

RESOLUTION NO. R25-44

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF PALOS VERDES ESTATES, CALIFORNIA, APPROVING THE RESTATEMENT OF THE CITY OF PALOS VERDES ESTATES SECTION 125 CAFETERIA PLAN

WHEREAS, Section 125 of the Internal Revenue Code ("Code") and the regulations thereunder permit an eligible employer to implement a Section 125 Plan ("Cafeteria Plan") for the benefit of its eligible employees; and

WHEREAS, a Section 125 Cafeteria Plan is a mechanism through which an employer can offer its employees certain pre-tax benefits; and

WHEREAS, the City of Palos Verdes Estates offers its employees pre-tax benefits and desires to restate the City of Palos Verdes Estates Section 125 Cafeteria Plan effective as of the date of this Resolution in order to reflect plan design changes and comply with current legal requirements; and

WHEREAS, the City Council desires to authorize the City Manager, or designee, to execute the proposed plan documents on behalf of the City, and to execute future amendments that are limited to (i) updates required by changes in applicable law or regulation, or (ii) non-substantive administrative changes that do not materially alter the benefits, eligibility, or contribution provisions of the plan documents; and

WHEREAS, the City Council determines that adoption of this Resolution is in the City's interest.

NOW, THEREFORE, THE CITY COUNCIL OF THE CITY OF PALOS VERDES ESTATES, CALIFORNIA DOES HEREBY RESOLVE, DETERMINE AND ORDER AS FOLLOWS:

SECTION 1. The City Council hereby adopts the restated City of Palos Verdes Estates Section 125 Cafeteria Plan, set forth in Exhibit A, effective as of the date of this Resolution, for the 2026-2027 fiscal plan year.

SECTION 2. The City Council authorizes the City Manager, or designee, to duly execute the Section 125 Cafeteria Plan on behalf of the City, and to execute future amendments that are limited to (i) updates required by changes in applicable law or regulation; or (ii) non-substantive administrative changes that do not materially alter the benefits, eligibility, or contribution provisions of the plan documents.

SECTION 3. This Resolution shall take effect immediately upon adoption.

SECTION 4. The City Clerk shall certify to the adoption of this resolution and shall cause a certified resolution to be filed in the book of original resolutions.

RESOLUTION NO. R25-44

PASSED, APPROVED, AND ADOPTED this 9th day of December 2025.

APPROVED:

Victoria A. Lozzi
Victoria A. Lozzi, Mayor
City of Palos Verdes Estates

ATTEST:

Tameka J. Cook
Tameka J. Cook, City Clerk
City of Palos Verdes Estates

APPROVED AS TO FORM:

Signed by: *Trevor L. Puzia*
Trevor L. Puzia, City Attorney
City of Palos Verdes Estates

CERTIFICATION

STATE OF CALIFORNIA)
COUNTY OF LOS ANGELES)
CITY OF PALOS VERDES ESTATES) SS:

I, Tameka Cook, City Clerk for the City of Palos Verdes Estates, California, do hereby certify that the foregoing Resolution **R25-44** was duly and regularly approved and adopted by the City Council of the City of Palos Verdes Estates at its regular meeting of the City Council on the 9th day of December 2025, by the following vote:

AYES: COUNCILMEMBERS: McGowan, Lazzaro, Quinn, Kemp, and Lozzi

NOES: COUNCILMEMBERS: None

ABSENT: COUNCILMEMBERS: None

ABSTAIN: COUNCILMEMBERS: None

ATTEST:



Tameka J. Cook, City Clerk

EXHIBIT A

City of Palos Verdes Estates

Section 125 Cafeteria Plan

Plan Document

Restated December 9, 2025

CITY OF PALOS VERDES ESTATES SECTION 125 CAFETERIA PLAN

ARTICLE I. Introduction

1.1 Establishment of Plan. City of Palos Verdes Estates (“City”) hereby establishes the City’s Section 125 Cafeteria Plan (“Plan”), restated on October 28, 2025. Capitalized terms shall have the meanings set forth in Article II unless defined elsewhere in the Plan. This Plan is designed to permit an Eligible Employee to pay for their share of Contributions under the Medical Insurance Plan, Dental Insurance Plan, Vision Insurance Plan, Health Flexible Spending Account (“FSA”), Dependent Care Assistance Program (“DCAP”), and Life Insurance Plan on a pre-tax Salary Reduction basis.

1.2 Legal Status. This Plan is intended to qualify as a cafeteria plan under Internal Revenue Code § 125 and the regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a self-insured medical reimbursement plan under Code §105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b). The DCAP Component is intended to qualify as a Dependent Care Assistance Program under Code §129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

Although reprinted within this document, the Health FSA Component and the DCAP Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of HIPAA and COBRA. In the event that the Health FSA Component is determined not to be a separate plan, the Plan shall be designated as a hybrid entity for purposes of HIPAA, such that it shall be a covered entity only with respect to the Health FSA Component. The Medical Insurance Plan, Dental Insurance

Plan, and Health FSA are intended to be part of an organized health care arrangement for purposes of HIPAA.

ARTICLE II. Definitions

2.1 Definitions.

Account(s) means the Health FSA Accounts and the DCAP Accounts described in Section 7.5 for Health FSAs, and Section 9.5 for DCAPs.

Benefits means the Premium Payment Benefits (which includes the Medical Insurance Plan, Dental Insurance Plan, and Vision Insurance Plan), Health FSA Benefits, the DCAP Benefits, and the Life Insurance Plan Benefits that are offered under the Plan and that are paid for or partially paid for on a pre-tax Salary Reduction basis as described in Section 6.1 for Premium Payment Benefits, Section 7.1 for Health FSA Benefits, Section 8.1 for Life Insurance Benefits, and Section 9.1 for DCAP Benefits.

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 health plan (such as an HMO or a PPO option under a health plan). Benefits prohibited under Code § 125(f) (such as long-term care insurance and certain Exchange-participating qualified health plans) are not permitted Benefit Package Options.

Change in Status means any of the events described below, as well as any other events included in subsequent changes to Code § 125, or regulations or guidance issued thereunder that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under applicable law 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;
- (c) **Employment Status.** Any of the following events that change the employment status

of the Participant or their 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 benefits plan of the Participant or their Spouse or Dependents 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 benefits 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, such as attaining a specified age, Student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or their Spouse or Dependents.

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; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code §401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

Component(s) means one or more of the following: the DCAP Component, the Health FSA Component, or the Premium Payment Component.

Contribution(s) means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, Section 8.2 for Life Insurance

Benefits, and Section 9.2 for DCAP Benefits.

DCAP means dependent care assistance program.

DCAP Account means the account described in Section 9.5.

DCAP Benefits has the meaning described in Section 9.1.

