Public Schools

Plan Document

Originally Effective January 01 1993
Amended and Restated July 01 2013

ARTICLE I INTRODUCTION

1.1 ESTABLISHMENT OF PLAN

Jefferson City Public Schools (the "Employer") hereby establishes the Jefferson City Public Schools Flexible Benefit Plan (the "Plan") originally effective January 01 1993. The Plan is hereby amended and restated effective July 01 2013 (the "Effective Date"), notwithstanding the actual date of execution.

1.2 PURPOSE OF THE PLAN

This Plan is designed to permit an Eligible Employee to pay his or her share of the premiums of the various insurance plans sponsored by the Employer on a pre-tax Salary Reduction basis and to contribute on a pre-tax Salary Reduction basis to an account for reimbursement of certain Medical Care Expenses and Dependent Care Expenses. The Plan is also designed to permit an Eligible Employee to make pre-tax salary reduction contributions to a Health Savings Account.

1.3 LEGAL STATUS

This Plan is intended to qualify as a "cafeteria Plan" under Code §125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The HSA Contribution Benefit is intended to meet all requirements of §223 of the Code.

The Health Care Reimbursement Plan is intended to qualify as a self-insured medical reimbursement plan under Code §105, and the Medical Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b). The Dependent Care Assistance Plan is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

Although reprinted within this document, the HSA Contribution Benefit, the Health Care Reimbursement Plan and the Dependent Care Assistance Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The Health Care Reimbursement Plan is also a separate plan for purposes of applicable provisions of COBRA and HIPAA.

ARTICLE II GENERAL INFORMATION

NAME OF THE PLAN	Jefferson City Public Schools Flexible Benefit Plan
NAME OF EMPLOYER	Jefferson City Public Schools
PLAN ADMINISTRATOR	Jefferson City Public Schools
NAMED FIDUCIARY & AGENT FOR SERVICE OF LEGAL PROCESS	Jefferson City Public Schools
TYPE OF ADMINISTRATION	The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the Jefferson City Public Schools Flexible Benefit Plan. It is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. Jefferson City Public Schools may hire a third party to perform some of its administrative duties such as claim payments and enrollment.

BENEFIT PLAN YEAR

The twelve-month period between July 1 and June 30 of the next calendar year.

CODE AND OTHER FEDERAL COMPLIANCE

It is intended that this Plan meet all applicable requirements of the Code and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

DISCRETIONARY AUTHORITY

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section.

FIDUCIARY LIABILITY

To the extent permitted by law, the Plan Administrator and other parties assuming a fiduciary or decision making role shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan. The standard shall be one of Ordinary Care.

ARTICLE III BENEFITS OFFERED AND METHOD OF FUNDING

3.1 BENEFITS OFFERED

Each Eligible Employee may elect one or more of the following Employer sponsored Benefits:

Premium Conversion Plan
Health Care Reimbursement Plan
Dependent Care Assistance Plan
Health Savings Account Contribution Benefit (HSA Contribution Benefit) Plan
or elect to receive his or her entire compensation in cash.

Benefits under the Plan shall not be provided in the form of deferred compensation.

3.2 EMPLOYER AND PARTICIPANT CONTRIBUTIONS

(a) **Employer Contributions.** The Employer may contribute a portion of the premium to fund Premium Conversion Plan benefits. There are no Employer contributions for the Health Care Reimbursement Plan or the Dependent Care Assistance Plan.

(b) **Participant Contributions.** The Employer shall withhold from a Participant's Compensation on a pre-tax Salary Reduction basis or with after-tax deductions (as elected by the Participant and permitted under the Plan) an amount equal to the contributions required from the Participant for the Benefits elected by the Participant under this Plan. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected.

3.3 COMPUTING SALARY REDUCTION CONTRIBUTIONS

(a) **Salary Reductions per Pay Period.** The Salary Reduction for a pay period for a Participant is an amount equal to the annual premium for such Benefits divided by the number of pay periods in the Period of Coverage, or an amount otherwise agreed upon between the Employer and the Participant, or an amount deemed appropriate by the Administrator.

If a Participant increases his or her election under the Health Care Reimbursement Plan or Dependent Care Assistance Plan as permitted under Section 9.4, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to the new annual amount elected pursuant to Section 9.4, less the aggregate premiums (if any) for the period prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change, or an amount otherwise agreed upon between the Employer and the Participant, or an amount deemed appropriate by the Administrator.

(b) **Considered Employer Contributions for Certain Purposes.** Salary Reductions that the Employer will apply to pay for the Participant's share of the premiums for benefits elected for the purposes of this Plan and the Code are considered to be Employer contributions.

(c) **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.

3.4 FUNDING THIS PLAN

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to 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 this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for

the payment of Benefits out of its general assets, it may hire an unrelated third party paying agent to make Benefit payments on its behalf. The maximum contributions that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions for the HSA Contribution Benefit, the Health Care Reimbursement Plan and the Dependent Care Assistance Plan.

ARTICLE IV ELIGIBILITY AND PARTICIPATION

4.1 ELIGIBILITY TO PARTICIPATE

An individual is eligible to participate in this Plan if the individual is an Employee who is regularly scheduled to work 30.0 hours or more per week; and has been employed by the Employer for 00 days, counting the Participant's Employment Commencement Date as the first such day.

The Employee may begin participation on the 1st of the month coincident with or next following the date on which the Employee has met the Plan's eligibility requirements or in accordance with the open enrollment requirements each year.

4.2 TERMINATION OF PARTICIPATION

A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) The expiration of the Period of Coverage for which the Employee has elected to participate (unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating);

(b) The termination of this Plan;

(c) The date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis (but not beyond the end of the current Plan Year).

The Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections and terminate the Premium Conversion Plan Benefits as of the date specified in the appropriate insurance Plan(s). Reimbursements from the Health Care Reimbursement Account and the Dependent Care Assistance Account after termination of participation will be made according to the individual plans.

4.3 PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT OR LOSS OF ELIGIBILITY

If a Participant separates from service with the Employer for any reason, including (but not limited to) disability, retirement, layoff, leave of absence without pay, or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Employee will be reinstated with the same elections that the Participant had before termination. If the Employer rehires a former Participant more than 30 days following termination of employment and the Participant is otherwise eligible to participate in the Plan,

4.4 ELIGIBILITY RULES REGARDING THE HSA CONTRIBUTION BENEFIT

An Employee must be an HSA Employee to elect to participate in the HSA Contribution Benefit Plan.

