# OneBridge Benefits

## CAFETERIA PLAN
WITH
FLEXIBLE SPENDING ACCOUNTS

## AS ADOPTED BY
## BENTON COUNTY PUD

# SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED EFFECTIVE AS OF THE
FIRST DAY OF ANY PLAN YEAR BEGINNING ON OR AFTER SEPTEMBER 1, 2020

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# SUMMARY PLAN DESCRIPTION

## PART 1. GENERAL INFORMATION ABOUT THE PLAN

Your Employer is pleased to sponsor an employee benefit program known as the Cafeteria Plan (the "Plan") for you and your fellow employees. It is called a Cafeteria Plan because it allows you to choose from several different benefit programs (which we refer to as "Benefit Options") according to your individual needs, and allows you to reduce your pay before taxes are deducted ("Pre-tax Contributions") to pay for the Benefit Options that you choose by entering into a salary reduction agreement with your Employer. This Plan helps you because the Benefit Options you elect are nontaxable (i.e., you save Social Security and income taxes on the amount of your salary reduction). Alternatively, you may choose to pay for any of the available benefits with after-tax payroll deductions (*i.e.* on a taxable basis) to the extent permitted by your Employer and set forth in your enrollment materials.

This "Summary Plan Description" or "SPD" describes the basic features of the Plan and other general information relating to the Plan. In addition, the **Plan Information Summary**, which is attached at the end of this SPD and may also have been delivered with your Welcome Letter, contains important information that is specific to your Employer and the unique Plan features implemented by your Employer for your Plan. For example, you can find the identity of the Employer, the Plan Administrator, the Plan Service Provider, your Benefits Coordinator, and other applicable contact information in the **Plan Information Summary**. The **Plan Information Summary** also identifies the Benefit Options available under the Plan and unique features implemented by your Employer with respect to some of these Benefit Options. The Plan is also established pursuant to a "Cafeteria Plan Document" (also referred to as the "Plan Document") approved and adopted by your Employer. You will also receive a "Cardholder Agreement" when you receive your OneBridge Benefits Card described in **Part 8** of this SPD. The Cardholder Agreement is part of the terms and conditions of this Plan and this SPD. The **Plan Information Summary** and the Cardholder Agreement are incorporated into and made a part of this SPD, and this SPD is further incorporated into and made a part of the Plan Document, and the **Plan Information Summary**, the Cardholder Agreement, this SPD, and the Plan Document work together to define the terms and conditions of your Plan and are referred to collectively as the "Plan Documents." You should keep all of the Plan Documents together where you normally keep all of your important information.

Capitalized terms used in the Plan Documents are important terms that are specifically defined for your benefit. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under this Plan. Note that, to the extent permitted by law, if there is a conflict between the terms of the Plan Document and this SPD, the specific terms of the Plan Document will control.

**Note:** By electing to participate in the Plan, using or claiming benefits under the Plan, and using the OneBridge Benefits Card for payment of benefits, you are agreeing to abide by and be subject to the terms and conditions (including any limitations under the Plan) set forth in the Plan Documents. Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator, who is identified in the **Plan Information Summary**.

## PART 2. CAFETERIA PLAN SUMMARY

### Q-1. What is the purpose of the Cafeteria Plan?

The purpose of the Cafeteria Plan is to allow eligible employees to pay for Benefit Options with Pre-tax Contributions. The Benefit Options to which you may contribute with Pre-tax Contributions under this Cafeteria Plan are described in the **Plan Information Summary**. Rules regarding Pre-tax Contributions are described in more detail below.

### Q-2. Who can participate in the Cafeteria Plan?

Each Employee of the Employer (or an Affiliated Employer identified in the **Plan Information Summary**) who satisfies the Plan's eligibility requirements will be eligible to participate in this Plan. If you meet your Employer's eligibility requirements, you may become a Participant on your Eligibility Date, which is the later to occur of your date of hire or the date you complete a Salary Reduction Election. The Plan's eligibility requirements are determined by your Employer based on Employer policies, collective bargaining agreements or other legal or contractual obligations of the Employer. Eligibility requirements for the Plan and the Health FSA and Dependent Care FSA are described in the **Plan Information Summary**. Those employees who elect to participate pursuant to in the Plan pursuant to a Salary Reduction Election are called "Participants". (See below for information on how to become a Participant.) You may use this Plan to pay for Benefit Options covering only yourself and your Dependents. The terms of eligibility of this Plan may be subject to more specific eligibility requirements for each of the Benefit Options. In other words, if you are eligible to participate in this Plan, it does not necessarily mean you are eligible to participate in all of the Benefit Options. The eligibility requirements, benefit amounts, and terms and conditions for the Health FSA and Dependent Care FSA are described in this SPD and in the **Plan Information Summary**. However, there may be some Benefit Options that are summarized in other documents that you may obtain from the Plan Administrator or Benefits Coordinator. If you do not have a summary for a Benefit Option, you should contact the Plan Administrator or your Benefits Coordinator for information on how to obtain a copy.

### Q-3. How do I become a participant?

If you have otherwise satisfied the Plan's eligibility requirements, you become a Participant by signing a Salary Reduction Election by which you agree to pay your share of the cost of the Benefit Options that you choose with Pre-tax Contributions. You must complete the form and submit it to the Plan Administrator or the Plan Service Provider (per the instructions provided with your Salary Reduction Election) during one of the election periods described in **Q-5** below. You may also enroll during the year if you previously elected not to participate and you experience an event described below that allows you to become a Participant during the year. If that occurs, you must complete an "Election Change Form" during the Election Change Period described in **Q-6** below. An Election Change Form is the **Qualifying Life Event (Change in Election Status)** form (or any other form approved by the Plan Administrator for a similar purpose) that you may obtain from your Plan Service Provider or the Plan Administrator.

In some cases, the Employer may *require* you to pay your share of the Benefit Option coverage that you elect with Pre-tax Contributions. If that is the case, your election to participate in the Benefit Option(s) will constitute an election under this Plan. NOTE: Although coverage under a

Benefit Option may be retroactively effective, the Pre-tax Salary Reduction elections made under this plan are typically effective on a prospective basis only, and will begin on the later of your Eligibility Date or the first pay period coinciding with or next following the date of your Salary Reduction Election is received.

You may be required to complete a Salary Reduction Election (which includes any Election Change Form you complete in cases when you are permitted to change your elections) via telephone or voice response technology, electronic communication, web-based portal, or any other electronic medium prescribed or approved by the Plan Administrator. In order to utilize a telephone system or other electronic medium, you may be required to use a unique login or personal identification number that will serve as your electronic signature. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your elections and directions received through use of such an alternative medium, and such elections and directions shall constitute a completed and signed Salary Reduction Election as if such elections and directions were issued in writing and signed by you.

### Q-4. What are the tax advantages and disadvantages of using Pre-Tax Contributions to purchase Benefit Options through the Cafeteria Plan?

Advantages. You save federal income tax, FICA (Social Security) and state income taxes (where applicable) by using Pre-Tax Contributions to purchase Benefit Options through the Plan. Consider the following example to illustrate the potential tax savings under a cafeteria plan:

*Example:* You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $3,600 in premiums ($600 for your share of the employee-only premium, plus $3,000 for family coverage under the Employer's major medical insurance plan). Plus, you contribute $2,400 towards a Health Flexible Spending Account (FSA). You earn $60,000 and your spouse (a student) earns no income. You file a joint tax return.*

| | **If you participate in the Cafeteria Plan** | | **If you do not participate in the Cafeteria Plan** |
|---|---|---|---|
| 1. Gross Income | **$60,000** | | **$60,000** |
| 2. Pre-tax Salary Reductions for Medical Premiums | $3,600 | | $0 |
| 3. Pre-tax Health FSA Contribution | $2,400 | | $0 |
| 3. Adjusted Gross Income (after pre-tax deductions) | **$54,000** | | **$60,000** |
| 4. Projected Income tax rate of 30% (for Federal, State, and FICA) | $16,200 | | $18,000 |
| 5. Take Home Pay (after taxes) | **$37,800** | | **$42,000** |
| 6. Post-tax Premiums & Medical Expenses | $0 | | $6,000 |
| 7. Take Home Pay Difference | **$1,800** | | |

** Example is based on deductions and taxes applicable for the 2019 tax year with an estimated 30% tax rate and assumes that no other applicable taxes, deductions or exemptions apply. Your circumstances may be different and could produce additional or less tax savings.*

Disadvantages. Plan participation will reduce the amount of your taxable compensation. However, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable compensation.

### Q-5. What are the election periods for entering the Cafeteria Plan in any Plan Year?

The Plan Year is generally a 12-month period. However, a short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan. The beginning and ending dates of the Plan Year are described in the **Plan Information Summary**.

The Cafeteria Plan has three "Election Periods": (i) the "Initial Election Period," (ii) the "Annual Election Period," and (iii) the "Election Change Period", which is the period following the date you have a Change in Status Event during which you may make an election change due to a Change in Status Event. The following is a summary of the Initial Election Period and the Annual Election Period. Change in Status Events and their applicable Election Change Periods are described in **Q-6** below.

Initial Election Period

If you want to participate in the Plan when you are first hired, you must enroll during the "Initial Election Period" described in the enrollment materials you will receive. If you make an election during the Initial Election Period, your participation in this Plan will begin on the later of your Eligibility Date or the first pay period coinciding with or next following the date your Salary Reduction Election is received. The effective date of coverage under the Benefit Options will be effective on the date established in the governing documents of the Benefit Options. The election that you make during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status Event described in **Q-6** below. If you do not make an election during the Initial Election Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. Failure to make an election under this Plan generally results in no coverage under the Benefit Options; however, the Employer may provide coverage under certain Benefit Options automatically. These automatic benefits are called "Default Benefits". Any Default Benefits provided by your Employer will be identified in the enrollment material. In addition, your share of the contributions for such Default Benefits may be automatically withdrawn from your pay on a pre-tax basis. You will be notified in the enrollment material whether there will be a corresponding Pre-tax Contribution for such Default Benefits.

Annual Election Period

The Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the entire Plan Year unless you have a Change in Status Event described below. If you fail to complete a Salary Reduction Election during the Annual Election Period, you may be deemed to have elected to continue participation in the Plan with the same Benefit Option elections that you had on the last day of the Plan Year in

which the Annual Election period occurred (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an "Evergreen Election". Alternatively, the Plan Administrator may deem you to have elected not to participate in the Plan for the next Plan Year if you fail to make an election during the Annual Election Period. The enrollment materials distributed to you prior to the Annual Election period will explain what happens if you do not complete a Salary Reduction Election during your Annual Election Period.