DCAP Component means the component of this Plan described in Article IX.

Dental Insurance Benefits means the Employee's Dental Insurance Plan coverage for

purposes of this Plan.

Dental Insurance Plan means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents who may be eligible under the terms of such plan), providing dental 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.

Dependent means: for purposes of health coverage (to the extent funded under the Premium

Payment Component), (1) a dependent as defined in Code § 105(b), (2) any child (as defined in Code § 152(f)(1)) of the Participant who has not attained age 26, and (3) any child of the

Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of

divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year).

Dependent Care Expenses has the meaning described in Section 9.3.

Earned Income shall have the meaning given such term in Code § 129(e)(2).

Election Form/Salary Reduction Agreement means the actual or deemed paper or electronic form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for Benefits. It includes an

agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

Eligible Employee means an Employee eligible to participate in this Plan, as provided in Section 3.1.

Eligible Opt Out Arrangement means an Opt Out Arrangement that meets the conditions of Section 6.5.

Employee means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or any individual classified by the Employer as an independent contractor for the period during which such individual is so classified (even if subsequently determined by the IRS, the Department of Labor, a court of competent jurisdiction, or the Employer to be a common-law employee of the Employer), whether or not any such individual is on the Employer's W-2 payroll; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any self-employed individual; (d) any partner in a partnership; and (e) any more-than-2% shareholder in a Subchapter S corporation. 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, but only to the extent specifically provided elsewhere under this Plan.

Employer means the City of Palos Verdes Estates.

Employment Commencement Date means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

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

General-Purpose Health FSA Option has the meaning described in Section 7.3(b).

Grace Period means the period that begins immediately following the close of a Plan Year and ends on the day that is 2 months plus 15 days following the close of that Plan Year.

Health Flex Contribution means any Employer Contribution that meets the following

requirements: (1) the Participant may not opt to receive the amount as a taxable benefit, (2) the Participant may use the amount to pay for minimum essential coverage, and (3) the Participant may use the amount exclusively to pay for medical care, within the meaning of Code § 213. The Health Flex Contribution includes the City's dollar allowance to eligible employee for their use in purchasing the various health insurance benefits offered by the City.

Health FSA means health flexible spending arrangement. The City offers a General-Purpose Health FSA.

Health FSA Account means the account described in Section 7.5.

Health FSA Benefits has the meaning described in Section 7.1.

Health FSA Component means the component of this Plan described in Article VII.

High-Deductible Health Plan means the high-deductible health plan offered by the Employer as a Benefit Package Option under the Medical Insurance Plan that is intended to qualify as a high-deductible health plan under Code §223(c)(2), as described in materials provided separately by the Employer.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended. HMO means the health maintenance organization Benefit Package Option (if any) under the Medical Insurance Plan.

Medical Care Expenses means expenses incurred by a Participant or their Spouse or Dependents for medical care, as defined in Code § 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise.

Medical Insurance Benefits means the Employee's Medical Insurance 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 who 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.

Non-Health Flex Contribution means an Employer designated Contribution that does not meet the definition of a Health Flex Contribution.

Open Enrollment Period with respect to a Plan Year means a period in September and October in the year preceding the Plan Year as prescribed by the Medical Insurance Plan, a period in September preceding the Plan Year as prescribed by the Dental and Vision Insurance Plans, and/or such other period as may be prescribed by the Administrator.

Participant means a person who is an Eligible Employee and who is participating in Benefits under this Plan in accordance with the provisions of Article III. Participants include (a) those who elect the Benefits and Salary Reductions to pay for such Benefits; and (b) those who decline to enroll in the Medical Insurance Plan and elect to receive a cash amount under an Opt Out Arrangement or Eligible Opt Out Arrangement.

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 on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

Plan means the City's Section 125 Cafeteria Plan as set forth herein and as amended from time to time.

Plan Administrator means the City. The contact persons are the Human Resource Analyst and Deputy City Manager for the City, who have the full authority to act on behalf of the Plan

Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 12.1.

Plan Year for the Medical, Dental, and Vision Insurance Plans means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31).

PPO means the preferred provider organization Benefit Package Option (if any) under the Medical Insurance Plan.

Premium Payment Component means the component of this Plan described in Article VI. **Prior Plan Year DCAP Amounts** has the meaning described in Section 9.4(e).

QMCSO means a qualified medical child support order, as defined in ERISA §609(a).

Qualifying Dependent Care Services has the meaning described in Section 9.3.

Qualifying Individual means (a) a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1); (b) a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a 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)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

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, as permitted for the applicable component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

Spouse means an individual who is treated as a spouse for federal tax purposes.

Notwithstanding the above, for purposes of the DCAP Component, 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 is married to the Participant and files a separate federal income tax return, where (i) the Participant maintains a household that constitutes a Qualifying Individual's principal place of abode for more than one-half of the taxable year, (ii) the Participant furnishes more than half of the cost of maintaining such household, and (iii) during the last 6 months of such taxable year, the individual is not a member of such household.

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.

Vision Insurance Benefits means the Employee's Vision Insurance Plan coverage for purposes of this Plan.

Vision Insurance Plan means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents who may be eligible under the terms of such plan), providing vision 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.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate. Subject to the eligibility requirements under a memorandum of understanding, resolution, or City policy, or contract, if any, an individual is eligible to participate in this Plan if the individual: (a) is an Employee; and (b) is eligible for the Medical

Insurance Benefits (whether or not coverage under such plan has been elected) subject to eligibility requirements under a resolution, policy, or contract, if any. Eligibility for the Benefits shall also be subject to the additional requirements, if any, specified in the Medical Insurance, Dental Insurance, Vision Insurance, Health FSA, DCAP, and Life Insurance Plans. Once an Employee has met the Plan's and the Medical Insurance, Dental Insurance, Vision Insurance, Health FSA, DCAP, and Life Insurance Plan's eligibility requirements, the Employee may elect coverage effective the first day of the next calendar month, or for any subsequent Plan Year, in accordance with the procedures described in Article IV.

3.2 Termination of Participation. A Participant will cease to be a Participant in this Plan upon the earlier of:

- (a) the termination of this Plan; or
- (b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.6 for Insurance Benefits and Section 7.8 for Health FSA Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical, Dental, and Vision Insurance Benefits will terminate as of the date(s) specified in the Medical, Dental, and Vision Insurance Plans. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits and Section 9.8 for DCAP Benefits.

3.3 Participation Following Termination of Employment or Loss of Eligibility. If a

Participant terminates their employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more

than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Medical, Dental, and/or Vision Insurance Plan is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including but not limited to a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete any waiting required by the Benefits before again becoming eligible to participate in those Benefits.