Only Employees who satisfy the following conditions may be considered an HSA Employee:

- Covered under a qualifying HDHP maintained by the Employer;
- Opened an HSA with the custodian chosen by the Employer;

- Not covered under any other non-HDHP maintained by one Employer that is determined by the Employer to offer disqualifying health coverage;

- Not claimed as a tax dependent by anyone else;

- Not enrolled in Medicare covereage; and

- Eligible to participate in the Plan.

4.5 FMLA LEAVES OF ABSENCE

Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health Care Reimbursement Account on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid FMLA leave, a Participant may elect to continue his or her Health Care Reimbursement Account during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the premium .

Coverage under a participant's Health Care Reimbursement Account will terminate if premium payments are not received by the due date established by the Employer. If a Participant's Health Care Reimbursement Account or Dependent Care Assistance Account coverage ceases while on FMLA leave for any reason (including for non-payment of premiums), the Participant will be entitled to re-enter the Health Care Reimbursement Account or the Dependent Care Assistance Account upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. A Participant whose coverage under the Health Care Reimbursement Account or the Dependent Care Assistance Account ceased will be entitled to elect whether to be reinstated in the Health Care Reimbursement Account or the Dependent Care Assistance Account at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay premiums. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for his or her Health Care Reimbursement Account premiums or his or her Dependent Care Assistance Account premiums will be equal to the amount withheld prior to the period of FMLA leave.

4.6 NON-FMLA LEAVES OF ABSENCES

If a Participant goes on an unpaid leave of absence that does not affect Eligibility, then the Participant will continue to participate and the premiums due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave or with catch up contributions after the leave ends, as may be determined by the Plan Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

4.7 USERRA

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Employer will continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid USERRA leave, a Participant may elect to continue such Benefits during the leave.

If the Participant elects to continue coverage while on USERRA leave, then the Participant may pay his or her share of the Contribution with:

- After-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or

- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on USERRA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter such Benefit upon return from such leave on the date of such resumption of employment and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of anything to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to Benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.

4.8 DEATH

A Participant's beneficiaries or representative of the Participant's estate, may submit claims for expenses that the Participant incurred through the end of the month in which the Participant ceases to be eligible for the Plan due to death. A Participant may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Plan Administrator or its designee may designate the Participant's Spouse, another Dependent, or representative of the estate. Claims incurred by the Participant's covered Spouse or any other of the Participant's covered Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement.

ARTICLE V METHOD AND TIMING OF ELECTIONS

5.1 ELECTIONS WHEN FIRST ELIGIBLE

An Employee who first becomes eligible to participate in the Plan mid-year will commence participation after the eligibility requirements have been satisfied on the earlier of the following: the 1st of the month coincident with or next following the Administrator's receipt and approval of an Election Agreement signed by the Employee or the 1st of the month coincident with or next following 0 days from the date on which the Employee first becomes eligible. Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit plan or policy. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable Benefit plan or policies.

5.2 ELECTIONS DURING OPEN ENROLLMENT PERIOD

During each Open Enrollment Period with respect to a Plan Year, the Administrator shall provide an Election Agreement to each Employee who is eligible to participate in this Plan. The Election Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Agreement must be returned to the Administrator on or before the last day of the Open Enrollment Period. If an Eligible Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year.

5.3 FAILURE OF ELIGIBLE EMPLOYEE TO FILE AN ELECTION FORM/SALARY REDUCTION AGREEMENT

If an Eligible Employee fails to file an Election Agreement within the time period described in Sections 5.1 and 5.2 as applicable, then the Employee will be deemed to have elected to receive his or her entire Compensation in cash. Such Employee may not make a different election to participate in the Plan: (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change.

However, a Participant who had previously elected any benefits listed in Section 6.1 (Premium Conversion Plan) and who fails to file an Election Agreement with regard to benefits listed in Section 6.1 shall be deemed to have elected the same benefits listed in Section 6.1 that he or she had at the end of the Plan Year preceding the Plan Year for which he or she failed to file an Election Agreement and to have agreed to a corresponding salary reduction for those benefits.

5.4 IRREVOCABILITY OF ELECTIONS

Unless an exception applies (as described in Article IX.), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. The irrevocability rules do not apply to the HSA Contribution Benefit election.

ARTICLE VI PREMIUM CONVERSION PLAN BENEFITS

An Eligible Employee may:

Elect benefits under the Premium Conversion Plan by electing to pay the premiums on a pre-tax Salary Reduction basis for
Worksite Products Benefits;
Medical Insurance Benefits;
Dental Insurance Benefits;
Vision Insurance Benefits;
or
Elect no benefits under the Premium Conversion Plan, and pay the premiums, if any, for Premium Conversion Plan Benefits with after-tax deductions outside of this Plan.

Unless an exception applies (as described in Article IX), the election is irrevocable for the duration of the Period of Coverage to which it relates.

6.1 INSURANCE COVERAGE NOT PROVIDED BY THIS PLAN

The only Insurance Benefits that are offered under the Premium Conversion Plan are benefits under the applicable insurance plan(s) listed in Section 3.1. The Insurance Benefits are subject to the terms and conditions of the applicable insurance Plan(s).

6.2 BENEFIT PREMIUMS

The annual premium for a Premium Conversion Plan Benefit is equal to the amount as set by The Employer.

ARTICLE VII HEALTH CARE REIMBURSEMENT PLAN BENEFITS

An Eligible Employee not enrolled in the HSA Contribution Benefit can elect to participate in the Health Care Reimbursement Plan by electing to receive benefits in the form of reimbursements for Medical Care Expenses (Health Care Reimbursement Benefits). Benefits elected will be funded by Participant contributions as provided in Section 3.2.

Unless an exception applies (as described in Article IX), such election is irrevocable for the duration of the Period of Coverage to which it relates.

The **HSA Contribution Benefit** cannot be elected with the **Health FSA**. In addition, a Participant who has an election for the **Health FSA** that is in effect on the last day of a Plan Year cannot elect the **HSA Contribution Benefit** for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's **Health FSA** is $0 as of the last day of that Plan Year. For this purpose, a Participant's **Health FSA** balance is determined on a cash basis – that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

7.1 BENEFIT PREMIUMS

The annual premium for a Participant's Health Care Reimbursement Account is equal to the annual benefit amount elected by the Participant.

7.2 ELIGIBLE MEDICAL CARE EXPENSES

Under the Health Care Reimbursement Plan, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) **Incurred**. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) **Medical Care Expenses**. Medical Care Expenses means expenses incurred by a Participant or Spouse or Dependent(s) for medical care, as defined in Code §§213(d) and 106(f), other than expenses that are excluded by this Plan below, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other accident or health Plan.