**Note: Evergreen Elections do not apply to Flexible Spending Accounts and, if offered under the Plan, Health Savings Account elections. Consequently, you must make an election each Annual Election Period in order to participate in the Flexible Spending Accounts and/or to contribute to a Health Savings Account during the next Plan Year.**

**Q-6. Under what circumstances can I change my election during the Plan Year?**

Generally, you cannot change your election under this Plan during the Plan Year. There are, however, a few exceptions.

First, your election will automatically terminate if you terminate employment or lose eligibility under this Plan or under all of the Benefit Options that you have chosen.

Second, an election under this Plan may be unilaterally modified by the Employer during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) as necessary to prevent the Plan from failing the applicable non-discrimination rules set forth in the Code**.**

Third, you may voluntarily change your election during the Plan Year if you satisfy the following conditions (prescribed by federal law):

(a) You experience a change in status, cost or coverage change, or any of the other events or change in circumstances described below (each a "Change in Status Event"); and

(b) You complete and submit a written Election Change Form to the Plan Service Provider within 30 days of the event or such longer time for certain Change in Status Events as described below, or as otherwise permitted by your Employer's internal policies or applicable law (each an applicable "Election Change Period").

With the exception of special enrollment rights (described below) resulting from birth, placement for adoption or adoption, all election changes are prospectively effective from the date of the election or such later time as determined by the Plan Administrator.

If coverage under a Benefit Option ends, the corresponding Pre-tax Contributions for that coverage will automatically end. No election change is needed to stop the contributions.

The following is a summary of the applicable change in status, cost or coverage changes, or other events or circumstances that may entitle you to change your elections under this Plan during a Plan Year. Note: These rules do not apply to a Code Section 223 Health Savings Account offered under

the Cafeteria Plan. See **Part 7** below for more information regarding election changes related to the Health Savings Account.

1. **Changes in Status**. If one or more of the following changes occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of, and correspond with, the Change in Status Event. Those occurrences which qualify as a Change in Status Event include the events described below, as well as any other events which the Plan Administrator determines are permitted or required under subsequent IRS regulations:

- Change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse),

- Change in the number of your tax Dependents or eligible Dependent children (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),

- Any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit,

- Event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a certain age), or

- Change in your, your Spouse's, or your Dependent's place of residence.

If one of the above Change in Status Events occur, you must inform the Plan Administrator and complete a new election for Pre-Tax Contributions within 30 days of the occurrence.

If you wish to change your election based on one of these Change in Status Events, you must establish that the change is on account of, and corresponds with, the Change in Status Event. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of, and corresponds with, a Change in Status Event. As a general rule, a desired election change will be found to be consistent with a Change in Status Event if the event affects coverage eligibility (for the Dependent Care FSA, the event may also affect eligibility for the dependent care exclusion). A Change in Status Event affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan.

However, you may increase your election to pay for COBRA coverage under the Employer's plan for yourself (if you still have pay) or any other individual who lost coverage but is still a tax dependent or your child (e.g. a child who has lost eligibility under the Plan). **Note: You cannot pay for COBRA coverage from your Health FSA.**

In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status Event:

- *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage, and Health FSA benefits), a special rule governs which type of election change is consistent with the Change in Status Event. For a Change in Status Event involving your divorce, annulment, or legal separation from your Spouse; the death of your Spouse or your Dependent; or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status Event. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

  Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status Event. An election to cancel coverage for Sharon is consistent with this Change in Status Event. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status Event. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status Event.

- *Gain of Coverage Eligibility under Another Employer's Plan*. For a Change in Status Event in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status Event *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care FSA Benefits*. With respect to the Dependent Care FSA benefit (when offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status Event that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status Event that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year, when the daughter turns 13 years old, however, she is no longer eligible to participate in the

dependent care program. This event constitutes a Change in Status Event. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status Event.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits.* In the case of group term life insurance or disability income and dismemberment benefits, if you experience any Change in Status Event (as described above), you may elect to either increase or decrease coverage.

  Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status Event. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status Event.

2. **Special Enrollment Rights**. If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (such as legal separation, divorce, death, termination of employment, reduction in hours, exhaustion of COBRA period, or if your employer or your eligible dependent's employer stops contributing toward your or your dependents' other coverage), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days back to the date of the birth, adoption, or placement for adoption. Please refer to paragraph 8 below for an explanation of special enrollment rights to enroll in a qualified group health plan through a Marketplace.

In addition, if an unenrolled but otherwise eligible Employee or such Employee's dependent (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act or under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act due to a loss of eligibility for coverage under Medicaid or CHIP; or (2) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the Employee is entitled to special enrollment rights under a Benefit Plan Option that is a group health plan and an election change to correspond with the special enrollment right is permitted. However, you must request enrollment **within 60 days** after your Medicaid or CHIP coverage is terminated due to a loss of eligibility or you become eligible for premium assistance subsidy, as applicable. Thus, for example, if an otherwise eligible Employee has medical coverage under Medicaid or SCHIP and eligibility for such coverage is subsequently lost, the Employee may be able to elect medical coverage under a Benefit Option for the Employee and his or her eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee and/or dependent gains eligibility for group health plan premium

assistance from SCHIP or Medicaid, the employee may also be able to enroll the Employee, and the Employee's Dependent, provided that a request for enrollment is made within the 60 days from the date of the loss of other coverage or eligibility for premium assistance. Please refer to the group health plan summary description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees, and Orders**. If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child) to be covered under this Plan, you may change your election to provide coverage for the Dependent child in accordance with the terms of such judgment, decree, or order. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If the Plan Administrator notifies you that the cost of your coverage under the Plan significantly increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of employees), you may make certain election changes. If the cost significantly increases, you may choose either (a) to make an increase in your contributions, (b) revoke your election and receive coverage under another Benefit Option which provides similar coverage, or (c) drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For insignificant increases or decreases in the cost of Benefit Options, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the requirements described in this **Part 2** are met. **The Change in Cost provisions do not apply to Health FSA benefits.**

> Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If the Plan Administrator notifies you that your coverage under the Plan or one of your Benefit Options is significantly curtailed (*i.e.* a significant reduction or elimination of benefits) you may revoke your election and elect coverage under another Benefit Option which provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a Benefit Option during the Plan Year, you may revoke your election and elect to receive, on a prospective basis, coverage provided by the newly-added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an

election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator (in its sole discretion) will determine whether the requirements for any of the election changes are satisfied. **The Change in Coverage provisions do not apply to Health FSA benefits.**

7. **Reduction in hours below 30 hours of service per week due to change in employment status without loss of eligibility**. You can drop major medical coverage for yourself, your spouse, and/or your dependents if:

- You were in an employment status where you were reasonably expected to work at least 30 hours per week *and* there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in you ceasing to be eligible under the major medical plan; and

- Your revocation of the election of coverage under the major medical plan corresponds to the intended enrollment of you, your spouse, and your dependent(s) (as applicable) in another plan that provides minimum essential coverage effective no later than the first day of the second month after the month that includes the date this coverage is revoked.

**You can only drop major medical coverage due to this event and cannot drop any other coverage (including but not limited to health FSA coverage) unless another election change event is available for that benefit.**

8. **Qualified Marketplace Coverage**. You can drop major medical coverage for yourself, your spouse, and/or your dependents if:

- You are eligible for a "special enrollment period" to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

- The revocation of the election under the major medical plan corresponds to the intended enrollment of you, your spouse, and your dependent(s) who revoked coverage in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of major medical plan coverage.

**You can only drop major medical coverage due to this event and cannot drop any other coverage (including but not limited to health FSA coverage) unless another election change event is available for that benefit.**

### Q-7. How is my Benefit Option coverage paid for under this Plan?

You may be *required* to pay for any Benefit Option coverage that you elect with Pre-tax Contributions. Alternatively, your Employer may allow you to pay your share of the contributions with After-tax Contributions. The enrollment material you receive will indicate whether you have to pay with Pre-Tax Contributions or whether you have the option to pay with After-tax Contributions.

When you elect to participate both in a Benefit Option and this Plan, an amount equal to your share of the annual cost of those Benefit Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use Pre-tax Contributions (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld as explained in the example under **Q-4** above.

An Employer may choose to contribute its own funds to pay for a share of the cost of some or all of Benefit Options you choose ("Employer Contributions"). The amount of Employer Contributions applied by the Employer towards the cost of the Benefit Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward at the Employer's sole discretion at any time. The Employer Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant.

The Employer may provide you with Employer Contributions over which you have discretion to allocate the contributions to one or more Benefit Options available under the Plan. These elective employer contributions are called "Flex Credits" and are more specifically defined in the Plan Document. The Flex Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

In no event will any Employer Contributions or Flex Credits be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material or in the **Plan Information Summary**.

### Q-8. What happens to my participation under the Cafeteria Plan if I take a leave of absence?

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Options) during a leave of absence. The specific election changes that you can make under this Plan following a leave of absence are governed by your Employer's internal policies and applicable law and certain specific rules regarding coverage under the Benefit Options during a leave of absence may be further be described in the Benefit Option summaries included with this SPD or as otherwise provided by your Employer. If there is a conflict between a Benefit Option summary and this **Q-8**, the Benefit Option summary will control.

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the Employer will continue to maintain your Benefit Options that provide health coverage on the same terms and conditions as

though you were still active to the extent required by FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all health coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:

(i) With after-tax dollars while you are on leave,

(ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave pay by making a special election to that effect before the date such pay would normally be made available to you. However, pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year (except as otherwise permitted by law).

(iii) By other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave).

The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA, and the Employer's internal policies and procedures regarding leaves of absence and will be applied uniformly to all Participants. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Plan Administrator. The Plan Administrator or your Benefits Coordinator will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan and the Benefit Option(s) upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Options providing health coverage may be automatically reinstated provided that coverage for

Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Option offered under this Plan, then you will continue to participate and the contribution due 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 you go on an unpaid leave that affects eligibility under this Plan or a Benefit Option, the election change rules described herein will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

### Q-9. When does my participation in the Cafeteria Plan end?

Your coverage under the Plan ends on the earliest of the following to occur:

(i) The date that you make an election not to participate in accordance with this SPD;
(ii) The date that you no longer satisfy the eligibility requirements of this Plan or all of the Benefit Options;
(iii) The date that you terminate employment with the Employer; or
(iv) The date that the Plan is either terminated or amended to exclude you or the class of employees of which you are a member.

(a) If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will *automatically* cease, and you will not be able to make any more Pre-tax Contributions under the Plan except as otherwise provided pursuant to Employer policy or individual arrangement (e.g., a severance arrangement where the former employee is permitted to continue paying for a Benefit Option out of severance pay on a pre-tax basis). If you are re-hired within the same Plan Year and are eligible for the Plan (or you become eligible again) *more than* 30 days after your employment terminated or you otherwise lost eligibility, you may make new elections if you are re-hired or become eligible again (subject to any limitations imposed by the Benefit Option(s)). If you are re-hired or again become eligible *within* 30 days after your employment terminated or you otherwise lost eligibility, your Plan elections that were in effect when you terminated employment or stopped

being eligible will be reinstated and remain in effect for the remainder of the Plan Year (unless you are allowed to change your election in accordance with the terms of the Plan).