3.4 FMLA Leaves of Absence.

(a) 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 Medical, Dental, and Vision Insurance Benefits, and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue their coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require Participants to continue all Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, and Health FSA Benefits coverage while they are on paid leave, provided that Participants on non-FMLA paid leave are required to continue such coverage. If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue their Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay their share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Medical Insurance, Dental Insurance, Vision Insurance, and/or Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions for such Benefit(s) until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant. If a Participant's Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, or Health FSA Benefits as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

In addition, the Plan may require Participants whose Medical Insurance Benefits, Dental Insurance Benefits, Vision Insurance Benefits, or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was 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 Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a per-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when Participants are on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant, or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions 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, then the election change rules in Section 11.3(d) will apply.

ARTICLE IV. Method and Timing of Elections

4.1 Elections When First Eligible. An Employee who first becomes eligible to participate in

the Plan mid-Plan Year ("midyear") may elect to commence participation in one or more

Benefits on the first day of the month after the eligibility requirements have been satisfied,

provided that an Election Form/Salary Reduction Agreement is submitted to the Plan

Administrator before the first day of the month in which participation will commence. An

Employee who does not elect benefits when first eligible may not enroll until the next Open

Enrollment Period, unless an event occurs that would justify a midyear election change, as

described under Section 11.3. The provisions of this Plan are not intended to override any

exclusions, eligibility requirements, or waiting periods specified in the Medical, Dental, and/or

Vision Insurance Plans.

4.2 Elections During Open Enrollment Period. During each Open Enrollment Period with

respect to a Plan Year, the Plan Administrator shall provide a paper or electronic Election

Form/Salary Reduction Agreement to each Eligible Employee. The Eligible Employee may

elect to participate in the Benefits of this Plan for the next Plan Year and authorize the

necessary Salary Reductions to pay for the Benefits elected by completing the Election

Form/Salary Reduction Agreement. The Election Form/Salary Reduction Agreement must be

returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and

it shall become effective on the first day of the next Plan Year.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement. If

an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the

time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits

under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would

justify a midyear election change, as described under Section 11.3 or 11.4.

If an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for

Medical Insurance Benefits and has made an effective election for such Benefits outside of Open Enrollment and does not have an event that would justify a midyear election change, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a midyear election change as described under Section 11.3), a timely Election Form/Salary Reduction Agreement to elect Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

4.4 Irrevocability of Elections. Unless an exception applies (as described in Article XI), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered. When first eligible or during the Open Enrollment Period as described under Article IV, Eligible Employees will be given the opportunity to elect one or more of the following Benefits:

- (a) Premium Payment Benefits, as described in Article VI;
- (b) Health FSA Benefits, as described in Article VII.
- (c) Life Insurance Benefits, as described in Article VIII; and
- (d) DCAP Benefits, as described in Article IX.

In no event shall Benefits under the Plan be provided in the form of deferred compensation. Amounts remaining in a Participant's DCAP Account at the end of a Plan Year may be used to reimburse the Participant for Dependent Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year as provided in Article IX. Amounts remaining in a Participant's Health FSA at the end of a Plan Year may also be used to reimburse the Participant for Health FSA Expenses that are incurred during the Grace Period

immediately following the close of that Plan Year as provided in Article VII.

5.2 Employer and Participant Contributions

(a) Employer Contributions. For Participants who elect Medical, Dental, Vision, Health

FSA, DCAP or Life Insurance Benefits, the Employer may contribute a portion of the

Contributions as provided in the Open Enrollment materials furnished to Employees, the

Election Form/Salary Reduction Agreement, and/or any applicable memorandum of

understanding, resolution, policy, or contract. The Employer may also designate a

Health Flex Contribution that a Participant may allocate to the Medical, Dental, and/or

Vision Insurance Plans, as provided by any applicable memorandum of understanding,

resolution, policy, or contract related to this Plan. The Employer may also designate a

non-health flex contribution, flex dollars, or any other named employer contribution

amount as permitted by an Employer policy, memorandum of understanding, resolution,

or other contract.

(b) Participant Contributions. Participants who elect Benefits may pay for the cost of

coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary

Reduction Agreement. Participants who elect Health FSA Benefits or DCAP Benefits

must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing

an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) Salary Reductions per Pay Period. The Salary Reduction for a pay period for a

Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions

for such Benefits (as described in Section 6.2 for Premium Payment Benefits, Section

7.2 for Health FSA Benefits, Section 8.2 for Life Insurance Benefits, and Section 10.2

for DCAP Benefits, as applicable), divided by the number of pay periods in the Period

of Coverage; (2) an amount otherwise agreed upon between the Employer and the

Participant; or (3) an amount deemed appropriate by the Plan Administrator. If a

Participant increases his or her election under the Health FSA Component, Life

Insurance, or DCAP Component to the extent permitted under Section 11.3, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 11.3, less the Salary Reductions made 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; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

(b) Considered Employer Contributions for Certain Purposes. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Benefits, and, 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 due Salary Reduction amounts from any remaining Compensation.

5.4 Funding This Plan. All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Benefits are paid as provided in the applicable Medical, Dental, or Vision Insurance Plan. Nothing herein will be construed to require the Employer or the Plan 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.

ARTICLE VI. Premium Payment Component

6.1 Benefits. The Premium Payment Component offers benefits under the Medical, Dental, and

Vision Insurance Plans. Notwithstanding any other provision in this Plan, the Medical, Dental,

and Vision Insurance Benefits are subject to the terms and conditions of the Medical, Dental,

and Vision Insurance Plans, and no changes can be made with respect to such Benefits under

this Plan (such as midyear changes in election) if such changes are not permitted under the

applicable Medical, Dental, and Vision Insurance Plans. An Eligible Employee can elect

Benefits by electing to pay for their share of the Contributions for the Benefits on a pre-tax

Salary Reduction basis; or elect no Benefits.

6.2 Contributions for Cost of Coverage. The annual Employer Contribution for a Participant's

Benefits is equal to the amount as set by the Employer, as described in a memorandum of

understanding, resolution, policy, contract, or other applicable document, which may or may not

be the same amount charged by the Medical, Dental, or Vision Insurance Plan or insurance

carrier. The Employer may also designate Health Flex Contributions that a Participant may

allocate to Medical, Dental, and Vision Insurance Benefits. Participants who elect benefits

under the Medical Insurance Plan and/or the Group Term Life Insurance Plan and contribute to

the cost of coverage, pay for the cost of that coverage on a pre-tax Salary Reduction basis up to

any applicable limitations by completing an Election Form/Salary Reduction Agreement.