(c) **Monthly Limits on Reimbursing OTC Drugs.** Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's account in a single calendar month, even assuming that the drug otherwise meets the requirements of this Section, including that it is for medical care under Code §§213(d) and 106(f). Stockpiling is not permitted.

(d) **Medical Expenses that are not reimbursable.** Insurance premiums; long-term care expenses are not reimbursable from the Health Care Reimbursement Plan; cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease; funeral and burial expenses; salary expense of a nurse to care for a healthy newborn at home; household and domestic help; custodial care; social activities such as dance lessons; cosmetics; toiletries; uniforms or special clothing, such as maternity clothing; marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician; any item that does not constitute *medical care* as defined under Code §§213(d) and 106(f); and any item that is not reimbursable under Code §§213(d) and 106(f) due to the rules in Prop. Treas. Reg. §1.125-2, Q-7(b)(4) or other applicable regulations.

7.3 MAXIMUM BENEFITS

(a) **Maximum Reimbursement Available** (Uniform Coverage). The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health Care Reimbursement Account. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied.

(b) **Maximum Dollar Limits.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be the lesser of any applicable maximum under federal law or $2,500.00. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health Care Reimbursement Account.

(c) **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual contributions to the Health Care Reimbursement Plan will also change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change effective date. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the aggregate premium for the period prior to such election change to (2) the total premium for the remainder of such Period of Coverage to the Health Care Reimbursement Account, reduced by (3) all reimbursements made during the entire Period of Coverage.

7.4 ESTABLISHMENT OF ACCOUNT

The Administrator will establish and maintain a Health Care Reimbursement Account with respect to each Participant who has elected to participate in the Health Care Reimbursement Plan, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a record keeping account with the purpose of keeping track of contributions and determining forfeitures.

(a) **Crediting of Accounts**. A Participant's Health Care Reimbursement Account will be credited following each salary reduction actually made during each Period of Coverage with an amount equal to the salary reduction actually made.

(b) **Debiting of Accounts**. A Participant's Health Care Reimbursement Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

(c) **Available Amount Not Based on Credited Amount**. The amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements during the Period of Coverage. It is not based on the amount credited to the Health Care Reimbursement Account at a particular point in time.

7.5 UNUSED YEAR END BALANCE

If any balance remains in the Participant's Health Care Reimbursement Account after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The remaining amounts will be used by the Plan in the following ways: (a) first, to offset any losses experienced by Jefferson City Public Schools during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the premiums paid by such Participant through Salary Reductions; (b) second, to reduce the cost of administering the Health Care Reimbursement Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Administrator); and (c) to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Administrator deems appropriate, consistent with applicable regulations.

In addition, any Health Care Reimbursement Plan benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be applied as described above.

7.6 REIMBURSEMENT PROCEDURE

(a) **Timing**. Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) **Claims Substantiation**. A Participant who has elected to receive Health Care Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting an application to the Administrator in such form as the Administrator may prescribe, by no later than a date set each year by the Administrator which such date shall not be earlier than September 30th following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

(1) The person or persons on whose behalf Medical Care Expenses have been incurred;

(2) The nature and date of the Expenses incurred;

(3) The amount of the requested reimbursement; and

(4) A statement that such Expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator may request. If the Participant's account is accessible by an electronic payment card, the Participant will be required to comply with substantiation procedures established by the Administrator in accordance with the most current IRS guidance.

(c) **Claims Denied**. For reimbursement claims that are denied, see Section 10.2.

7.7 REIMBURSEMENTS AFTER TERMINATION; LIMITED COBRA CONTINUATION

The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant (or the Participant's estate) files a claim by the date established in Section 7.7(b) following the close of the Plan Year in which the Medical Care Expense arose.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Health Care Reimbursement Plan because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that he or she had under the Health Care Reimbursement Plan the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). The premiums for such continuation coverage will be equal to the cost of providing the same coverage to an active employee taking into account all costs incurred by the employee and the employer plus two percent (2%). Specifically, an individual will be eligible for COBRA continuation coverage only if, under Section 7.5(c), the participant's remaining available amount is greater than the participant's remaining premium payments as calculated in this paragraph. Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health Care Reimbursement Plan will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Coverage may terminate sooner if the premium payments for a period of Coverage are not received by the due date established by the Administrator for that period of Coverage. Continuation coverage is only granted after the Administrator has received the premium payment for that period of coverage.

7.8 NAMED FIDUCIARY; COMPLIANCE WITH COBRA, HIPAA, ETC.

(a) **Laws Applicable to Group Health Plans**. The Health Care Reimbursement Plan shall be provided in compliance with COBRA, HIPAA**,** etc.

(b) **Coordination of Benefits**. Health Care Reimbursement Plans are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health Care Reimbursement Plan shall not be considered a group health plan for coordination of benefits purposes, and the Health Care Reimbursement Plan shall not be taken into account when determining benefits payable under any other plan.

QUALIFIED RESERVIST DISTRIBUTION

If a Participant meets all of the following conditions, the Participant may elect to receive a qualified reservist distribution from the **Health FSA**:

The Participant's Contributions to the **Health FSA** for the Plan Year as of the date the qualified reservist distribution is requested exceeds the reimbursements the Participant has received from the **Health FSA** for the Plan Year as of that date.

The Participant is ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.
The Participant has provided the Plan Administrator with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.

The Participant is ordered or called to active military duty on or after April 1, 2009, or the Participant's period of active duty begins before April 1, 2009 and continues on or after the date.

During the period beginning on the date of the Participant's order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant submits a qualified reservist distribution election form to the Plan Administrator.

Amount of Qualified Reservist Distribution. If the above conditions are met, the Participant will receive a distribution from the **Health FSA** equal to his or her Contributions to the **Health FSA** for the Plan Year as of the date of the distribution request, minus any reimbursements received for the Plan Year as of that date.

No Reimbursement for Expenses Incurred After Distribution Request. Once a Participant requests a qualified reservist distribution, the Participant forfeits the right to receive reimbursements for Health Care Expenses incurred during the period that begins on the date of the distribution request and ends on the last day of the Plan Year. The Participant may, however, continue to submit claims for Health Care Expenses that were incurred before the date of the distribution request (even if the claims are submitted after the date of the qualified reservist distribution), so long as the total dollar amount of the claims does not exceed the amount of the **Health FSA** election for the Plan Year, minus the sum of the qualified reservist distribution and the prior **Health FSA** reimbursements for the Plan Year.