**Q-10. How long will the Cafeteria Plan remain in effect?**

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and for any reason. Plan amendments and terminations will be conducted in accordance with the terms of the Plan Document.

**Q-11. What happens if my claim for benefits or election for a Benefit Option under this Cafeteria Plan (e.g., an election change or other issue germane to Pre-tax Contributions) is denied?**

For any claim for reimbursement of expenses under the Health or Dependent Care FSA, you will have the right to a full and fair review process. You should refer to the Claims Review Procedures in **Part 9** for a detailed summary of the Claims Procedures for the Health FSA or Dependent Care FSA. For review and appeals procedures applicable to any other Benefit Option or relating to a denial of any salary reduction election to make Pre-Tax Contributions to one or more Benefit Options, please contact the Plan Administrator.

**Q-12. How do Run-out Periods, Grace Periods, and Carryovers work under my Benefit Options?**

Run-out Period. A run-out period extends the time a participant has to file claims for expenses incurred during the Plan Year or coverage period for a Benefit Option. The run-out period begins the day after the Plan Year ends or following any grace period (as described below) as determined by your Employer. Any run-out period permitted by your employer may also vary for active employees at the end of a Plan Year or terminated employees to allow them time to file claims after termination. The terms and conditions of any run-out period provided for the Health FSA and Dependent Care FSA are described in the **Plan Information Summary.** For information about a run-out period for any other Benefit Option, contact the Plan Administrator.

Grace Period. If the Employer has adopted a grace period for your Health FSA or Dependent Care FSA, you will be able to use unused amounts allocated to your account at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms and timing (or duration) of the "grace period," if adopted, will be described in the **Plan Information Summary**

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period (if applicable):

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Because run-out claims (explained below) may be submitted after grace period claims, claims may be reordered at the discretion of the Plan Administrator in order to maximize your reimbursement; as a result, grace period claims and/or payments may be reassigned to the current plan year.

  For example, assume that $200 remains in your Health FSA account at the end of the current Plan Year (Plan Year 1), and further assume that you have elected to allocate $2400 to the Health FSA for the following Plan Year (Plan Year 2). If you submit, for reimbursement, an eligible medical expense of $500 that was incurred on January 15, of Plan Year 2, $200 of your claim will be paid out of the unused amounts remaining in your Health FSA from the prior Plan Year 1, and the remaining $300 will be paid out of amounts allocated to your Health FSA for Plan Year 2. Let us further assume that you then submit, for reimbursement, an eligible medical expense of $200 that was incurred on November 10 of Plan Year 1. At the discretion of the Plan Administrator, the amount that had been reimbursed using the $200 from the Plan Year 1 (grace period money) may then be reordered to pay the November 10, Plan Year 1 claim, and the full $500 January 15, Plan Year 2 claim would then be reordered to be reimbursed from Plan Year 2 the money.

- Expenses incurred during a grace period must be submitted before the end of the "run-out period" described in the **Plan Information Summary**. The run-out period applies to claims, incurred both during the previous plan year and the grace period, that are reimbursable from the previous plan year. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the run-out period.

**You may not use Health FSA amounts to reimburse Eligible Dependent Care Expenses, and if the grace period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse Eligible Medical Expenses (defined below in Part 5, Q-11).**

Carryover. A carryover option is available for Health FSAs but not for Dependent Care FSAs. For your Health FSA, in lieu of adopting a grace period, the Employer may instead permit you to carryover from year-to-year up amounts allocated to a Health Care Reimbursement Account that are unused at the end of the Plan Year (*i.e.*, "Plan Year 1") for expenses incurred in the next Plan Year (*i.e.*, "Plan Year 2"). The maximum permitted carryover amount ("Carryover Maximum") is limited by applicable law and may be lower depending on your Employer's Plan terms. The Carryover Maximum, if adopted by your Employer, will be described in the **Plan Information Summary**.

With a carryover, Health Care Reimbursement Account balances that are unused for Plan Year 1 may be used for reimbursement of Eligible Medical Expenses incurred at any time in Plan Year 2

(in addition to the amount that is otherwise available for reimbursement in Plan Year 2 during the run-out period for Plan Year 1 (described below)), subject to the following terms and conditions:

- The specific carryover amount for Plan Year 2 is generally determined at the end of the run-out period following Plan Year 1, taking into account expenses that you incurred during Plan Year 1.

  For example, assume that your permitted Carryover Maximum is $500. If you have an unused Health FSA balance at the end of the current Plan Year 1 equal to $1000, and you have no other expenses that were incurred during Plan Year 1, your carryover amount that may be used in the following Plan Year 2 is $500. However, if you have Plan Year 1 expenses equal to $600 that you timely submit during the run-out period for Plan Year 1, then your carryover amount that may be used in Plan Year 2 will only be $400.

- If you incur an eligible expense during Plan Year 2 but before the end of the run-out period for the prior Plan Year 1, the Plan Administrator may, at its discretion, apply any portion of your unused carryover amount from Plan Year 1 towards the Plan Year 2 expense. NOTE: This will reduce the amount that is available to reimburse expenses incurred during Plan Year 1 that you may subsequently submit during the run-out period for Plan Year 1, and it will reduce the permitted Carryover Maximum for Plan Year 1 by the same amount.

  For example, assume that your permitted Carryover Maximum is $500 and that the run-out period for Plan Year 1 ends on March 31 of Plan Year 2. Also assume you have $800 at the end of Plan Year 1 and you have elected $2500 for the following Plan Year 2. On February 1 of Plan Year 2, you incur a $2700 eligible medical expense. The entire $2,700 expense will be reimbursed with the $2,500 elected for Plan Year 2 and $200 of the $800 unused at the end of Plan Year 1. However, only $600 will be available for Plan Year 1 expenses submitted during the run-out period for Plan Year 1, and your Plan Year 1 Carryover Maximum is reduced to $300 (the $500 maximum minus the $200 already applied to the expense incurred on February 1 of Plan Year 2). Further assume that after reimbursement of the $2,700 expense that was incurred on February 1 of Plan Year 2, but before the end of the run-out period for Plan Year 1, you submit a $750 expense that was incurred on November 15 of Plan Year 1. Only $600 of that Plan Year 1 expense will be reimbursed (the $800 unused at the end of Plan Year 1 minus the $200 applied to the expense incurred on February 1 of Plan Year 2) and you will have no carryover amount for use in Plan Year because $200 of the $500 Maximum Carryover was applied to the Plan Year 2 expense and all of the remaining $600 unused at the end of Plan Year 1 was applied to the Plan Year 1 expense 2.

- The carryover amount for any Plan Year does not count against the maximum salary reduction election permitted for the next Plan Year.

- If you are otherwise eligible for the Health FSA for a Plan Year but you do not make an election to participate, your Employer may still allow you to use any carryover from the prior Plan Year for expenses incurred during the prior Plan Year or in the current Plan Year (in accordance with terms of the Plan and the ordering rules described

above). Please refer to the **Plan Information Summary** to determine your Plan's specific carryover terms.

- Under IRS rules, if you have unused Health FSA amounts on the last day of a Plan Year in a general purpose Health FSA (i.e., anything other than a $0 balance), you (and your spouse, if you are married) cannot contribute to an health savings account (or HSA), as defined in Code Section 223, during the following Plan Year. For this purpose, whether you have unused Health FSA amounts is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not the claims have been submitted). However, your Carryover will not prevent eligibility for the HSA in the following Plan Year if the Plan Administrator (1) allows you to waive any Carryover eligibility before the last day of the Plan Year, or (2) requires or allows you to convert the Carryover to limited-purpose Health FSA coverage. For more information about limited-purpose Health FSA coverage, including the type of expenses covered, refer to **Part 5, Q-11**. For more information about health savings accounts, refer to **Part 7**. To find out whether your Plan includes an HSA and/or limited-purpose Health FSA coverage, please refer to the **Plan Information Summary**.

  For example, assume that your Employer offers an HSA Benefit Option and limited-purpose Health FSA coverage, and that you elect HSA compatible medical coverage for the next plan year. Also assume that the Plan requires a Carryover to be converted the limited-purpose Health FSA coverage if you elect HSA compatible medical coverage. Also assume the Health Care FSA allows you to carry over up to $500. At the end of Plan Year 1, you have $600 unused in your general purpose Health FSA. For Plan Year 2, you elected HSA compatible medical coverage and decided to contribute $2,500 to the limited-purpose Health FSA. On January 15 of Plan Year 2, you incur a dental claim for $2,700 (which can be paid by the limited-purpose Health FSA coverage) and the plan pays you $2,500, which is your total election for the limited-purpose Health FSA coverage for Plan Year 2. On February 1 of Plan Year 2, you submit and are reimbursed for $300 in general medical expenses that you incurred on December 26 of Plan Year 1, which reduces the unused amount in your Plan Year 1 general purpose Health FSA from $600 to $300. As a result, $300 from your Plan Year 1 general purpose Health FSA is unused and will be carried over to your Plan Year 2 limited-purpose Health FSA at the end of the run-out period for Plan Year 1. This carryover is then used to reimburse you for the $200 left over from your dental claim incurred on January 15 of Plan Year 2, leaving $100 that you can use for limited-purpose Health FSA expenses in Plan Year 2 or to carryover to the next year.

- You must be a participant in the Health FSA as of the last day of the Plan Year to benefit from the Carryover. Termination of employment and cessation of eligibility will generally result in a loss of Carryover eligibility unless a COBRA election is made.

### Q-13. How are administrative fees paid for under the Plan?

Administrative fees for the Cafeteria Plan, Health FSA, and Dependent Care FSA are paid for by your Employer unless otherwise indicated in the **Plan Information Summary**. For information

about administrative or other fees that may apply to any of the other Benefit Options that may funded with contributions through the Cafeteria Plan, contact the Plan Administrator.

## PART 3. CASH BENEFITS

During any one Plan Year, the maximum salary reduction amount a Participant can elect under this Plan cannot exceed the sum of the cost of the Benefit Options offered under this Plan. Any part of this maximum salary reduction amount that you do not elect will be paid to you as regular, taxable compensation. Except to the extent set forth in the enrollment material, any Flex Credits not used towards the cost of Benefit Options made available under the Plan will revert back to the employer.

## PART 4. HEALTH CARE PREMIUM REIMBURSEMENT BENEFITS

If listed as a Benefit Option offered under the Plan in the **Plan Information Summary**, you can elect to allocate pre-tax salary reduction amounts for health care premium reimbursements.