6.3 Benefits Provided Under the Medical, Dental, and Vision Insurance Plans. The types

and amounts of Medical, Dental, and Vision Insurance Benefits, the requirements for

participating in the Medical, Dental, and Vision Insurance Plans, and the other terms and

conditions of coverage, benefits, and claims of the Medical, Dental, and Vision Insurance Plans

are set forth in the Medical, Dental, and Vision Insurance Plans, not this Plan.

6.4 Eligible Opt Out Arrangement. The Employer may establish an Opt Out Arrangement for

Eligible Employees ("Eligible Opt Out Arrangement") who decline to enroll in the Medical

Insurance Plan in an applicable memorandum of understanding, resolution, policy, or contract.

The conditions that must be satisfied for an Eligible Opt Out Arrangement are as follows:

- (a) The Participant and the Participant's Tax Family must have (or will have) minimum essential coverage ("MEC") through another source (other than coverage in the individual market, whether or not obtained through Covered California);
- (b) A Tax Family means all individuals for whom the Participant reasonably expects to claim a personal exemption deduction for the taxable year(s) that cover the Participant's Plan Year to which the opt-out arrangement applies;
- (c) The Participant must provide reasonable evidence of the MEC for the Participant and their Tax Family for the applicable period. Reasonable evidence may include an attestation by the Participant;
- (d) The Participant must provide the evidence/attestation every Plan Year;
- (e) The Participant must provide the evidence/attestation no earlier than a reasonable time before coverage starts (e.g. Open Enrollment). The evidence/attestation may also be provided within a reasonable time after the Plan Year starts; and

6.5 Reserved.

6.6 Medical Insurance Benefits; COBRA Contributions. Contributions for COBRA coverage for Medical Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For individuals who cease to be eligible because of retirement, termination of employment, or layoff, Contributions for COBRA coverage for Medical Insurance Benefits shall be paid on an after-tax basis (unless otherwise permitted by the Plan Administrator on a uniform and consistent basis). Contributions for COBRA coverage may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits. An Eligible Employee can elect to participate in the Health FSA

Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses under one of the Health FSA coverage options described in Section 7.3(b) (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XI), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

Notwithstanding any other provision of this Plan, an Eligible Employee shall not be eligible for the Health FSA Component unless he or she is also eligible for the Medical Insurance Plan.

7.2 Contributions for Cost of Coverage of Health FSA Benefits. A Participant may direct Health Flex Contributions or non-Health Flex Contributions (if applicable) to Health FSA

Benefits as provided by an Employer policy, memorandum of understanding, resolution, or other contract related to this Plan, subject to the limitations in Section 5.2(a). The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount

electd by the Participant, subject to the dollar limits set forth in Section 7.4(b).

7.3 Eligible Medical Care Expenses for Health FSA. Under the Health FSA Component, a

Participant may receive reimbursement for certain Medical Care Expenses incurred during the Period of Coverage for which a current election is in force. In addition, certain individuals may receive reimbursement for Medical Care Expenses incurred during the Grace Period

immediately following the close of a Plan Year from amounts remaining in their Health FSA Accounts for that Plan Year in accordance with Section 7.4(e).

(a) Incurred. A Medical Care Expense is generally considered to be incurred at the time

the medical care or service giving rise to the expense is furnished, not when the

Participant is formally billed for, is charged for, or pays for the medical care. Certain limited exceptions may apply (e.g., for orthodontia expenses pursuant to an approved

payment plan).

(b) Medical Care Expenses. Medical Care Expenses means expenses incurred by a

Participant or his or her Spouse or Dependents for medical care, as defined in Code

§213(d) (including expenses for menstrual care products as defined in Code

§223(d)(2)(D)), but only to the extent that the expense has not been reimbursed through

insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical or Dental Insurance Plan imposes copayment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VII.

Notwithstanding the foregoing, the term Medical Care Expenses does not include:

- (1) premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer);
- (2) 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 (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease);
- (3) any expense that is not legally provided under applicable state or federal law; or
- (4) any other expense excluded under Appendix B or otherwise under the terms of this Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.

7.4 Maximum and Minimum Benefits for Health FSA.

(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 FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care

Expenses incurred after participation in this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8. 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 (or during a Grace Period, if applicable under section 7.4(e)), provided that the other requirements of this Article VII have been satisfied.

(b) *Maximum and Minimum 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 not exceed the limit established by Internal Revenue Code §125(i)(1), as adjusted annually by the most recent IRS guidelines. The minimum 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 amount established by the Plan Administrator, if any. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) *Changes; No Proration.* The maximum and minimum dollar limit may be changed by

the Plan Administrator through an applicable memorandum of understanding, resolution, policy, or contract and shall be communicated to Employees through the Election

Form/Salary Reduction Agreement or another document, provided that the maximum dollar limit shall not exceed the maximum amount permitted under Code §125(i). If a Participant enters the Health FSA Component midyear or wishes to increase his or her election midyear as permitted under Section 11.3, then there will be no proration rule-i.e.,

the Participant may elect coverage up to the maximum dollar limit or may increase

coverage to the maximum dollar limit, as applicable. Notwithstanding the foregoing, the Plan Administrator may limit the elections of a Participant who is terminated and rehired during the same Plan Year to the extent necessary to comply with the requirements of

Code §125(i).

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XI (other than under Section 11.3(c) for FMLA leave) that increases contributions to the Health FSA Component 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 (if any) made by the Participant 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 FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 11.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

- **(e) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.*** Notwithstanding any contrary provision in this Plan and subject to the conditions in Section 7.4(b), an individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA Account at the end of the Plan Year to which that Grace Period relates (“Prior Plan Year Health FSA Amounts”) if he or she is a Participant in the Plan with Health FSA coverage that is in effect on the last day of that Plan Year.
 - Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.
 - Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 7.7 will be reimbursed first from any available Prior Plan Year Health FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year. An individual's Prior Plan Year Health FSA Amounts will be debited for any

reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Health FSA Amounts.

- Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than the March 15th following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health FSA Amounts. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.6(b).

7.5 Establishment of Health FSA Account. The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

- (a) *Crediting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.
- (b) *Debting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period (or for reimbursement of Medical Care Expenses incurred during any Grace Period to which he or she is entitled as provided in Section 7.4(e)).
- (c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year (or during the Grace Period, if applicable); it is not based on the

amount credited to the Health FSA Account at a particular point in time except as provided in Section 7.4(e). Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Forfeiture of Health FSA Accounts; Use-It-or-Lose-It Rule.

(a) *Use-It-or-Lose-It Rule.* Except as otherwise provided in Section 7.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) *Use of Forfeitures.* All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year, including any Grace Period and time period for reimbursing claims for such Grace Period when applicable, following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for Health FSA.