Tax Treatment of a Qualified Reservist Distribution. If the Participant receives a qualified reservist distribution, it will be included in his or her gross income and will be reported as wages on the Participant's Form W-2 for the year in which it is paid.

ARTICLE VIII DEPENDENT CARE ASSISTANCE PLAN

8.1 BENEFITS

An Eligible Employee can elect to participate in the Dependent Care Assistance Plan by electing to receive benefits in the form of reimbursements for Dependent Care Expenses (Dependent Care Assistance Benefits). Benefits elected will be funded by Participant contributions as provided in Section 3.2.

Unless an exception applies (as described in Article IX), such election is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 BENEFIT PREMIUMS

The annual premium for a Participant's Dependent Care Assistance Benefit is equal to the annual benefit amount elected by the Participant.

8.3 ELIGIBLE DEPENDENT CARE EXPENSES

Under the Dependent Care Assistance Plan, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) **Incurred.** A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense are furnished, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.

(b) **Dependent Care Expenses.** Dependent Care Expenses means expenses that are considered to be employment-related expenses under Code §21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse), and expenses for incidental household services, if incurred by the Eligible Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other Plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the Dependent Care Assistance Plan can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article.

(c) **Qualifying Individual.** Qualifying Individual means:

(1) A Participant's qualifying child and tax dependent who is under the age of 13;

(2) A Participant's tax dependent who is mentally or physically incapable of self-care; or

(3) A Participant's Spouse who is mentally or physically incapable of self-care.

(d) **Qualifying Dependent Care Services.** Qualifying Dependent Care Services means the following: services that both relate to the care of a Qualifying Individual that enable the Participant and Spouse to remain gainfully employed after the date of participation in the DCAP and during the Period of Coverage; and are performed:

(1) In the Participant's home; or

(2) Outside the Participant's home for
(i) The care of a Participant's Dependent who is under age 13; or
(ii) The care of any other Qualifying Individual who regularly spends at least 8 hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a facility that provides care for more than 6 individuals not residing at the facility and that receives a fee, payment or grant for such services, then the facility must comply with all applicable state and local laws and regulations.

(e) **Exclusions.** Dependent Care Expenses do not include amounts paid to or for:

(1) An individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or Participant's Spouse;

(2) A Participant's Spouse;

(3) A Participant's child who is under 19 years of age at the end of the year in which the expenses were incurred;

(4) a Participant's Spouse's child who is under l9 years of age at the end of the year in which the expenses were incurred;

(5) Overnight camps;

(6) Instructional or sport specific camps; e.g. Ballet camp, soccer camp, summer school; or

(7) Kindergarten or other educational expenses.

8.4 MAXIMUM BENEFITS

Maximum Reimbursement Available and Statutory Limits. The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's Dependent Care Assistance

Account less amounts debited to the Participant's Dependent Care Assistance Account pursuant to the maximum contribution paragraph below. Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied. Notwithstanding the foregoing, no reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the applicable statutory limit. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year; or
- the Earned Income of the Participant's Spouse for the calendar year (a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense, and (2) is either physically or mentally incapable of self-care or a full-time Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or
- $5,000 for the calendar year, if:
    - The Participant is married and files a joint federal income tax return; or
    - The Participant is married, files a separate federal income tax return, and meets the following conditions:
        - The Participant maintains as his or her home a household that constitutes, for more than half of the taxable year, the principal abode of a Qualifying Individual; The Participant furnishes over half of the cost of maintaining such household during the taxable year; and during the last six months of the taxable year, the Participant's Spouse is not a member of such household; or
    - The Participant is single or is the head of the household for federal income tax purposes; or
- $2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

Maximum Dollar Limits. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000.00 (subject to the other limitations described above).

8.5 ESTABLISHMENT OF ACCOUNT

The Administrator will establish and maintain a Dependent Care Assistance Account with respect to each Participant who has elected to participate in the Dependent Care Assistance Plan, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a record keeping account with the purpose of keeping track of contributions and determining forfeitures.

(a) **Crediting of Accounts.** A Participant's Dependent Care Assistance Account will be credited following each salary reduction actually made during each Period of Coverage with an amount equal to the salary reduction actually made.

(b) **Debiting of Accounts.** A Participant's Dependent Care Assistance Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) **Available Amount is Based on Credited Amount.** The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's Dependent Care Assistance Account, less any prior reimbursements.

(d) **Effect on Maximum Benefits If Election Change Permitted**. Any change in an election under Article IX affecting annual contributions to the Dependent Care Assistance Plan also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change effective date), as further limited above. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the aggregate premium for the period prior to such election change to (2) the total premium for the remainder of such Period of Coverage to the Dependent Care Assistance Account, reduced by (3) all reimbursements made during the entire Period of Coverage.

8.6 UNUSED YEAR END BALANCE

If any balance remains in the Participant's Dependent Care Assistance Account after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the participant for Dependent Care Expenses incurred during a subsequent Plan Year.. The Participant shall forfeit all rights with respect to such balance. The remaining amounts will be used by the Plan in the following ways: (a) to offset any losses experienced by the Employer as a result of making reimbursements in excess of Participant premiums paid through salary reductions; (b) to reduce the cost of administering the Dependent Care Assistance Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Administrator); or (c) to increase the Employer's general revenues consistent with applicable regulations. In addition, any Dependent Care Assistance Plan benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be applied as described above.

8.7 REIMBURSEMENT PROCEDURE

(a) **Timing.** Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete and incomplete reimbursement claim.

(b) **Claims Substantiation.** A Participant who has elected to receive Dependent Care Assistance Plan Benefits for a Period of Coverage may apply for reimbursement by completing, signing, and returning an application to the Administrator in such form as the Administrator may prescribe, by no later than a date set each year by the Administrator which such date shall not be earlier than September 30th following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

(1) The person or persons on whose behalf Dependent Care Expenses have been incurred;

(2) The nature and date of the Expenses so incurred;

(3) The amount of the requested reimbursement;

(4) The name of the person, organization or entity to whom the Expense was or is to be paid; and

(5) A statement that such Expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source.

The Participant shall include bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator may request.

(c) **Claims Denied.** For reimbursement claims that are denied, see Section 10.2.

8.8 REIMBURSEMENTS AFTER TERMINATION

If a Participant's employment terminates, the Participant may submit for reimbursement Dependent Care Expenses incurred after the date of termination up to the amount of the Participant's remaining dependent care account balance.