### Q-1. Who can elect Health Care Premium Reimbursement ("HCPR")?

If you are eligible to be a participant in the Cafeteria Plan, you can elect to make pre-tax salary reductions to pay the premiums for certain employer approved individual insurance policies. If you this election, amounts equal to Health Care Premium Expenses (described in **Q-2** below) that you incur or pay will be withheld from your pay and you will be reimbursed (either directly or indirectly) for such expenses with these amounts.

### Q-2. What are Health Care Premium Expenses?

Health Care Premium Expenses are the premiums that you pay for an individual insurance policy(ies) that you purchase outside of any employer-sponsored plan. Such expenses must meet the following conditions: (a) the individual insurance policy must be determined by the Plan Administrator to be a "Qualified Benefit" before the beginning of the Plan Year or, if you are a new hire, before the effective date of your participation in the Plan. For purposes of the HCPR, a Qualified Benefit is an individual insurance policy that provides accident and health insurance described in Code Section 106 (individual major medical policies, including but not limited to individual policies obtained through the Health Insurance Marketplace or "Marketplace Exchange," do not qualify), (b) the contract must be an individually purchased contract and not an employer-sponsored insurance plan; and (c) you must be the policyholder of the insurance policy. Please note that Health Care Premium Expenses do not include premiums paid to obtain individual major medical policies, including but not limited to individual policies obtained through the Health Insurance Marketplace or "Exchange," which under IRS guidance cannot be paid on a pre-tax basis through this Plan.

### Q-3. How do I become a Participant?

During the applicable Election Periods described in **Part 2**, **Q-6** you must submit a Salary Reduction Election wherein you elect the amount you want withheld for reimbursement of Health Care Premium Expenses. In addition, you must (a) provide the Plan Administrator with a copy of the individual accident or health insurance policy that you have purchased for yourself outside of

any employer plan and (b) indicate on the Salary Reduction Election the premium amount that you will expect to pay during the Plan Year for such policy. The Plan Administrator will notify you if the insurance policy is determined to be a "Qualified Benefit" under the Plan. The effective date of coverage may vary by Election Period.

If you elect the HCPR, a record will be kept of all salary reductions made for reimbursement of Health Care Premium Expenses as well as all actual reimbursements.

### Q-4. What happens if I fail to return my Salary Reduction Agreement?

If you fail to return a Salary Reduction Election electing HCPR (whether you are currently participating or not) before the end of the applicable Election Period, it will be assumed that you have elected to forgo HCPR as a Benefit Option. See **Part 2**, **Q-6** above for further discussion regarding elections.

### Q-5. How do I receive Reimbursement under a HCPR?

If you elect to participate in the HCPR, you will have to take certain steps to be reimbursed for your Eligible Health Care Premium Expenses. You will be supplied with the necessary claim forms. In addition to the claim form, you must submit to the Plan Administrator a statement from the insurance carrier indicating that you have paid the Health Care Premium Expenses for which you are requesting reimbursement unless the Employer is paying the carrier directly. In that case, you must submit a statement or invoice from the carrier indicating the amount of the premium and the period of coverage. If the Employer is paying the carrier directly, the insurance carrier will be paid the premium (up to the amount of pre-tax contributions you have set aside for that period) in the next check processing cycle. The Plan Administrator will advise you how often the checks are processed. The Employer, the Plan, the Plan Administrator, and the Plan Service Provider are not responsible for any coverage that you lose for failure to pay a premium if your salary reduction election for Health Care Premium Expenses is insufficient to cover the premium amount.

The salary reduction amount for such benefits cannot exceed the amount of premiums you are required to pay for such coverage. The amount of your reimbursement cannot exceed the amount of your salary reductions made at that time for Eligible Health Premium Expenses, reduced by prior reimbursements. If your salary reduction amount to date is equal to or less than your claim, your claim for eligible expenses will be reimbursed in full. If the amount that you have salary reduced is less than your claim amount, the excess part of the claim will be carried over into the following pay cycles during the year (or as otherwise permitted by applicable law) to be paid up to your balance. In other words, as additional salary reduction amounts are made, a reimbursement check will be processed automatically for any unpaid portions of any previously submitted claims (to the extent such claims are eligible for reimbursement). Remember, no expenses can be reimbursed that exceed the salary reductions you have made up to that date reduced by any previous reimbursements. You cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Eligibility Date, or after the end of the Plan Year (or as otherwise permitted by applicable law).

At the end of the Plan Year, you will have a Run-Out period (as specified in the **Plan Information Summary** to turn in claims for premiums incurred during the Plan Year. No claims can be submitted for reimbursement after that time. Your Employer may set a different claims submission

Run-Out Period for terminated employees; if so, you will find this information in the **Plan Information Summary**.

### Q-6. Can I change the election during the year?

You can change elections during the year only if you experience one of the Change in Status Events listed in **Part 2**, **Q-6** and follow the procedures outlined within that section.

### Q-7. What happens if my salary is reduced more than my actual Health Care Premium Expenses at the end of the Plan Year?

The cafeteria plan rules prohibit the return of any salary reductions that are not used for Health Care Premium Expenses incurred during the Plan Year (or as otherwise permitted under the applicable law).

The Employer will use the forfeitures to offset administration expenses. Also, any uncashed reimbursement checks will be forfeited if not cashed within 180 days of issue.

## PART 5. HEALTH FSA SUMMARY

### Q-1. Who can participate in the Health FSA?

Each Employee who satisfies the Employer's eligibility requirements and who is eligible to participate in the Employer's major medical plan is eligible to participate in the Health FSA on your Eligibility Date. The Employer's eligibility requirements for the Health FSA are described in the **Plan Information Summary**.

### Q-2. How do I become a Participant?

If you have otherwise satisfied your Employer's eligibility requirements, you become a participant in the Health FSA by making an election on your Salary Reduction Election during the Initial or Annual Election Periods described in **Part 2, Q-5**. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Health FSA elections.

You may also become a participant if you experience a Change in Status Event that permits you to enroll mid-year (see **Part 2, Q-7** for more details regarding mid-year election changes and the effective date of those changes).

Once you become a Participant, your Dependents (as defined in the Health FSA Plan) also become covered. For purposes of the Health FSA, Dependents will generally include the following:

(i) Your legal Spouse (as determined in accordance with federal law);

(ii) Your child, until the end of the year in which your child turns age 26; and

(iii) any other individuals who would qualify as a tax Dependent under Code Section 105(b).

For purposes of (ii) above, your "child" means your son, daughter, stepchild, foster child, legally adopted child, or child placed with you for legal adoption, regardless of such child's tax dependent status, marital status, employment status, student status or residency. If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage to the person or persons ("alternate recipients") named in the order to the extent the QMCSO requires coverage the that Health FSA does not otherwise provide. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree, or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health FSA, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

Spousal Exclusion Election (for HSA coordination): Your participation in this Health FSA could disqualify your spouse from making/receiving tax favored contributions to a health savings account (or HSA) as defined in Code Section 223 unless you have elected limited-purpose Health FSA coverage described below in **Q-11**. However, as an alternative, if your spouse wants to make contributions to an HSA during any Plan Year, your Employer may allow you make an election during the Initial Election and/or the Annual Election Period to exclude your spouse from coverage under the Health FSA for that Plan Year and cover only the participant and the participant's eligible dependents (but only to the extent this is identified as an option in the **Plan Information Summary**).

### Q-3. What is my "Health Care Reimbursement Account"?

If you elect to participate in the Health FSA, the Employer will establish a "Health Care Reimbursement Account" to keep a record of the reimbursements to which you are entitled, as well as the Pre-tax Contributions you elected to pay for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Health FSA are paid as needed from the Employer's general assets except as otherwise set forth in the **Plan Information Summary**.

### Q-4. When does coverage under the Health FSA end?

Your coverage under the Health FSA ends on the earlier of the following to occur:

(i) The date that you elect not to participate in accordance with this SPD and the Plan Document;

(ii) The last day of the Plan Year unless you make an election during the Annual Election Period or an Election Change Period;

(iii) The date that you no longer satisfy the Health FSA eligibility requirements;

(iv) The date that you terminate employment; or

(v) The date that the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan.

You may be entitled to elect Continuation Coverage (as described in **Q-17** below) under the Health FSA once your coverage ends because you terminate employment or experience a reduction in hours of employment.

Coverage for your eligible Dependents ends on the earliest of the following to occur:

(i) The date your coverage ends;

(ii) The date that your Dependents cease to be eligible dependents (e.g. you and your spouse divorce);

(iii) The date the Plan is terminated or amended to exclude the individual or the class of Dependents of which the individual is a member from coverage under the Health FSA.

You and/or your covered Dependents may be entitled to continue coverage if coverage is lost for certain reasons. The continuation of coverage provisions are described in more detail below.

### Q-5. Can I ever change my Health FSA election?

You can change your election under the Health FSA in the following situations:

(i) *For any reason during the Annual Election Period*. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(ii) *Following a Change In Status Event*. You may change your Health FSA election during the Plan Year only if you experience an applicable Change in Status Event that entitles you to make a change. See **Part 2, Q-6** or contact your Benefits Coordinator for more information on election changes and whether you are eligible to make changes as a result of a Change in Status Event. **NOTE: You may not make Health FSA election changes as a result of any cost or coverage changes**.

### Q-6. What happens to my Health Care Reimbursement Account if I take an approved leave of absence?

Refer to **Part 2, Q-8** to determine what, if any, specific changes you can make during a leave of absence. If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at either (a) the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or (b) at the same coverage level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under the Health FSA.

### Q-7. What is the maximum annual Health Care Reimbursement that I may elect under the Health FSA, and how much will it cost?

You may elect any annual reimbursement amount subject to the minimum and maximum salary reduction contribution amounts described in the **Plan Information Summary**. The maximum salary reduction contribution that can be made to the Health Care Reimbursement Account for any Plan Year shall be the IRS maximum or such lesser amount as is communicated in the **Plan Information Summary** or enrollment materials. You will be required to pay the annual contribution equal to the coverage level you have chosen reduced by any Employer Contributions and/or Flex Credits allocated to your Health Care Reimbursement Account.

Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

### Q-8. How are Health Care Reimbursement benefits paid for under this Plan?

When you complete the Salary Reduction Election, you specify the amount you want to allocate to your Health FSA using Pre-tax Contributions and/or Flex Credits, to the extent available. Your enrollment material will indicate if Flex Credits are available for Health FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Flex Credits allocated to your Health Care Reimbursement Account.

**Note: Notwithstanding that you may make Pre-tax Contributions to your Health FSA, your claims for Health Care Reimbursements are paid for with general assets of the Employer and are not held by the Employer, the Plan Service Provider, or any other party in trust or otherwise on behalf or for the benefit of the Plan or Plan Participants. Paper and electronic payments may be facilitated through a Plan Service Provider engaged by your Employer.**

If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you; (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the participant); (iii) if you use your OneBridge Benefits Card, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's right of reimbursement for purchases that are unsubstantiated or are for unqualified expenses).