(a) *Timing.* Within 30 days after receipt by the Plan Administrator of a reimbursement

claim from a Participant, the Employer will reimburse the Participant for the Participant's

Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan

Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the

Plan Administrator, including in cases where a reimbursement claim is incomplete. The

Plan 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 the previously

incomplete reimbursement claim.

(b) Claims Substitution. A Participant who has elected to receive Health FSA Benefits

for a Period of Coverage may apply for reimbursement by submitting a request in writing

to the Plan Administrator in such form as the Plan Administrator may prescribe, by no

later than the May 15th following the close of the Plan Year in which the Medical Care

Expense was incurred (except that for a Participant who ceases to be eligible to

participate, this must be done no later than 90 days after the date that eligibility ceases, as

described in Section 7.8) setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;

- the nature and date of the Medical Care Expenses so incurred;

- the amount of the requested reimbursement;

- a statement that such Medical Care Expenses have not otherwise been reimbursed and

- that the Participant will not seek reimbursement through any other source; and

- other such details about the expenses that may be requested by the Plan Administrator

- in the reimbursement request form or otherwise (e.g., a statement from a medical

- practitioner that the expense is to treat a specific medical condition, documentation

- that a medicine or drug was prescribed, or a more detailed certification from the

- Participant).

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

showing the amounts of such Expenses, along with any additional documentation that the

Plan Administrator may request. Except for the final reimbursement claim for a Participant's Health FSA Account for a Plan Year or other Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least the minimum amount (if any) established by the Plan Administrator. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Section 7.9 and applicable IRS guidance regarding electronic payment card programs.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XII.

(d) *Claims Ordering; No Reprocessing.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA.

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in Section 7.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during the Grace Period) and this Section 7.8, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible, (or during any Grace Period to which he or she is entitled as provided in Section 7.4(e)), provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a

Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). 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 FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year, except that qualified beneficiaries who continue coverage through the end of the Plan Year may receive reimbursement for amount of unused Health FSA amounts remaining at the end of such Plan Year in accordance with the Plan's provisions regarding Health FSA Grace Periods (see Section 7.4). Such continuation coverage shall be subject to all conditions and limitations under COBRA, except that it shall not be terminated early for after-acquired group health coverage or Medicare entitlement.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

7.9 Electronic Payment Cards. If the Employer allows the Health FSA to be accessed by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Participants will be required to comply with substantiation procedures and all other provisions established by the Plan Administrator in accordance with applicable IRS guidance regarding electronic payment card programs.

ARTICLE VIII. Life Insurance

8.1 Benefits. An Eligible Employee can elect to participate in Life Insurance Plans.

Notwithstanding any other provision in this Plan, the Life Insurance Benefits are subject to the terms and conditions of the Life Insurance Plans, and no changes can be made with respect to such Life Insurance Benefits under this Plan (such as midyear changes in election) if such changes are not permitted under the Life Insurance Plans. An Eligible Employee can elect Life Insurance Benefits by electing to pay for their share of the Contributions for the Life Insurance Benefits on a pre-tax Salary Reduction up to a maximum described in Section 8.4; or elect no Benefits.

8.2 Contributions for Cost of Coverage. The annual Employer Contribution for a Participant's Life Insurance Benefits is equal to the amount as set by the Employer, as described in an applicable memorandum of understanding, resolution, policy, contract, or other document, which may or may not be the same amount charged by the Life Insurance Plan or insurance carrier.

8.3 Benefits Provided Under the Life Insurance Plans. The types and amounts of Life Insurance Benefits, the requirements for participating in the Life Insurance Plans, and the other terms and conditions of coverage, benefits, and claims of the Life Insurance Plans are set forth in the Life Insurance Plans, not this Plan.

8.4 Maximum Excludable Amounts. Pursuant to section 79 of the Internal Revenue Code, the employer-paid premium cost of a group-term life insurance policy on the life of the employee shall be included as taxable gross income, but only to the extent that such cost exceeds the sum

of:

(1) the cost of \$50,000 of such insurance, and

(2) the amount (if any) paid by the employee toward the purchase of such insurance.

The cost of the employer-paid premiums paid by the employer on the first \$50,000 of group-term life insurance through a nondiscriminatory plan may be excluded from the employee's income. A taxable fringe benefit arises if coverage exceeds \$50,000 and the policy is considered carried directly or indirectly by the employer. A policy is considered carried directly or indirectly by the employer if:

(1) The employer pays any cost of the life insurance, or

(2) The employer arranges for the premium payments and the premiums paid by at least one employee subsidize those paid by at least one other employee (the "straddle" rule).

The determination of whether the premium charges straddle the costs is based on the IRS Premium Table rates, not the actual cost.

"Group-term life insurance" has the meaning defined in section 1.79-1, title 26 of the Code of Federal Regulations. Other forms of life insurance that are not group-term life insurance, such as voluntary permanent life insurance, are not excludable from tax.

The cost of employer-paid premiums for group-term life insurance on the life of an employee's spouse or dependent is not taxable to the employee if the face amount of the coverage does not exceed \$2,000. This coverage is excluded as a de minimis fringe benefit.

ARTICLE IX. DCAP Component

9.1 DCAP Benefits. An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XI), such election of DCAP Benefits is irrevocable for the

duration of the Period of Coverage to which it relates.

9.2 Contributions for Cost of Coverage for DCAP Benefits. The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 9.4(b). (For example, if the maximum \$5,000 annual benefit amount is elected, then the annual Contribution amount is also \$5,000.)

9.3 Eligible Dependent Care Expenses. Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force. In addition, certain individuals may receive reimbursement for Dependent Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in their DCAP Accounts for that Plan Year in accordance with Section 9.4(e).

(a) Incurred. A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) Dependent Care Expenses. "Dependent Care Expenses" are 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, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services-provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article IX.

(c) Qualifying Dependent Care Services. "Qualifying Dependent Care Services" means

services that: (1) relate to the care of a Qualifying Individual that enable the Participant

and his or her Spouse to remain gainfully employed after the date of participation in the

DCAP Component and during the Period of Coverage; and (2) are performed-

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility (including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(d) *Exclusion.* Dependent Care Expenses do not include amounts paid to:

- an individual whom a Participant or his or her Spouse can claim as a dependent for federal income tax purposes;
- a Participant's Spouse;
- a Participant's child (as defined in Code §152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or

- a parent of a Participant's under age 13 qualifying child as defined in Code §152(a)(1) (e.g., a former spouse who is the child's noncustodial parent).

9.4 Maximum and Minimum Benefits for DCAP.

(a) *Maximum Reimbursement Available.* The maximum dollar amount elected by the

Participant for reimbursement of Dependent Care Expenses incurred during a Period of

Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be

available during the Period of Coverage to the extent of the actual amounts credited to the

Participant's DCAP Account pursuant to Section 9.5. (No reimbursement will be made to

the extent that such reimbursement would exceed the balance in the Participant's Account

(that is, the year-to-date amount that has been withheld from the Participant's

Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements.) 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 (or during a Grace Period, if applicable under Section 9.4(e)), provided that the other requirements of this Article IX have been satisfied.