8.9 REPORT TO PARTICIPANTS

On or before January 31 of each year, the Administrator shall furnish to each Participant who has received reimbursement for or made premium payments for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the Dependent Care Assistance Plan, as the Administrator deems appropriate.

ARTICLE IX IRREVOCABILITY OF ELECTIONS AND EXCEPTIONS

9.1 IRREVOCABILITY OF ELECTIONS

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates except as described in this Article.

9.2 PROCEDURE FOR MAKING NEW ELECTION IF EXCEPTION TO IRREVOCABILITY APPLIES

(a) **Timing for Making New Election if Exception to Irrevocability Applies**. A Participant may make a new election within 0 days of the occurrence of an event described in Section 9.4, as applicable, but only if the election under the new Election Agreement is made on account of and corresponds to the event.

(b) **Effective Date of New Election**. Elections made pursuant to this Section shall be effective on the 1st of the month coincident with or next following the event and the Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. All election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the 1st of the month coincident with or next following the date that the election change was filed, but, as determined by the Administrator, election changes may become effective later to the extent the coverage in the applicable Benefit Package Option commences later), except for changes allowed to be retroactive as outlined by Section 9.4 as it relates to *Certain Judgments, Decrees and Orders* and any *HIPAA Special Enrollment Rights* (if such HIPAA Special Enrollment Rights are allowed by this Plan).

(c) **Changes; No Pro ration.** For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Election Agreement or another document. If a Participant enters the Dependent Care Assistance Plan or the Health Care Reimbursement Plan mid-year, or wishes to increase his or her election mid-year as permitted under Section 9.4, the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit for either plan, as applicable.

(d) **Effect on Maximum Benefits.** Any change in an election affecting annual contributions to the Health Care Reimbursement Plan or the Dependent Care Assistance Plan also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions made by the Participant (if any) as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health Care Reimbursement Plan or the Dependent Care Assistance Plan, reduced by (3) all reimbursements made during the entire Period of Coverage.

9.3 CHANGE IN STATUS DEFINED

A Participant may make a new election that corresponds to and is on account of a gain or loss of eligibility and coverage under a benefit under this plan or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence a Change in Status. A Change in Status is any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued there under, which the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) **Legal Marital Status.** A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(b) **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the Dependent Care Assistance Plan, a change in the number of qualifying individuals as defined in Code § 21(b)(1);

(c) **Employment Status.** Any of the following events that change the employment status of the Participant or Spouse or Dependents:

(1) A termination or commencement of employment;

(2) A strike or lockout;

(3) A commencement of or return from an unpaid leave of absence;

(4) A change in worksite; and

(5) If the eligibility conditions of this Plan or other employee benefit Plan of the Participant, Spouse or Dependent(s) depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefit Plan;

(d) **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit; and

(e) **Change in Residence.** A change in the place of residence of the Participant, Spouse or Dependent(s).

9.4 EVENTS PERMITTING EXCEPTION TO IRREVOCABILITY RULE

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Benefit Plan:

(a) **Open Enrollment Period** (*Applies to Premium Conversion Plan, Health Care Reimbursement Plan and Dependent Care Assistance Plan Benefits*). A Participant may change an election during the Open Enrollment Period.

(b) **Termination of Employment** *(Applies to Premium Conversion Plan, Health Care Reimbursement Plan and Dependent Care Assistance Plan Benefits).* A Participant's election will terminate upon termination of employment as described in eligibility and participation.

(c) **Leaves of Absence** *(Applies to Premium Conversion Plan, Health Care Reimbursement Plan and Dependent Care Assistance Plan Benefits).* A Participant may change an election upon leave as described in Article IV.

(d) **Change in Status** *(Applies to Premium Conversion Plan, Health Care Reimbursement Plan as limited below and Dependent Care Assistance Plan as limited below).* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 9.3), but only if such election change is made on account of and corresponds with a

gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer caused by that Change in Status that affects eligibility for coverage (referred to as the general consistency requirement). Any increase or decrease to Worksite Products under this Plan will be deemed to satisfy this general consistency requirement.

A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

The Administrator, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status:

(1) **Loss of Spouse or Dependent Eligibility**; For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health coverage for:

(i) The Spouse involved in the divorce, annulment, or legal separation;
(ii) The deceased Spouse or Dependent; or
(iii) The Dependent that ceased to satisfy the eligibility requirements.

Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which a Participant or Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Administrator has reason to believe that the Participant's certification is incorrect.

(e) **Certain Judgments, Decrees and Orders** *(Applies to Premium Conversion Plan and Health Care Reimbursement Plan).* If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health Care Reimbursement Plan Benefits) for a Participant's Dependent child, a Participant may

(1) Change an election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage); or

(2) Change an election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(f) **Medicare and Medicaid** *(Applies to Premium Conversion Plan and Health Care Reimbursement Plan).* If a Participant or Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage (the Health Care Reimbursement coverage may be cancelled but not reduced) of the person becoming entitled to Medicare or Medicaid. Further, if a Participant or Spouse or Dependent who has been entitled to

Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage (including Health Care Reimbursement coverage) of the individual who loses Medicare or Medicaid eligibility.

(g) **Change in Cost** *(Applies to Premium Conversion Plan and Dependent Care Assistance Plan as limited below).* For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals.

(1) **Significant Cost Increases**. If the Administrator determines that the cost charged to an Employee for a Benefit significantly increases during a Period of Coverage, the Participant may

(i) Make a corresponding prospective increase to elective contributions (by increasing Salary Reductions); or

(ii) Revoke the election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Option that provides similar coverage; or

(iii) Drop coverage going forward if there is no other Benefit Option available that provides similar coverage. The Administrator, on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(2) **Insignificant Cost Increases.** Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for the benefits and to decrease their elective contributions to reflect insignificant decreases in the required contribution. The Plan Administrator on a uniform and consistent basis will determine whether an increase or decrease is insignificant based on all the surrounding facts and circumstances, including but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator on a reasonable consistent basis will automatically make this increase or decrease in affected Employees' elective contributions on a prospective basis.

(3) **Limitation on Change in Cost Provisions for Dependent Care Assistance Benefits**. The above Change in Cost provisions apply to Dependent Care Assistance Benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee. For this purpose, a relative is an individual who is related as described in Code § 152(a)(1) through (8), incorporating the rules of Code § 152(b)(1) and (2).

(h) **Change in Coverage** *(Applies to Premium Conversion Plan and Dependent Care Assistance Benefits).* The definition of "similar coverage" under Section 9.4(g) applies also to this Section.