### Q-9. What amounts will be available for Health Care Reimbursement at any particular time during the Plan Year?

So long as coverage is effective, the full, annual amount of Health Care Reimbursement you have elected, reduced by the amount of previous Health Care Reimbursements received during the Year, will be available at any time during the Plan Year, without regard to how much you have contributed.

### Q-10. How do I receive reimbursement under the Health FSA?

Under this Health FSA, you have two reimbursement options. You can complete and submit a claim for reimbursement (see "Traditional Claims" below for more information). Alternatively, if applicable you can use your OneBridge Benefits Card to pay the expense. The following is a summary of how both options work.

Traditional Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's Plan Service Provider by completing and submitting a request for reimbursement either online through the electronic web portal or on a paper form, in each case a provided by the Plan Service Provider. You must include with your request for reimbursement a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

1. Name of person receiving service
2. Name and address of service provider
3. Nature of service or supplies (drug name if a prescription or prescribed over-the-counter medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service

The Plan Service Provider will process the claim once it receives the request for reimbursement from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined not to be an Eligible Medical Expense you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the run-out period following the end of the Plan Year (or if applicable, the following the date that you cease to be a participant). Information about the "run-out period" and the "grace period" (if applicable) is described in the **Plan Information Summary**.

Depending on your plan design, you may be allowed to submit a claim by means of a provider supplied electronic claim file ("Import"). In other words, the claim is provided directly to the Plan Service Provider by the provider or health plan. In that case, you do not need to file a claim with the Plan Service Provider; it is deemed filed when the Plan Service Provider receives the claim. You will be notified in the enrollment material of this Plan or the applicable Benefit Option if this option is available. If you elect this option when made available to you, you must hereby agree not to seek reimbursement for an imported claim from any other source, such as other insurance, a health reimbursement arrangement, or another medical expense reimbursement plan.

OneBridge Benefits Card. Alternatively, you may use the OneBridge Benefits Card to pay the expense. In order to be eligible for the OneBridge Benefits Card, you must agree to abide by the terms and conditions of the OneBridge Benefits Card Program (the "Program") as set forth in **Part 8** of this SPD and in the OneBridge Benefits Card Cardholder Agreement (the "Cardholder Agreement") including any limitations as to card usage and the Plan's right of reimbursement or offset for unqualified or unsubstantiated transactions, etc.

### Q-11. What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible Dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d);
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. All over-the-counter drugs and medications purchased after December 31, 2019 may be reimbursed without a prescription. Over-the-counter products and devices other than drugs or medicine (including feminine hygiene products, medical masks, bandages, etc.) will still constitute an Eligible Medical Expense even if not prescribed by a physician. Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Service Provider/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. "Stockpiling" of over-the-counter drugs (even with a prescription) and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator).

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long-term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the **Plan Information Summary**.

*If you currently maintain or wish to establish a personal Health Savings Account, you may be able to make an election to limit the scope of your coverage as set forth below.*

Limited-purpose Health FSA Coverage (for HSA coordination). According to rules set forth in Code Section 223 (applicable to a Health Savings Account or HSA), your participation in this Health FSA may disqualify you (and any covered Dependents) from being able to make/receive tax favored contributions to an HSA unless you elect the Spousal Exclusion (described above in **Q-2)** or you limit the scope of expenses eligible for reimbursement under the Health FSA is limited

to the following expenses (to the extent such expenses constitute "medical care" as defined in Code Section 213(d)):

(i) Services or treatments for dental care (excluding premiums)

(ii) Services or treatments for vision care (excluding premiums)

(iii) Services or treatments for "preventive care" Preventive care is defined in accordance with applicable rules and regulations. This may include any prescribed drugs to the extent such drugs are taken by an eligible individual (a) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic), (b) to prevent the recurrence of a condition from which the eligible individual has recovered, or (c) as part of a preventive care treatment program (e.g., a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.

In order to preserve your eligibility to make contributions to an HSA, you may elect limited-purpose Health FSA coverage during Initial and/or Annual Election Period. Contact the Plan Service Provider to make this election.

**Note: If your Employer has included an HSA Benefit Option, you may be required to convert your Health FSA to limited-purpose coverage if you elect HSA compatible medical coverage and elect to make contributions to an HSA.**

**Newborns' and Mothers' Health Protection Act of 1996**: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Reimbursement for expenses relating to hospital stays in connection with childbirth for the mother or newborn child are not limited by length of stay but are subject to the amount available for reimbursement in your Health Care Reimbursement Account and other Plan requirements, such as when expenses must be incurred to be eligible for reimbursement (see **Q-12** below).

### Q-12. When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred ***during*** the Plan Year and while you are a participant in the Plan. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses incurred before the Health FSA becomes effective, before your

Eligibility Date, or after the Plan Year and any grace period (or that are not permitted to be carried over), or after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period). Refer to the **Plan Information Summary** for information about any grace period, carryover, or run-out period that may apply. Refer to **Part 1**, **Q-12** for more information about how grace periods, carryovers, and run-out periods work. Information about COBRA continuation rights is described below in **Q-17.**

### Q-13. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have elected for Health Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that exceeds the annual coverage level you have elected. Any amount allocated to a Health Care Reimbursement Account that not used for expenses incurred during the Plan Year and during the grace period, or that are not permitted to be carried over, will be forfeited. The sole exception to this rule is the "Qualified Reservist Distribution," described in **Q-14**. Refer to the **Plan Information Summary** for information about any grace period, carryover, or run-out period that may apply. Refer to **Part 1**, **Q-12** for more information about how grace periods, carryovers, and run-out periods work. Amounts forfeited by participants will be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's sole discretion).

### Q-14. What is a "Qualified Reservist Distribution"?

If the Employer has adopted a Qualified Reservist Distribution, you may be able to receive a taxable distribution of amounts allocated to the Health FSA that are unused in the event you are called to active duty if you meet the following criteria:

- You are a member of a "reserve component" (as defined in section 101 of title 37 of the United States Code), which means a member of the Army National Guard; the Reserve for the U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard; Air National Guard of the United States; or the Reserve Corps of the Public Health Service;

- You are called or ordered to active military duty for (i) 180 days or more or (ii) for an indefinite period;

- You provide a copy of your order or call to active duty; and

- You are a Participant in the Health FSA on the date you are called or ordered to duty.

If Employer has adopted the Qualified Reservist Distribution and you believe you are eligible for a Qualified Reservist Distribution, you must contact the Plan Administrator to request a distribution request form as soon as possible. A request for a Qualified Reservist Distribution must be made in writing on the form provided by the Plan Administrator. You must submit a copy of your order or call to active duty along with your request. Requests for a Qualified Reservist Distribution must be made on or after the date of the order or call to duty but before the last day of the Plan Year (or grace period, if applicable) during which the order or call to duty occurred. You will receive your Qualified Reservist Distribution within a reasonable period of time, but no later than sixty (60) days after your request has been received.

A Qualified Reservist Distribution will be made based on all salary reduction amounts credited to your Health FSA for the applicable Plan Year that have not been applied to provide Health Care Reimbursements submitted before the Qualified Reservist Distribution request is submitted. Notwithstanding anything to the contrary, if you elect to receive a Qualified Reservist Distribution, you may continue to submit reimbursement requests for eligible expenses incurred after the Qualified Reservist Distribution but before the end of the Plan Year, provided that the aggregate amount of claims reimbursed cannot exceed the difference between the Qualified Reservist Distribution and the annual salary reduction election.

Claims incurred and submitted but not yet reimbursed at the time the Qualified Reservist Distribution Request is received will be treated like any other claim submitted for reimbursement under the Health FSA.

The Plan Administrator will determine what this amount is on a uniform basis, consistent with applicable law and IRS interpretations. Notwithstanding any other provision of this Plan, an individual who has selected a Qualified Reservist Distribution shall be considered to have made such election as an alternative to COBRA or USERRA continuation coverage for the Health FSA (except as may otherwise be required by applicable law).

Unlike your reimbursements from your Health FSA for Eligible Medical Expenses, the amount of your Qualified Reservist Distribution is taxed as income and will be reported as income on your W-2.

Qualified Reservist Distributions may not be made from amounts allocated to your Dependent Care FSA.

Refer to the **Plan Information Summary** to confirm whether your Employer has adopted the Qualified Reservist Distribution.

### Q-15. What happens if a Claim for Benefits under the Health FSA is denied?

You will have the right to a full and fair review process. You should refer to the Claims Review Procedures in **Part 9**, for a detailed summary of the Claims Procedures under this Plan.

### Q-16. What happens to unclaimed Health Care Reimbursements?

Any Health Care Reimbursement benefit payments that are unclaimed (e.g., uncashed benefit checks) within 180 days after reimbursement is made shall be forfeited.

### Q-17. What is COBRA and USERRA continuation coverage?

**COBRA**

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to this Health FSA unless the Employer sponsoring the Health FSA is not subject to these rules (e.g., the employer is a "small employer" or the Health FSA is a church Plan). The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). These

rules are intended to summarize the continuation rights set forth under federal law. If federal law changes, only the rights provided under applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued under COBRA. Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A "Qualified Beneficiary" is the Participant, covered Spouse, and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

| | Covered Employee | Covered Spouse | Covered Dependent |
|---|---|---|---|
| 1. Covered Employee's Termination of employment or reduction in hours of employment | √ | √ | √ |
| 2. Divorce or Legal Separation | | √ | |
| 3. Child ceasing to be an eligible dependent | | | √ |
| 4. Death of the covered employee | | √ | √ |

**NOTE:** Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage. If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health FSA upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements You or your covered Dependents (including your Spouse) must notify the COBRA Administrator (if a COBRA Administrator is not identified in the **Plan Information Summary**, then contact the Plan Administrator) in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) the date of the event (ii) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has

occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g. divorce decree).

An employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines. Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the election form(s) and return it to the COBRA Administrator identified in the **Plan Information Summary** within 60 days from the date you would lose coverage for one of the reasons described above, or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost. You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends. The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs, as may be extended by any grace period, carryover, or run-out period indicated in the **Plan Information Summary**. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-Elective contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);
- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;
- if you become entitled to Medicare; or
- if the employer no longer provides group health coverage to any of its employees.

**USERRA**

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the **Uniformed Services Employment** and **Reemployment Rights Act** (**USERRA**). Accordingly, if you are absent from work due to a period of active duty in the military, you may continue to maintain your coverage under the plan as provided for other leaves of absences described above in **Part 2**, **Q-8**. You may also be eligible to revoke or make a new election as a result of your leave of absence for active military duty, as described above in **Part 2**, **Q-6.**

If you do not elect to continue to participate in the Plan during an absence for military duty, or if you revoke or change a prior election, you and your covered family members will have the opportunity to elect COBRA continuation coverage as described above.