(b) *Maximum and Minimum 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 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

- the Participant's Earned Income for the calendar year;
- the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse will be deemed to have earned income of at least \$250 (\$500 if the Participant has two or more Qualifying Individuals) for each month in which the Spouse is either (1) physically or mentally incapable of self-care (provided that the Spouse must have the same principal place of abode as the Participant for more than one-half of such year), or (2) a Student); or
- either \$5,000 or \$2,500 for the calendar year, as applicable:
 - (1) \$5,000 for the calendar year if one of the following applies:
 - the Participant is married and files a joint federal income tax return;
 - the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) 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 (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (2) the

Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) 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) \$2,500 for the calendar year if the Participant is married and files a separate federal income tax return under circumstances other than those described above.

The minimum 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 the minimum amount (if any) established by the Plan Administrator.

(c) *Changes; No Provision.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document.

If a Participant enters the DCAP Component midyear or wishes to increase his or her election midyear as permitted under Section 11.3, then there will be no proration rule-i.e.,

the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XI affecting annual contributions to the DCAP Component also

will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 9.4(a)

and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions, if any, made by the

Participant 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 DCAP Account,

reduced by (3) reimbursements during the Period of Coverage.

(e) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.*

Notwithstanding any contrary provision in this Plan and subject to the conditions of Sections 9.4(b), an individual may be reimbursed for Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her DCAP Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year DCAP Amounts") if he or she is a Participant in the Plan with DCAP coverage that is in effect on the last day of that Plan Year.

- Prior Plan Year DCAP Amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, Prior Plan Year DCAP Amounts may not be used to reimburse Medical Care Expenses.
- Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 9.7 will be reimbursed first from any available Prior Plan Year DCAP Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year. An individual's Prior Plan Year DCAP Amounts will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such Prior Plan Year DCAP Amounts.
- Claims for reimbursement of Dependent Care Expenses incurred during a Grace Period must be submitted no later than May 15th following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year DCAP Amounts. Any Prior Plan Year DCAP Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 9.6.

9.5 Establishment of DCAP Account. The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose.

The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 9.6.

(a) *Crediting of Accounts.* A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary

Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's DCAP Account will be debited during each

Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage (or for reimbursement of Dependent Care Expenses incurred during any Grace Period to which he or she is entitled as provided in Section 9.4(e)).

(c) *Available Amount Is Based on Credited Amount.* As described in Section 9.4, the

amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior

reimbursements for Dependent Care Expenses incurred during the Plan Year (or during the Grace Period, if applicable)-i.e., it is based on the amount credited to the DCAP

Account at a particular point in time. Thus, a Participant's DCAP Account may not have a negative balance.

9.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule.

(a) *Use-It-or-Lose-It Rule.* Except as otherwise provided in Section 9.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year DCAP Amounts for expenses

incurred during a Grace Period), if any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then

such balance 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.

(b) *Use of Forfeitures.* All forfeitures under this Plan shall be used as follows: first, to offset

any losses experienced by the Employer during the Plan Year as a result of making

reimbursements (i.e., providing DCAP Benefits) with respect to all Participants in excess of the

Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

9.7 Reimbursement Claims Procedure for DCAP.

(a) *Timing.* Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan 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 the previously incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the May 15th following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 90 days after the date that eligibility ceases, as described in Section 9.8), setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;

• the amount of the requested reimbursement;

• the name of the person, organization, or entity to whom the Expense was or is to be

paid, and taxpayer identification number (Social Security number, if the recipient is a

person);

• a statement that such Expenses have not otherwise been reimbursed and that the

Participant will not seek reimbursement through any other source;

• the Participant's certification that he or she has no reason to believe that the

reimbursement requested, added to his or her other reimbursements to date for

Dependent Care Expenses incurred during the same calendar year, will exceed the

applicable statutory limit for the Participant as described in Section 9.4(b); and

• other such details about the expenses that may be requested by the Plan Administrator

in the reimbursement request form or otherwise (e.g., a more detailed certification

from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an

independent third party showing that the Dependent Care Expenses have been

incurred and showing the amounts of such Expenses, along with any additional

documentation that the Plan Administrator may request.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure

in Article XII.

9.8 Reimbursements From DCAP After Termination of Participation. When a Participant

ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to

participate will terminate. Except as otherwise provided in Section 9.4(e) (regarding certain

individuals who may be reimbursed from Prior Plan Year DCAP Amounts for expenses

incurred during a Grace Period), the Participant will not be able to receive reimbursements for

Dependent Care Expenses incurred after the end of the day on which the Participant's

employment terminates or the Participant otherwise ceases to be eligible, with one exception:

such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care

Expenses incurred in the month following termination of employment or other cessation of

eligibility if such month is in the current Plan Year, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible. In addition, such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled as provided in Section 9.4(e)), provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

9.9 Report to DCAP Participants. On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement 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 DCAP Component, as the Plan Administrator deems appropriate. This may be done using Box 10 on the Participants Form W-2.

ARTICLE X. HIPAA Provisions for Health FSA

10.1 General. As a HIPAA Health Plan, the Health FSA shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic personal health information ("PHI") as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

10.2 Definitions. For purposes of this Article, the following definitions shall apply:

- (a) "Breach" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan determines there is a low probability that the PHI has been compromised. A Breach does not include: (1) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if

such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement, and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) "Breach Notification Rule" means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(c) "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media.

(d) "Health Care Operations" is as defined under 45 CFR §164.501.

(e) "HIPAA Health Plan," as defined under 45 CFR §160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR §160.103.

(f) "Payment" is as defined under 45 CFR §164.501, and means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for the coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(g) "Privacy Policy" means the Employer HIPAA Privacy Policy.

(h) "Privacy Rule" means the regulations issued under HIPAA set forth in subpart B of 45 CFR Part 164.

(i) "Protected Health Information" or "PHI" means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care to a Participant, Spouse, or Dependent, or payment for such health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the

information can be used to identify the Participant, Spouse, or Dependent; and (3) is received or created by or on behalf of the Health FSA.

(j) "Responsible Employee" means an employee (including a contract, temporary, or leased employee) of the Health FSA or of the Employer whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the employee will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 10.3.

(k) "Security Incident," as defined under 45 CFR §164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(l) "Security Rule" means the regulations issued under HIPAA set forth in subpart C of 45 CFR Part 164.