(1) **Significant Curtailment.** If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under a benefit package option that provides similar coverage. In addition, if the coverage curtailment results in a "Loss of Coverage" (as defined below), Participants may drop coverage if no similar coverage is offered by the Employer. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(2) **Significant Curtailment Without Loss of Coverage.** If the Administrator determines that a Participant's coverage under a Benefit Plan (or the Participant's Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed without a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage and prospectively elect coverage under another Benefit Plan if offered, that provides similar coverage. Coverage under a Plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally.

(3) **Significant Curtailment With a Loss of Coverage.** If the Administrator determines that a Participant's coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage, and may either prospectively elect coverage under another Benefit Plan that provides similar coverage or drop coverage if no other Benefit Plan providing similar coverage is offered by the Employer.

(4) **Definition of Loss of Coverage.** For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage (including the elimination of the Benefit Plan).

(i) **Addition or Significant Improvement of a Benefit Plan** *(Applies to Premium Conversion Plan and Dependent Care Assistance Benefits).* If during a Period of Coverage, the Plan adds a new Benefit Plan or significantly improves an existing Benefit Plan, the Administrator may permit the following election changes:

(1) Participants who are enrolled in a Benefit Plan other than the newly-added or significantly improved Benefit Plan that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Plan and instead to elect the newly-added or significantly improved Benefit Plan; and

(2) Employees who are otherwise eligible under the Eligibility and Participation section may elect the newly-added or significantly improved Benefit Plan on a prospective basis, subject to the terms and limitations of the Benefit Plan. The Administrator in its sole discretion, on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(j) **Loss of Coverage Under Other Group Health Coverage** *(Applies to Premium Conversion Plan Benefits).* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(k) **Change in Coverage Under Another Employer Plan** *(Applies to Premium Conversion Plan and Dependent Care Assistance Benefits).*A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as

(1) The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or

(2) The Plan permits Participants to make an election for a Period of Coverage that is different from the Plan year under the other cafeteria plan or qualified benefits plan. The Administrator, on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(l) **Dependent Care Assistance Plan Coverage Changes** *(Dependent Care Assistance Benefits).* A Participant may make a prospective election change that corresponds with a change in the dependent care service provider. For example:

(1) If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and

(2) If the Participant terminates a dependent care service provider because a relative or other person becomes available to take care of the child at no charge, the Participant may cancel coverage.

(3) A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described in Section 9.2.

(m) **HIPAA Special Enrollment Rights** If a Participant or Spouse or Dependent is entitled to special enrollment rights under a Group Health Plan, as required by HIPAA under Code §9801, then a Participant may revoke a prior election for Group Health Plan coverage and make a new election, provided that the election change corresponds with a HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if a Participant or Spouse or Dependent declined to enroll in group health plan coverage because they had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan be effective retroactively up to thirty (30) days.

9.5 ELECTION MODIFICATIONS FOR HAS CONTRIBUTION BENEFITS MAY BE CHANGED PROSPECTIVELY AT ANY TIME

An election to make a Contribution to an **HSA Contribution Benefit** can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the 1st day of the next calendar month following the date that the election change was filed. No other Benefit Option election changes can occur as a result of a change in an **HSA Contribution Benefit** election except as otherwise permitted in this Section.

A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described above.

9.6 ELECTION MODIFICATIONS REQUIRED BY ADMINISTRATOR

The Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Administrator determines that such action is necessary or advisable in order to

(a) Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan;

(b) Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized;

(c) Maintain the qualified status of benefits received under this Plan; or

(d) Satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified Plans. In the event that contributions need to be reduced for a class of Participants, the Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, continuing with the Participant in the class who had elected the next- highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE X CLAIMS

10.1 CLAIMS UNDER THE PLAN

If a claim for reimbursement under the Health Care Reimbursement Plan or Dependent Care Assistance Plan is wholly or partially denied, or a Participant is denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue particular to the Participant's coverage under the Plan then the claims procedure established by the Administrator and described below will apply.

10.2 APPEAL PROCEDURES

If a claim is denied in whole or in part, the Administrator will notify the Participant in writing within 30 days of the date that the Administrator received the claim. This time may be extended for an additional 15 days for matters beyond the control of the Administrator, including cases where a claim is incomplete. The Administrator will provide written notice of any extension, including the reason(s) for the extension and the date a decision by the Administrator is expected to be made. When a claim is incomplete, the extension notice will also specifically describe the required information, and will allow the Participant at least 45 days from receipt of the notice to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided. Notification of a denied claim will include:

- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take to appeal the Administrator's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit under ERISA,where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

First Level Appeal to the Administrator

If a claim is denied in whole or in part, the Participant, or the Participant's authorized representative, may request a review of the adverse benefits determination upon written application to the Administrator. The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 30 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe, all rights to appeal the adverse benefits determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

Action on Appeal

The Administrator, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. The Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;

- The specific Plan provisions on which the decision is based;

- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

- Appropriate information on the steps to take to appeal the Administrator's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit under ERISA, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

Second and Final Level Appeal to the Administrator

If the decision on review affirms the Administrator's initial denial, the Participant may request a review of the adverse appeal determination upon written application to the Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse appeal determination must be made in writing within 30 days after receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe, all rights to appeal the adverse benefits determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

Administrator Action on Appeal

The Administrator, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. The Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason(s) for the decision on review;

- The specific Plan provision(s) on which the decision is based;

- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

- A statement regarding the right to bring suit under ERISA §502(a), where and if applicable.

Appeal Procedure for Eligibility or Salary Reduction Issues

If the Participant is denied a Benefit under the Plan due to questions regarding the Participant's eligibility or entitlement for coverage under the Plan or regarding the amount the Participant owes, the Participant may request a review upon written application to the Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 180 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe, all rights to appeal the adverse benefits determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The Administrator, within a reasonable time, but no later than 30 days after receipt of the request for review, will decide the appeal. The Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- Appropriate information on the steps to take to appeal the Plan Adminstrator's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit under ERISA, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

If the decision on review affirms the Administrator's initial denial, the Participant may request a review of the adverse appeal determination upon written application to the Administrator. The Second and Final Level of Appeals Procedures described above will apply.

ARTICLE XI GLOSSARY

Administrator means Jefferson City Public Schools.

Benefits means the Premium Conversion Plan Benefits, theHealth Care Reimbursement Plan Benefits and the Dependent Care Assistance Plan Benefits offered under the Plan.