### Q-18. What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year as set forth in this SPD, or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the excess reimbursements may be recouped in one or more of the following ways during the Plan Year that you receive an excess repayment: (i) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer; (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement; or (iii) your Employer may withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement by the means set forth in (i) – (iii), or if for any reason the steps in (i)-(iii) are not applied during the Plan Year that the excess reimbursement was made, the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

### Q-19. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. The HIPAA Privacy Notice that applies to the Health FSA is located in **Part 11** of this SPD. You may also receive one or more separate notices that outlines the health privacy policies of your Employer or other group health plans offered by your Employer or paid for through this Cafeteria Plan.

### Q-20. How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

### Q-21. How does this Health FSA interact with a Health Reimbursement Arrangement (HRA) Sponsored by the Employer? (Only if Applicable)

Typically, a Health FSA is the payer of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in an HRA sponsored by the Employer that covers expenses also covered by this Health FSA, the terms of your HRA plan may require that you use all of the funds allocated to your Health FSA before you seek reimbursement for expenses under your HRA. Check the terms of your HRA plan document or contact the Plan Administrator or Benefits Coordinator if you want to use your HRA funds before depleting amount in your Health Care Reimbursement Account under the Health FSA.

## MISCELLANEOUS RIGHTS UNDER THE HEALTH FSA

### ERISA Rights (not applicable to non-ERISA Plans)

The Health FSA Plan may be an ERISA welfare benefit plan if your employer is a private employer. The **Plan Information Summary** will indicate whether your Health FSA is subject to ERISA. If this is an ERISA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants shall be entitled to:

*Receive Information About Your Plan and Benefits*

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

*Continue Group Health Plan Coverage*

You may continue health care coverage for yourself, Spouse, or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Dependents will have to pay for such coverage. You should review **Part 5, Q-17** for more information concerning your COBRA continuation coverage rights.

*Prudent Actions by Plan Fiduciaries*

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan,

called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

*Enforce Your Rights*

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and have the claim reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

*Assistance with Your Questions*

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## PART 6. DEPENDENT CARE FSA COMPONENT SUMMARY

### Q-1. Who can participate in the Plan?

Each employee who satisfies the Employer's eligibility requirements is eligible to participate in the Dependent Care FSA on his or her Eligibility Date.

### Q-2. How do I become a Participant?

If you have otherwise satisfied the Employer's eligibility requirements, you become a participant in the Dependent Care FSA by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods described in **Part 2**, **Q-5**. If you have made an election to participate and you want to participate during the next Plan Year, you must make an election during the

Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Dependent Care FSA elections.

You may also become a participant if you experience a Change in Status Event that permits you to enroll mid-year (see **Part 2, Q-6** for more details regarding mid-year election changes and the applicable Election Change Periods).

### Q-3. What is my "Dependent Care Reimbursement Account"?

If you elect to participate in the Dependent Care FSA, the Employer will establish a "Dependent Care Reimbursement Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care FSA are paid as needed from the Employer's general assets except as otherwise set forth in the **Plan Information Summary**.

### Q-4. When does my coverage under the Dependent Care FSA end?

Your coverage under the Dependent Care FSA ends on the earlier of the following to occur:

(i) The date that you elect not to participate in the Dependent Care FSA or the Cafeteria Plan;

(ii) The last day of the Plan Year unless you make an election during the Annual Election Period;

(iii) The date that you no longer satisfy the Dependent Care FSA eligibility requirements;

(iv) The date that you terminate employment; or

(v) The date that the Plan is terminated or you, or the class of eligible employees of which you are a member, are specifically excluded from the Plan.

Spend-down. If you terminate employment or you cease to be eligible during the Plan Year, you may be allowed to submit for reimbursement Eligible Dependent Care Expenses incurred after the date of separation up to the available amount of your Dependent Care Reimbursement Account. Refer to the **Plan Information Summary** to find out if your Employer permits a Spend-down of your Dependent Care Reimbursement Account following termination of employment or eligibility.

### Q-5. Can I ever change my Dependent Care FSA election?

You can change your election under the Dependent Care FSA in the following situations:

(i) *For any reason during the Annual Election Period*. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the Plan Year following the end of the Annual Election Period.

(ii) *Following a Change In Status Event*. You may change your Dependent Care FSA election during the Plan Year only if you experience an applicable Change in Status

Event. See **Part 2, Q-6** or contact your Benefits Coordinator for more information on election changes and whether you are eligible to make changes as a result of a Change in Status Event.

### Q-6. What happens to my Dependent Care Reimbursement Account if I take an unpaid leave of absence?

Refer to **Q-9**, **Part 2** to determine what, if any, specific changes you can make during a leave of absence.

### Q-7. What is the maximum annual Dependent Care Reimbursement that I may elect under the Dependent Care FSA?

The maximum annual Dependent Care Reimbursement that you may elect will be set forth in the **Plan Information Summary** and in your enrollment materials. The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code and may be limited according to whether you are:

- are married and file a joint return;
- are married but your Spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or
- are single.

In addition, the amount of reimbursement that you receive on a tax free basis during the Plan Year cannot exceed the lesser of your earned income (as defined in Code Section 32) or your spouse's earned income.

Depending on the number of Qualified Individuals you have, your Spouse will be deemed by applicable tax rules to have a minimum level of earned income, for each month in which your Spouse is:

(i) physically or mentally incapable of caring for himself or herself, or
(ii) a full-time student (as defined by Code Section 21).

### Q-8. How Do I Pay for Dependent Care Reimbursements?

When you complete the Salary Reduction Election, you specify the amount of Dependent Care Reimbursement you wish to pay for with Pre-tax Contributions and/or Flex Credits, to the extent available. Your enrollment material will indicate if Contributions or Flex Credits are available for Dependent Care FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Flex Credits allocated to your Dependent Care Reimbursement Account.

**Your benefits are paid for with general assets of the Employer and are not held by the Employer, the Plan Service Provider, or any other party in trust or for the benefit of the Plan**

**or Plan Participants. Paper or electronic payments may be facilitated through a Plan Service Provider engaged by the Employer.**

If your claim for benefits is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways: (i) a check made payable to you; (ii) electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the participant); (iii) if the OneBridge Benefits Card (see **Part 8**) is used, payment may be made directly to a valid child care services or elementary and secondary school provider at the point of purchase (subject to the Plan's right of reimbursement for unqualified or unsubstantiated transactions).

### Q-9. What is an "Eligible Dependent Care Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses ("Eligible Dependent Care Expenses"). Generally, an expense must meet all of the following conditions for it to be an Eligible Dependent Care Expense:

1. The expense is incurred (expenses are considered incurred only if the service has already occurred) for services rendered after your Eligibility Date and during the Plan Year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual". A Qualifying Individual is:

   (i) An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support; or

   (ii) a Spouse or other tax Dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

   Note: there is a special rule for children of divorced parents. The child is a qualifying individual of the "custodial parent", as defined in Code Section 152(e).

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your Spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your Spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your Spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care.

Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expense is not paid or payable to a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 by the end of the year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent. Moreover, the day care cannot be provided by a parent of the Qualifying Individual.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Dependent Care Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address, and taxpayer identification number of the dependent care service provider on your federal income tax return.

### Q-10. How do I receive reimbursement under the Dependent Care FSA?

Under this Dependent Care FSA, you have two reimbursement options. You can complete and submit a claim for reimbursement ("traditional claim") or, alternatively, you can use the OneBridge Benefits Card (see **Part 8**) to pay the expense. The following is a summary of how both options work.

Traditional Claims: If you have elected to participate in the Dependent Care FSA, you must take certain steps to be reimbursed for your Eligible Dependent Care Expenses. When you incur an Eligible Dependent Care Expense, you file a claim with the Plan Service Provider by completing and submitting a request for reimbursement either online through the electronic web portal or on a paper form, in each case as provided by the Plan Service Provider. If there are enough credits to your Dependent Care Reimbursement Account, you will be reimbursed for your Eligible Dependent Care Expenses on the next scheduled processing date.

Depending on how the Plan Service Provider administers Dependent Care Reimbursements, if any claim you submit is for an amount that exceeds your current Dependent Care Reimbursement Account balance, you may have to re-submit your claim again when your available balance becomes adequate or the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, you cannot be reimbursed for any total expenses above your available Dependent Care Reimbursement Account balance. You

may not be reimbursed for any expenses that arise before your Eligibility Date or for any expense incurred after the close of the Plan Year.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Dependent Care Expenses -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

Benefits Card. Alternatively, you may use the OneBridge Benefits Card to pay the expense. In order to be eligible for the OneBridge Benefits Card, you must agree to abide by the terms and conditions of the OneBridge Benefits Card Program (the "Program") as set forth in **Part 8** and in the OneBridge Benefits Card Cardholder Agreement (the "Cardholder Agreement") including limitations as to card usage and the Plan's right of reimbursement or offset for unqualified or unsubstantiated transactions, etc.

### Q-11. When must the expenses be incurred in order to receive reimbursement?

Eligible Dependent Care Expenses must be incurred ***during*** the Plan Year. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Eligibility Date, or for any expenses incurred after the close of the Plan Year or (unless your Plan includes a Spend-down as described above in **Q-4**), after your participation in the Dependent Care FSA ends.

If the Employer has adopted a grace period, you may also be able to use amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The terms of the "grace period", if adopted, will be described in the **Plan Information Summary**.

### Q-12. What if the Eligible Dependent Care Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Reimbursement?

Any amount allocated to a Dependent Care Reimbursement Account that not used for expenses incurred during the Plan Year and during any applicable grace period, will be forfeited. Refer to the **Plan Information Summary** for information about any grace period or run-out period that may apply. Refer to **Part 1**, **Q-12** for more information about how grace periods and run-out periods work. Amounts forfeited by participants will be returned to the Employer, used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's sole discretion).

### Q-13. Will I be taxed on the Dependent Care Reimbursement benefits I receive?

You will not be taxed on your Dependent Care Reimbursements so long as your family's aggregate reimbursement for Eligible Dependent Care Expenses (under this Dependent Care FSA and/or another employer's dependent care FSA) does not exceed the maximum annual reimbursement limits described above in **Q-7**.

**Q-14. If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?**

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Dependent Care Expenses may be eligible for the dependent care credit.

**Q-15. What is the household and dependent care credit?**

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Dependent Care Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Dependent Care Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.

**Illustration:** Assume you have one Qualifying Individual for whom you have incurred Eligible Dependent Care Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. On the other hand, if you have two or more Qualifying Individuals and incur the same $3,600 in expenses (or any amount less than $6,000), your credit would have been $3,600 X 32% = $1,152, because the entire expense amount is less than the $6,000 allowed for two or more Qualifying Individuals, and therefore all $3,600 would have been taken into account, not just the first $3,000.