10.3 Responsible Employees. Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a Health FSA. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health FSA administration functions that the Employer performs on behalf of a Health FSA pursuant to Section 10.4.

(a) Employer employees who perform the following functions on behalf of the Health FSA are Responsible Employees: (1) claims determination and processing functions; (2) Health FSA vendor relations functions; (3) benefits education and information functions; (4) Health FSA administration activities; (5) legal department activities; (6) Health FSA compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions.

(b) In addition to those individuals described in subsection (a), the Health FSA HIPAA privacy official and security official, and Employer employees to whom the Health FSA HIPAA privacy official and security official have delegated any of the following responsibilities, shall also be Responsible Employees: (1) implementation, interpretation, and amendment of the Privacy Policy; (2) Privacy Rule, Breach Notification Rule, or

Security Rule training for Employer employees; (3) investigation of and response to complaints by Participants, Spouses, Dependents, and/or employees; (4) preparation, maintenance, and distribution of the health FSA's privacy notice; (5) response to requests by Participants, Spouses, or Dependents to restrict the use or disclosure of their PHI; (7) response to requests by Participants, Spouses, or Dependents to receive communications of their PHI by alternate means or in an alternate manner; (8) amendment and response to requests to amend the PHI of Participants, Spouses, or Dependents; (9) response to PHI; (10) response to requests for information by the Department of Health and Human Services; (11) approval of disclosures to law enforcement or to the military for government purposes; (12) maintenance of records and other documentation required by the Privacy Rule, Breach Notification Rule, or Security Rule; (13) negotiation of Privacy Rule, Breach Notification Rule, and Security Rule provisions and/or reasonable security provisions into contracts with third-party service providers; (14) maintenance of Health FSA PHI or Electronic PHI security documentation; or (15) approval of access to Electronic PHI by Participants, Spouses, or Dependents.

10.4 Permitted Uses and Disclosures. Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the Health FSA, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health FSA's own Payment and Health Care Operations functions, as defined in 45 CFR § 164.501;

(b) uses and disclosures for another HIPAA Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 CFR § 160.103, for the health care provider's treatment activities;

(d) disclosures to the Employer, acting in its role as Plan sponsor, or (1) summary health information for purposes of obtaining health insurance coverage or premium bids for

- HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;
- (e) disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g);
 - (f) disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;
 - (g) uses and disclosures to comply with workers' compensation laws;
 - (h) uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;
 - (i) disclosures to the Secretary of Health and Human Services to demonstrate the Health FSA's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;
 - (j) uses and disclosures for other governmental purposes, such as for national security purposes;
 - (k) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
 - (l) uses and disclosures to identify a decedent or cause of death, or for tissue-donation purposes;
 - (m) uses and disclosures required by other applicable laws; and
 - (n) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508.

10.5 Prohibited Uses and Disclosures. Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.

- (a) ***Genetic Information.*** Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining

eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

(b) *Employment-Related Actions*. Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

(c) *Other Benefits*. Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted in Section 10.4, shall not be a permitted use or disclosure.

10.6 Certification Requirement. The Health FSA shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Health FSA agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Health FSA any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 10.4, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance

with 45 CFR §164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health FSA, available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

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

(j) to take reasonable steps to ensure that there is adequate separation between the Health FSA and the Employer's activities in its role as Health FSA sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the FSA.

10.7 Mitigation. In the event of noncompliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy official or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy official or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy official and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

10.8 Breach Notification. Following the discovery of a Breach of unsecured PHI, the Health RSA shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Health RSA shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

ARTICLE XI. Irrevocability of Elections; Exceptions

11.1 Irrevocability of Elections. A Participant's election under the Plan, including its Components, is irrevocable for the duration of the Period of Coverage to which it relates, except as provided in this Article XI. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- (a) participation in this Plan;
- (b) Salary Reduction amounts; or
- (c) election of particular Benefit Package Options.

11.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 4.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 11.3 (or within 60 days of the occurrence of an event described in Section 11.3(e)(3) or (4)), as applicable, but only if the election

under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 11.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 11.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change request was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that any replacement coverage commences later).

11.3 Events Permitting Exception to Irrevocability Rule for All Benefits. A Participant may change an election as described below upon the occurrence of the stated events for the applicable component of this Plan in accordance with the procedures described in Section 11.2.

(a) *Open Enrollment Period.* A Participant may change an election during the Open Enrollment Period in accordance with Section 4.2.

(b) *Termination of Employment.* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.2 and 3.3, as applicable.

(c) *Leaves of Absence.* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) *Change in Status.* A Participant may change their election under the Plan upon the occurrence of a Change in Status event only if the election is consistent with the event under both the applicable special consistency rules and the general consistency rule. The

Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested election change meets the consistency requirements below.

General Consistency Rule: A Participant's election change satisfies the general consistency requirement only if the election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependents' employer.

Special Consistency Rules: Assuming that the general consistency rule is also satisfied, a requested election change must satisfy the following specific consistency requirements in order for a Participant to be able to alter their election based on the specified Change in Status:

1. **Loss of Spouse or Dependent Eligibility; Special COBRA Rules.** 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, a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel Benefits for the Spouse or Dependent, as applicable. However, if the Participant or their Spouse or Dependent becomes eligible for COBRA because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a Participant under this Plan), then the Participant may increase their election to pay for such coverage.

2. **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which a Participant or their Spouse or Dependent gains eligibility for coverage under another employer's cafeteria plan or qualified benefit plan as a result of a change in marital or employment status, 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 other employer's plan. The Plan 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 Plan Administrator has reason to believe that the Participant's certification is incorrect.

Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

(c) *HIPAA Special Enrollment Rights.* If a Participant or their Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(1) a Participant or their Spouse or Dependent declined to enroll in group health plan coverage because they had coverage, and eligibility for such coverage is subsequently lost because: (A) the coverage was provided under COBRA, and the COBRA coverage was exhausted; or (B) the coverage was non-COBRA coverage, and the coverage terminated due to loss of eligibility for coverage or the employer

contributions for the coverage were terminated;

(2) a new Dependent is acquired as a result of marriage, birth, adoption, or

placement for adoption;

(3) the Participant's or Dependents coverage under a Medicaid plan or state

children's health insurance program is terminated as a result of loss of eligibility for

such coverage; or

(4) the Participant or Dependent becomes eligible for a state premium assistance

subsidy from a Medicaid plan or through a state children's health insurance program

with respect to coverage under the group health plan.

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 the amount of time provided by the underlying group health plan).