Benefit Package Option means a qualified benefit under Code §125(f) that is offered under a cafeteria Plan, or an option for coverage under an underlying accident or health Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to (a) any salary Reduction election under this Plan, (b) any salary reduction election under any other cafeteria Plan, (c) any compensation reduction under any Code §132(f)(4) Plan, and (d) any salary deferral elections under any Code §§401(k), 408(k) or 457(b) Plan or arrangement.

Dependent means any individual who is a tax dependent of the Participant as defined in Code §§105(b) and 152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under any applicable Premium Conversion Plan, and for purposes of the Health Care Reimbursement Plan), a dependent is defined as in Code §§105(b) and 152, determined without regard to §152 subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and any child to whom IRS Rev. Proc. 2008-48 applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents; and (b) for purposes of the Dependent Care Assistance Plan, a dependent means a qualifying individual as defined in Code §21(b)(1) with respect to the Participant, and in the case of divorced parents, the child shall, as provided in Code §21(e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code §152(e)(1)) and shall not be treated as a qualifying individual with respect to the non-custodial parent. Notwithstanding the foregoing, the Health Care Reimbursement Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

Dependent Care Expenses has the meaning described in Dependent Care Assistance Plan.

Earned Income means all income derived from wages, salaries, tips, self-employment, and other compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any Dependent Care Assistance Plan established under Code §129; or (b) any other amounts excluded from earned income under Code §32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

Effective Date of this Plan has the meaning described in Introduction.

Election Agreement means the form provided by the Administrator or the Internet web site and procedures used for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any benefits offered under this Plan..

Eligible Employee means an Employee eligible to participate in this Plan, as provided in Eligibility and Participation.

Employee Means an individual that Jefferson City Public Schools classifies as a common-law employee and who is on Jefferson City Public Schools's W-2 payroll. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Worksite Products means the Employee's Worksite Products Plan coverage for purposes of this Plan.
Medical Insurance Plan means the Plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such Plan), providing major medical type benefits through a group insurance policy or policies. The Employer may substitute, add, subtract or revise at any time the menu of such Plans and/or the benefits, terms and conditions of any such Plans. Any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HSA means a Health Savings Account established under Code §223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

HSA Contribution Benefit means the election to allow an Employee to receive HSA Contributions on a pre-tax, Salary Reduction basis and such Employer Contributions are excludable from the HSA Employee's income.

HSA Employee means an Employee covered under a qualifying High Deductible Health Plan (HDHP) (as defined by IRC §223). In order to receive Employer **HSA Contribution Benefit**, the Employee must certify that he or she:

cannot be claimed as another person's tax dependent; is not entitled to Medicare Benefits, and does not have any health coverage other than HDHP coverage.

Medical Care Expenses has the meaning defined in Health Care Reimbursement Plan.

Open Enrollment Period with respect to a Plan Year means a period as described by the Administrator preceding the Plan Year during which Participants may make benefit elections for the Plan Year.

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Eligibility and Participation. Participants include (a) those who elect one or more of the Premium Conversion Plan Benefits, Health Care Reimbursement Benefits, or Dependent Care Assistance Benefits, and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their premiums under the Premium Conversion Plan (if any) with after-tax dollars outside of this Plan and who have not elected any Health Care Reimbursement or Dependent Care Assistance Benefits.

Period of Coverage means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Eligibility and Participation; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Eligibility and Participation.

PHI means protected health information.

Plan means the Jefferson City Public Schools Flexible Benefit Plan as set forth herein and as amended from time to time.

Plan Year means the twelve-month period between January 1 and December 31 of the next calendar year.

Premium means the amount contributed to pay for the cost of Benefits as calculated under the Health Care Reimbursement Plan, and the Dependent Care Assistance Plan.

Protected Health Information means information that is created or received by the Jefferson City Public Schools Flexible Benefit Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

QMCSO means a Qualified Medical Child Support Order, as defined in ERISA §609(a).

Qualifying Dependent Care Services has the meaning described in the Dependent Care Assistance Plan.

Qualifying Individual has the meaning described in the Dependent Care Assistance Plan.

Related Employer means any employer affiliated with Jefferson City Public Schools that, under Code §414(b), (c), or (m), is treated as a single employer with Jefferson City Public Schools for purposes of Code §125(g)(4).

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits.

Spouse means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the Dependent Care Assistance Plan, the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, file a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

Student means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE XII RECORD KEEPING AND ADMINISTRATION

12.1 ADMINISTRATOR

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

12.2 POWERS OF THE ADMINISTRATOR

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters there under, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority: (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 12.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 12.1); (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan; (c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate; (d) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan; (e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;(f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper; (g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants; (h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;. (i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and (j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

12.3 RELIANCE ON PARTICIPANT, TABLES, ETC.

The Administrator may rely upon the direction, information or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

12.4 PROVISION FOR THIRD-PARTY PLAN SERVICE PROVIDERS

The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligations of the Employer and the Administrator.

12.5 FIDUCIARY LIABILITY

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

12.6 COMPENSATION OF PLAN ADMINISTRATOR

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

12.7 INSURANCE CONTRACTS

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

12.8 INABILITY TO LOCATE PAYEE

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

12.9 EFFECT OF MISTAKE

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued there under, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XIII GENERAL PROVISIONS

13.1 EXPENSES

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Sections 7.6 and 8.6, and then by the Employer.

13.2 NO CONTRACT OF EMPLOYMENT

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

13.3 AMENDMENT AND TERMINATION

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

13.4 GOVERNING LAW

This Plan shall be construed, administered and enforced according to the laws of the State of Missouri, to the extent not superseded by the Code or any other federal law.

13.5 CODE COMPLIANCE

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued there under. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

13.6 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

13.7 INDEMNIFICATION OF EMPLOYER

If any Participant receives one or more payments or reimbursements under this Plan on a pre-tax Salary Reduction basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

13.8 NON-ASSIGNABILITY OF RIGHTS

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

13.9 HEADINGS

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

13.10 PLAN PROVISIONS CONTROLLING

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

13.11 SEVERABILITY

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

13.12 COMPLIANCE WITH HIPAA

It is intended that this Plan meet all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) and of all regulations issued there under. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and HIPAA, the provisions of HIPAA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

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

(a) **Meaning of Payment.** Payment has the meaning specified in The Code of Federal Regulations §164.501, specifically: Payment means

(1) The activities undertaken by:

- A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or
- A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

- Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
- Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- Utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and
- Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: Name and address, Date of birth, Social Security Number, Payment history, Account number, and Name and address of the health care provider and/or health plan.