**Q-16. What happens to unclaimed Dependent Care Reimbursements?**

Any Dependent Care Reimbursements that are unclaimed (e.g., uncashed benefit checks) within 180 days after reimbursement is made shall be forfeited. You can prevent this from happening by electing direct deposit for reimbursements or by using your OneBridge Benefits Card to pay for Eligible Dependent Care Expenses.

**Q-17. What happens if my claim for reimbursement under the Dependent Care FSA is denied?**

You will have the right to a full and fair review process. You should refer to **Part 9** for a detailed summary of the Claims Procedures under this Plan

**Q-18. What happens if I receive erroneous or excess reimbursements?**

If, as of the end of any Plan Year, it is determined that you have received payments under this Dependent Care FSA that exceed the amount of Eligible Dependent Care Expenses that have been

properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the excess reimbursements may be recouped in one or more of the following ways during the Plan Year that you receive an excess payment: (i) The Plan Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer; (ii) The Plan Administrator may offset the excess reimbursement against any other Eligible Dependent Care Expenses submitted for reimbursement; or (you're your Employer may withhold such amounts from your pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursements by the means set forth in (i) – (iii), or if for any reason the steps in (i)-(iii) are not applied during the Plan Year that the excess reimbursement was made, the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse tax consequences to you.

### Q-19. How long will the Dependent Care FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

## PART 7. HEALTH SAVINGS ACCOUNTS

### Q-1. What is a Health Savings Account for which contributions can be made under this Plan?

A Health Savings Account ("HSA") is a personal savings account established with a Custodian or Trustee to be used primarily for reimbursement of "eligible medical expenses" you (the Account Beneficiary) and your eligible tax dependents (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) incur, as set forth in Code Section 223. An HSA is administered by the HSA Custodian or Trustee or its designee, and the terms of the HSA are set forth in the Custodial or Trust Agreement. The **Plan Information Summary** will indicate whether you may contribute to an HSA with contributions through this Cafeteria Plan. However, you may also be eligible to contribute to an HSA independently or through a cafeteria plan offered by your spouse's employer.

The HSA is not an Employer sponsored employee benefit plan. The Employer's role with respect to the HSA is limited to making an HSA available to you and to making contributions to the HSA on your behalf through this Plan (through non-elective Employer contributions and/or pre-tax salary reductions elected by the Account Beneficiary). The fact that contributions to the HSA may made through this Plan should not be construed as endorsement of the HSA by the Employer. The Employer has no authority or control over the funds deposited to the Account Beneficiary's HSA. As a result, an HSA that is funded with contributions made through this Cafeteria Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

### Q-2. Who is eligible for an HSA?

Only individuals who satisfy the following conditions on the first day of a month are eligible for an HSA offered under this Plan for that month:

(a) You are covered under a qualifying High Deductible Health Plan (HDHP) maintained by your Employer;

(b) You have opened an HSA with the Custodian chosen by the Employer;

(c) You are not covered under any other non-high deductible health plan maintained by the Employer that is determined by the Employer to offer disqualifying health coverage. **Note that you are not eligible for an HSA if you are covered under any non-qualifying coverage whether maintained by the Employer or not (including but not limited to coverage maintained by your spouse's employer, such as coverage under a spouse's general purpose health flexible spending account or medical plan) and it is solely your responsibility to ensure that any other coverage you have that is not maintained by the Employer qualifies under Code Section 223**;

(d) You cannot be claimed as a tax dependent by anyone else;

(e) You are not enrolled in Medicare coverage; and

(f) You are otherwise eligible for this Plan.

**Q-3. Who is an Account Beneficiary?**

An Account Beneficiary is an eligible Participant who has properly enrolled in an HSA in accordance with the terms of the applicable Custodial Agreement.

**Q-4. Who is a Custodian or Trustee?**

The Custodian or Trustee is the entity with whom the Account Beneficiary's HSA is established (for purposes of this Plan, use of the term "Custodian" includes reference to both Custodian and Trustee). The HSA is not sponsored by or maintained by the Employer. The Custodian or its designee will provide each Account Beneficiary with a Custodial Agreement and other information that describes how to enroll in the HSA and your rights and obligations under the HSA. The Employer may choose to restrict contributions made through this Plan to HSAs maintained by a particular Custodian; however, you will be permitted to rollover funds from the HSA offered under this Plan to another HSA of your choosing (in accordance with the terms of the Custodial Agreement).

**Q-5. What are the rules regarding contributions made to an HSA under the Plan?**

Contributions made under this Plan may consist of both employee pre-tax contributions made pursuant to a Salary Redirection Agreement and/or non-elective Employer contributions (if any). You may elect to contribute any amount to the HSA that you wish; however, the maximum amount of all contributions that can be made to the HSA through this Plan (including both Employer non-elective contributions and pre-tax salary reductions) during the Plan Year cannot exceed the sum of monthly limits for each month during the Plan Year that you are an eligible individual (as described in **Q-2** above). The monthly limit is 1/12 of the maximum amount set forth in Code Section 223(b).

If the Account Beneficiary will be age 55 or older before the end of the tax year, and the Account Beneficiary properly certifies his or her age to the Employer, the maximum contribution amount described above may be increased by the "additional annual contribution" amount (as set forth in Code Section 223(b)(3)), but only to the extent set forth in the separate written HSA material provided by the Employer and/or the Custodian.

To the extent set forth in the Plan's enrollment material or the HSA communication material, the Employer may automatically withhold pre-tax contributions from your compensation to contribute to an HSA unless you affirmatively indicate that you do not wish to contribute to the HSA with pre-tax contributions. Pre-tax contributions will equal the maximum annual contribution amount set forth above (reduced by any Employer non-elective contributions) divided by the number of pay periods remaining during the Plan Year. Non-elective Employer contributions may be made at any time during the Plan Year in a lump sum amount or through periodic contributions (as determined in the sole discretion of the Employer) and communicated in Plan or HSA enrollment materials.

Your HSA election under this Plan will not be effective until the later of the date that you make your election or the date that you establish your HSA. Employer may adjust contributions made under this Plan as necessary to ensure the maximum contribution amount is not exceeded.

Any pre-tax contributions that cannot be made to the HSA because you have been determined to be ineligible for such contribution will be returned to you as taxable compensation or as otherwise set forth in the Plan enrollment material. Any non-elective contributions that cannot be made to the HSA because the employee is not eligible for such contribution will be returned to the Employer except as otherwise set forth in the applicable communication material.

### Q-6. What are the election change rules under this Plan for HSA elections?

You may change your HSA contribution election at any time during the Plan Year for any reason by submitting an Election Change Form to the Plan Administrator (or its designee). Your election change will be prospectively effective as of the first day of the next pay period following the day that you properly submit your election change (or such later date as uniformly applied by the Plan Administrator to accommodate payroll changes). Your ability to make pre-tax contributions under this Plan to the HSA ends on the date that you cease to meet the eligibility requirements under this Plan.

### Q-7. Where can I get more information on my HSA and its related tax consequences?

If an HSA is funded with contributions through this Cafeteria Plan, you may refer to your HSA Custodial Agreement and/or the HSA communication material provided by your Employer for details concerning your rights and responsibilities with respect to your HSA (including information concerning the terms of eligibility, qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA).

## PART 8. BENEFITS CARD

The OneBridge Visa® Benefits Card (the "OneBridge Benefits Card") allows you to pay for Eligible Medical Expenses or Eligible Dependent Care Expenses as defined by the Plan(s) in which you participate ("Eligible Card Expenses") at the time that you incur the expense.

*The OneBridge Visa® Benefits Card is issued by the Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card can be used for qualified expenses wherever Visa Debit Cards are accepted. See cardholder agreement for details.*

Here is how the OneBridge Benefits Card works, if indicated as an option under the Plan in the **Plan Information Summary**.

(a) *You must agree to the terms and conditions of the card program.* In order to be eligible for the OneBridge Benefits Card, you must agree to abide by the terms and conditions of the card program (the "Program") through which the OneBridge Benefits Card is offered, as set forth herein and in the OneBridge Benefits Card Cardholder Agreement (the "Cardholder Agreement") including limitations as to card usage (it cannot be used at all Visa® acceptance locations and has no cash assess), the Plan's right to

reimbursement for unqualified or unsubstantiated transactions, and your agreement that each time you use the OneBridge Benefits Card you are certifying that you are in compliance with the terms and conditions of the Plan for which you are using the OneBridge Benefits Card, etc. A Cardholder Agreement will be provided to you when your OneBridge Benefits Card is provided to you. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) *The card will be turned off when employment or coverage terminates.* The Electronic Payment will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify, during the applicable Election Period, that the OneBridge Benefits Card will only be used for Eligible Card Expenses and that you will not have been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

(d) R*eimbursement under the card is limited to specific providers.* Use of the card for Health FSA expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.) identified by the Plan Administrator or its designee as an eligible merchant. For the Dependent Care FSA, you may only use your OneBridge Benefits Card to pay for Eligible Dependent Care Expenses at merchants categorized as childcare services or elementary and secondary schools. In addition, the OneBridge Benefits Card will be administered in accordance with applicable IRS guidance. Use of the card for other Plan expenses may be limited to merchants of qualified classifications. The card cannot be used at all Visa® acceptance locations.

(e) *You swipe the card at the provider like you do any other credit or debit card.* When you incur an Eligible Card Expense at a qualified merchant, you swipe the card much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under the Plan (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Plan is being made is an Eligible Card Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source. If you are using the card for Eligible Dependent Care Expenses, you certify that you are using the card for services already incurred (and the payment is not made in advance of the date services will be provided).

(f) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain a third party statement from the provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

- The nature of the expense (e.g., what type of service or treatment was provided).

- If the expense is for an over the counter item other than a drug or medicine (e.g., bandages), the written statement must indicate the name of the item. If the name of the item is abbreviated heavily, please include a copy of the box top or packaging so the receipt abbreviation can be tied to the actual over-the-counter item purchased. If the expense is for a DCAP payment, the written statement must indicate the tax ID number of the provider.

- The date the expense was incurred or the period during which the services were provided (for example, DCAP expenses should show the period during which the services were provided if payment is made for than one day).

- The amount of the expense.

You must retain this receipt for one year following the close of the Plan year in which the expense is incurred. Even though payment is made under the card arrangement, a written third party receipt or expense statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement or as otherwise permitted under applicable law and associated guidance). You will receive written notice from the Plan Service Provider that and independent third party receipt or statement is needed in order to substantiate the expense and the timeframe within which you must provide it in order to ensure that the expense is permitted to be reimbursed by the Plan.

(g) *There are situations where the third party statement will not be required to be provided to the Plan Service Provider.* There are many situations in which you will not be required to provide the written statement to the Plan Service Provider. Situations in which you may not be required to submit the third party statement are detailed in the Cardholder Agreement.