(f) Certain Judgments, Decrees, and Orders (Applies to Premium Payment and Health

FSA Benefits, but Not to DCAP Benefits). If a judgment, decree, or order (collectively,

an "Order") resulting from a divorce, legal separation, annulment, or change in legal

custody (including a QMCSO) requires health coverage for a Participant's child

(including a foster child who is a Dependent of the Participant), then a Participant may

(1) change their election to provide coverage for the child if the Order requires the

Participant to provide coverage; or (2) change their election to revoke coverage for the

child if the Order requires that another individual provide coverage under that

individual's plan, and such coverage is actually provided.

(g) Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA

Benefits as Limited Below, but Not to DCAP Benefits). If a Participant or their Spouse

or Dependent who is enrolled in a health plan under this Plan becomes entitled to or

enrolled in Medicare or Medicaid, then the Participant may prospectively reduce or

cancel the health coverage of the person becoming entitled to Medicare or Medicaid. Furthermore, if a Participant or their Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the Medical Insurance Benefit of the individual who loses Medicare or Medicaid eligibility.

(h) Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits). For purposes of this Section 11.3(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) Increase or Decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon 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 and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) Significant Cost Increases. If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the

PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in their elective contributions (by increasing Salary Reductions); (b) revoke their election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) Significant Cost Decreases. If the Plan Administrator determines that the cost of any Benefit Package Option (such as a PPO) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) Limitation on Change in Cost Provisions for DCAP Benefits. The above "Change in Cost" provisions (Sections 1.3(h)(1) through 1.3(h)(3)) apply to DCAP 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(d)(2)(A) through (G), incorporating the rules of Code §§152(f)(1) and 152(f)(4).

(i) *Change in Coverage (Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits).*

The definition of "similar coverage" under Section 11.3(h) applies also to this Section 11.3(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan 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.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under their employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under a health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke their election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). 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.

(b) *Significant Curtailment With a Loss of Coverage.* If the Plan Administrator

determines that a Participant's Benefit Package Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under their employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke their election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) Definition of Loss of Coverage. For purposes of this Section 1.3(1)(1), a "Loss of Coverage" means a complete loss of coverage, including the

elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or their Spouse or Dependent resides, or a Participant or their Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation. In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or their Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(d) DCAP Coverage Changes. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates

one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and 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.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change their election to add group health coverage for the Participant or their 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 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).

(4) Change in Coverage Under Another Employer Plan. 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 Spouses' or Dependent's employer), so long as (a) 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 (b) 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. For example, if an election is made by the Participant's Spouse during their employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and 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.

(j) Reduction of Hours (Applies Only to Premium Payment Benefits for the Medical Insurance Plan). A Participant who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Medical Insurance Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform that is effective no later than the first day of the second month following the month that includes the date the Medical Insurance Plan coverage is revoked.

(k) Exchange Enrollment (Applies Only to Premium Payment Benefits for the Medical Insurance Plan). A Participant who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Medical Insurance Plan coverage, provided that the Participant certifies that he or she and any related

individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Medical Insurance Plan coverage. If one or more of a Participant's related individuals are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period, the Participant may prospectively revoke an election for Medical Insurance Plan coverage for the individual or individuals (and switch to self-only coverage or family coverage including one or more other related individuals), provided that the Participant certifies that the individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of their Medical Insurance Plan coverage.

A Participant entitled to change an election as described in this Section 11.3 must do so in accordance with the procedures described in Section 11.2.

11.4 Election Modifications Required by Plan Administrator. The Plan 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 Plan 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, if any, 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, if any. In the event that contributions need to be reduced for a class of Participants, the Plan 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 and 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 XII. Appeals Procedure

12.1 Procedure If Benefits Are Denied Under This Plan. If a claim for benefits under this Plan is wholly or partially denied, then the Employee or Participant may request review upon written application to the Committee. The Committee acts on behalf of the Plan Administrator with respect to appeals.

12.2 Claims Procedures for Benefits. Claims and reimbursement for Medical, Dental, and Vision Insurance Benefits shall be administered in accordance with the claims procedures for the Medical, Dental, Vision Insurance Benefits, as set forth in the plan documents for the Medical, Dental, and Vision Insurance Plans.

12.3 Claims Deadline. Unless otherwise provided herein or required pursuant to applicable law, a claim for benefits under this Plan must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Employee or his or her designee to make sure this requirement is met.

12.4 Limitations Period for Filing Suit. Unless otherwise provided herein or required pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedure.

ARTICLE XIII. Recordkeeping and Administration

13.1 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan 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.

13.2 Powers of the Plan Administrator. The Plan 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 thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall

have the following 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 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 Plan Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the Plan 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 Plan 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 regarding the benefits covered by this Plan as the Plan 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; and

(f) 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.

13.3 Reliance on Participant, Tables, etc. The Plan 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 Plan 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 Plan Administrator.

13.4 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

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

13.6 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that 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.

13.7 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.

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

13.9 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, 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 Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, 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 they are properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XIV. General Provisions

14.1 Expenses. All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 9.6 with respect to DCAP Benefits, and then by the Employer.

14.2 No Contract of Employment. Nothing herein contained is intended to be construed as an employment contract or other arrangement between any Employee and the Employer and shall not be construed to imply that Employee will be employed for any specific period of time.

14.3 Amendment and Termination. This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may restate, amend or terminate all or any part of this Plan (including any Component) at any time for any reason by resolution of the Employer's governing body or by any person or persons authorized by the

governing body to take such action.

14.4 Governing Law/Venue. This Plan shall be construed, administered, and enforced

according to the laws of the State of California, to the extent not superseded by the Code or any other federal law. Any claim or action resulting from, relating to, or arising under the Plan shall only be brought in the County of Los Angeles in the Central District of California, and such Court shall have personal jurisdiction over any party named in the action.

14.5 Compliance With Code and Other Applicable Laws. It is intended that this Plan meet

all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

14.6 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer

makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under 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 Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

14.7 Indemnification of Employer. If any Participant receives one or more payments or

reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

14.8 Non-Assignability of Rights. The right of any Participant to receive reimbursement under

this Plan shall not be assigned by the Participant and shall not be subject to claims by the

Participant's creditors. Any attempt to cause such right to be so subjected will not be

recognized, except to the extent required by law.

14.9 Plan Provisions Controlling. In the event that the terms or provisions of any summary or description of this Plan conflict with the provisions of this Plan, the provisions of this Plan shall control.

14.10 Severability. If any part of this Plan is invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent permitted by law.

* * *

CERTIFICATION:

I, Tameka Cook, City Clerk of the City of Palos Verdes Estates, California, do hereby certify that the foregoing Resolution No. R25-44, was duly and regularly approved and adopted by the City Council of the City of Palos Verdes Estates, California, at a regular meeting thereof held on the 9th day of December, 2025 by the following vote, to wit:

AYES:

NOES:

ABSENT:

ABSTAIN:

Tameka Cook, City Clerk
City of Palos Verdes Estates, California