(b) **Meaning of Health Care Operations.** Health care operations has the meaning as specified in The Code of Federal Regulations §164.501, specifically, health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;

(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(6) Business management and general administrative activities of the entity, including, but not limited to:

(i) Management activities relating to implementation of and compliance with the requirements of this subchapter;
(ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.
(iii) Resolution of internal grievances;
(iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
(v) Consistent with the applicable requirements of §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

(c) **As required by law and authorization.** The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Plan will disclose PHI to the Employer's other medical, disability and workers' compensation plans for purposes related to administration of those plans.

(d) **Disclosures to the Employer.** The Plan will disclose PHI to the Employer as sponsor of the Plan provided that the Employer agrees to:

(1) Not use or further disclose PHI other than as permitted or required by this Plan document or as required by law;

(2) Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual;

(4) Not use or disclose PHI in conjunction with any other benefit or employee benefit plan of the Employer unless authorized by the individual;

(5) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(6) Make PHI available to an individual in accordance with HIPAA's access requirements;

(7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(8) Make available the information required to provide an accounting of disclosures;

(9) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and

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

(e) **Employees with access to PHI.** In accordance with HIPAA, only the following employees of the Employer will be given access to PHI solely for the purpose of performing Employer Plan administrations functions.

(1) Any employee responsible for establishing and maintaining employee deduction and reduction records for the Employer,

(2) Any employee with oversight responsibility for management of the Plan or any component of the Plan.

If the above employees do not comply with this Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance including disciplinary sanctions.

ARTICLE XIV HSA CONTRIBUTION BENEFIT

Unless otherwise specified, terms capitalized in this Schedule C shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

14.1 HSA Tax Advantages

An Employee may elect to participate in the **HSA Contribution Benefit** by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's Health Savings Account (HSA) established and maintained outside the Plan by a trustee/custodian to which the Employer can forward Contributions to be deposited. This funding feature constitutes the **HSA Contribution Benefit**.

As described more fully herein, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

14.2 Establishing an HSA

For administrative convenience, the Employer may chose to make Contributions for Employees to HSAs established at a bank selected by the Employer or the limit the number of HSA providers to whom it will forward Contributions - such a list is not an endorsement of any HSA provider. The selected bank will be an authorized HSA trustee. The forms necessary to establish an HSA at the selected bank will be provided to Participants. Participants are responsible for managing their own **HSA**, including choosing how **HSA** funds are invested and following the rules of the selected bank and the IRS. Once the Employer Contributions have been deposited in a Participant's **HSA Contribution Benefit**, the Participant has a non-forfeitable interest in the funds and is free to request a distribution of the funds or to move them to another **HSA** provider, to the extent permitted by law.

The HSA Contribution Benefit cannot be elected with the **Health FSA** unless the **Limited Scope Health FSA** is selected. In addition, a Participant who has an election for the **Health FSA** (other than the **Limited Scope Health FSA**) that is in effect on the last day of a Plan Year cannot elect the **HSA Contribution Benefit** for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's **Health FSA** is $0 as of the last day of the Plan Year. For this purpose, a Participant's **Health FSA** balance is determined on a cash basis -- that is, without regard to claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

14.3 Certification of HSA Contribution Benefit Eligibility

To be eligible for the **HSA Contribution Benefit**, an HSA Employee must complete a Certification of HSA Contribution Benefit Eligibility and return it to the Employer. A married Participant must also certify that his or her Spouse does not have any non-HDHP coverage. A Participant is required to notify the Employer immediately if there are any changes in the information contained in the Certification of HSA Eligibility. Failure to provide accurate and updated information could cause the **HSA Contribution Benefit** to be included in a Participant's gross income and may also be subject to a 6% excise tax.

14.4 Maximum Contribution

The annual Contribution for a Participant's **HSA Contribution Benefit** is equal to the annual Benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's HDHP coverage option for the calendar year in which the Contribution is made (for calendar year 2010, $3,050 for self-coverage or $6,150 for family coverage).

Participants age 55 or older may make an additional catch-up Contribution of $1,000 per year.

In addition, the maximum annual Contribution shall be:

- Reduced by any matching or other Employer Contribution made on the Participant's behalf; and
- Prorated for the number of months in which the Participant is an HSA Eligible Individual.

14.5 Recording Contributions for HSA

The Plan Administrator will maintain records to keep track of Contributions an Employee makes via pre-tax Salary Reductions to his or her HSA, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

14.6 Distributions from HSA Contribution Benefit

Distribution from an **HSA Contribution Benefit** will be tax-free if the distribution is for expenses incurred for a Participant's health care as defined in IRC §213(d) or the health care of a Participant's legal Spouse or tax Dependents. Expenses must have been incurred after the establishment of the **HSA Contribution Benefit** to be tax-free. **HSA Contribution Benefit** distributions used to pay insurance premiums will not be tax-free unless they are used for COBRA coverage, qualified long-term care insurance, health insurance maintained while the individual is receiving unemployment compensation under federal or state law, or health insurance for an individual age 65 or over, other than a Medicare supplemental policy.

14.7 Tax Treatment of HSA Contributions and Distributions

The tax treatment of the HSA is governed by Code §223.

14.8 Reporting Issues

Each Participant will be responsible for reporting Contributions made to his or her **HSA Contribution Benefit** and for reporting distributions from the HSA. A Participant is also responsible for reporting whether or not HSA distributions were used for qualified health expenses or whether the distributions were taxable. A Participant should maintain records sufficient to demonstrate whether or not distributions were taxable.

14.9 Voluntary Participation

Participation in the **HSA Contribution Benefit** is entirely voluntary and may be terminated at any time by notifying the Employer. Although the Employer expects to continue this **HSA Contribution Benefit** indefinitely, it has the right to amend or terminate **HSA Contribution Benefit** at any time and for any reason. It is also possible that changes to the program will be necessary or advisable as a result of future changes in state for federal tax laws.

14.10 HSA Not Intended to be an ERISA Plan

The **HSA Contribution Benefit** under this Plan consists solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and Benefits will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible health expenses" as set forth in Code §223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Jefferson City Public Schools Flexible Benefit Plan, Jefferson City Public Schools has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 20 ___.

Jefferson City Public Schools

By: _____
Its Board

Witness
Signature: _____.

Appendix A
Related Employers That Have Adopted This Plan,
With the Approval of Jefferson City Public Schools.

No Related Employers have adopted this plan. Jefferson City Public Schools is the only employer participating in this Plan.