***Note: You must obtain the third party receipt for ALL card transactions when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Plan Service Provider or the IRS requests it.***

(h) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Plan Service Provider, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is determined by the Plan Administrator. If you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Plan. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they

are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement), or the remaining unpaid amount will be included in your gross income as taxable "wages".

(i) *You can use either the OneBridge Benefits Card or the traditional claims approach.* You have the choice as to how to submit most of your eligible claims. If you elect not to use the OneBridge Benefits Card, you may also submit claims under the Traditional Claims approach discussed above. Claims for which the OneBridge Benefits Card has been used cannot be submitted as Traditional Claims.

**IMPORTANT:** Recent federal regulations permit over the counter (OTC) drugs and medicines purchased after December 31, 2019 to be reimbursed by the Health FSA without a prescription. Note: a prescription is also not required for eligible OTC medical items (including, for example feminine hygiene products, bandages, contact lens solution, etc.).

## PART 9. CLAIMS AND APPEALS

The Plan and the Benefit Options have claims review procedures in the event you are denied a request for benefits under the Plan or any of the Benefit Options under the Plan. The procedure set forth below applies only to benefit claims under the Health FSA and Dependent Care FSA. For information about claims review procedures for any other Benefit Option funded through the Plan, contact the Plan Administrator of your Benefits Coordinator.

A person (referred to in this **Part 9** as the "Claimant") claiming or requesting Health Care Reimbursements or Dependent Care Reimbursements ("Reimbursement") under the Health FSA or Dependent Care FSA, shall deliver a request for Reimbursement in writing to the Plan Service Provider. The Plan Service Provider shall review the Claimant's request for Reimbursement and shall thereafter notify the Claimant of its decision as follows:

1. If the Claimant's request for Reimbursement is approved by the Plan Service Provider, it shall notify the Claimant of such approval and distribute such benefits to the Claimant.

2. In the event the Plan Service Provider determines that a claim is questionable, the Plan Service Provider shall within thirty (30) days from the date the Claimant's request for Plan benefits was received by the Plan Service Provider, unless special circumstances require an extension of time for reviewing said claim, provide the Claimant with written notice of its need for additional information. In the event special circumstances require an extension of time for reviewing the Claimant's request for Reimbursement, the Plan Service Provider shall, prior to the expiration of the initial thirty (30) day period referred to above, provide the Claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Plan Service Provider expects to render its decision. In no event shall such extension exceed a period of fifteen (15) days from the date of the expiration of the initial period, totaling forty-five (45) days at a maximum.

3. If the Claimant's request for Reimbursement is denied, in whole or in part, by the Plan Service Provider, the Plan Service Provider shall notify the Claimant of such denial and shall include in such notice, set forth in a manner calculated to be understood by the Claimant, the following:

    a. The specific reason or reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes;

    b. Specific reference to pertinent Plan provisions or IRS rules and regulations on which the denial is based;

c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

d. A description of available internal appeals processes, including information regarding how to initiate an appeal pursuant to paragraph 5 below; and

e. The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

4. The Plan Service Provider shall provide written notice of a denial of a request for Benefits. In the event written notice of a denial of a request for Benefits is not received by the Claimant within forty-five (45) days of the date the written claim is submitted to the Plan Service Provider, the request shall be deemed denied as of that date.

5. Any Claimant whose request for Benefits has been denied or deemed denied, in whole or in part, or such Claimant's authorized representative, may appeal said denial of Plan benefits by submitting to the Plan Service Provider a written request for a review of such denied claim. Any such request for review must be delivered to the Plan Service Provider no later than one hundred eighty (180) days from the date the Claimant received written notification of the Plan Service Provider's initial denial of the Claimant's request for Benefits or from the date the claim was deemed denied, unless the Plan Service Provider, upon the written application of the Claimant or his authorized representative, shall in its discretion agree in writing to an extension of said period.

6. During the period prescribed in paragraph 5 for filing a request for review of a denied claim, the Plan Service Provider shall permit the Claimant to review pertinent documents and submit written issues and comments concerning the Claimant's request for Benefits.

7. Upon receiving a request by a Claimant, or his authorized representative, for a review of a denied claim, the Plan Service Provider shall deliver the complete file to the Plan Administrator, who shall consider such request promptly and shall advise the Claimant of its decision within thirty (30) days from the date on which said request for review was received by the Plan Service Provider, unless special circumstances require an extension of time for reviewing said denied claim. In the event special circumstances require an extension of time for reviewing said denied claim, the Plan Service Provider shall, prior to the expiration of the initial 30-day period referred to above, provide the Claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Plan Administrator expects to render its decision. In no event shall such extension exceed a period of forty-five (45) days from the date on which the Claimant's request for review was received by the Plan Service Provider. The Plan Administrator’s decision shall be furnished to the Claimant and shall:

a. Be written in a manner calculated to be understood by the Claimant;

b. Include specific reasons for the decision and sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable) and a statement describing the availability, upon request, of diagnosis code, the treatment code, and the corresponding meanings of these codes;

c. Include specific references to the pertinent Plan provisions on which the decision is based;

d. A description of available external review processes, including information regarding how to initiate an appeal pursuant to paragraph 9 below; and

e. The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

8. The Plan Administrator may, in its discretion, determine that a hearing is required in order to properly consider the Claimant's request for review of a denied claim. In the event the Plan Administrator determined that such hearing is required, such determination shall, in and of itself, constitute special circumstances permitting an extension of time in which to consider the Claimant's request for review.

9. After exhausting the above claims procedures in full, any Claimant whose request for Reimbursement has been denied or deemed denied, in whole or in part, or such Claimant's authorized representative, may file a request for an external review of such denied claim. Any such request for review must be delivered to the Plan Service Provider no later than the first day of the fifth month following the date the Claimant received written notification of the Plan Administrator's final denial of the Claimant's request for Reimbursement or from the date the claim was deemed denied. Within five (5) business days of receiving the external review request, the Plan Service Provider must complete a preliminary review to determine if the Claimant was covered under the Plan, the Claimant provided all the information and forms necessary to process the external review, and the Claimant has exhausted the internal appeals process.
Once the review above is complete, the Plan Service Provider has one (1) business day to notify the Claimant in writing of the outcome of its review. If Claimant is not eligible for external review, the notice must include contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT). If the Claimant's request for external review was incomplete, the notice must describe materials needed to complete the request and provide the later of 48 hours or the four- month filing period to complete the filing.

   Upon satisfaction of the above requirements, the Plan Service Provider will provide that an independent review organization (IRO) will be assigned using a method of assignment that assures the independence and impartiality of the assignment process. Claimant may

submit to the IRO in writing additional information to consider when conducting the external review, and the IRO must forward any additional information submitted by the Claimant to the Plan Service Provider within one (1) business day of receipt. The decision by the IRO is binding on the Plan and, as well as the Claimant, except to the extent other remedies are available under State or Federal law. For standard external review, the IRO must provide written notice to the Plan Service Provider and the Claimant of its decisions to uphold or reverse the benefit denial within no more than forty-five (45) days.

10. The claims procedures set forth in this **Part 9** shall be strictly adhered to by each Participant or Dependent under this Plan, and no judicial or arbitration proceedings with respect to any claim for Plan benefits hereunder shall be commenced by any such Participant or Dependent until the proceedings set forth herein have been exhausted in full.

## PART 10. ADDITIONAL TERMS AND CONDITIONS OF THE PLAN

The terms and conditions set forth below apply to the Cafeteria Plan and the Flexible Spending Account Plans. Additional terms and conditions may apply for other Benefit Options funded through the Cafeteria Plan as set forth in the governing documents, plan summaries, or summary plan descriptions for those other Benefit Options. Contact the Plan Administrator or your Benefits Coordinator to obtain this information for the Benefit Options other than the Flexible Spending Accounts.

By enrolling and participating in the Cafeteria Plan and taking any action with respect to your benefits under the Plan, you agree to the following Terms & Conditions. You agree that the Plan and the parties involved in this Plan (including, but not limited to, the Employer, Plan Administrator, Plan Service Provider, and the agents of each of them, collectively referred to as the "Plan and its agents") cannot guarantee any federal or state tax results or investment results. Any benefits to which you may become entitled to under the Plan and any Benefit Option are subject to the terms and conditions of the Plan Documents, and any other governing plan documents for any Benefit Option funded through the Plan, and applicable law. The Plan and its agents may withhold from such benefits (and may transmit to the government if required by law) any tax, charge, penalty, assessment, or other amount that is determined to be attributable to or allocable to such benefits or on account of the operations of the Plan. You agree to hold the Plan and its agents harmless with respect to such withholding or any failure to withhold or pay such amounts and any other actions taken in good faith for the operation of the Plan.

You understand that for proper administration of the Plan and compliance with applicable law, you must provide true and accurate information to the Plan and regularly confirm and update your enrollment information, including name, address, phone number, dependents, and social security numbers for yourself and your dependents. Information submitted to the Plan fraudulently may result in adverse tax consequences or penalties and/or your termination from the Plan. You also understand that it is your responsibility to review each statement to confirm that there are no financial or recordkeeping errors reflected on your account. Any errors must be reported by you to the Plan Service Provider within ninety (90) days after the error is first viewed by you online or first reflected in a statement or other written information delivered to you by the Plan and its agents.

**E-communication Terms & Conditions.** For your e-communication election to be effective, you must provide the Plan with your e-mail address. The electronic documents you will receive include e-statement notifications and newsletters, explanations of benefits (EOBs) notices, and other important Plan information. Please note the following:

- You may withdraw your consent for electronic documents at any time at no charge
- To update your e-communication election or email address, please login to **myonebridge.com** and click on **My Profile** on the menu bar
- It is your responsibility to keep your email address current with the Plan. If your electronic documents are returned to the Plan due to an undeliverable e-mail address, the Plan may remove your e-communication election.
- Any electronically delivered documents will **not** be mailed to you by US Mail

- You can view and print copies of your electronic documents or request paper copies (at no charge) from our Customer Care Center

You will need Adobe Acrobat Reader software loaded on a computer in order to access electronic documents. A free copy of Adobe Acrobat Reader is available at www.adobe.com

## PART 11. HEALTH FSA HIPAA PRIVACY NOTICE

Introduction

This Privacy Notice (the "Notice") describes the legal obligations of the Health FSA and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). This Notice is provided by the Health FSA Plan Service Provider and does not apply to any of other medical or health plan coverages funded with contributions through your Cafeteria Plan or otherwise provided by your Employer. For privacy notices applicable to any plans other than the Health FSA, contact the Plan Administrator identified in the **Plan Information Summary**.

Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. As the Plan Service Provider for the Health FSA, we are required to provide this Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" or "PHI." Generally, PHI is health information, including demographic information, collected from you or created or received by the Plan from which it is possible to individually identify you and relates to (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present, or future payment for the provision of health care to you.

Who will follow this Notice

The Health FSA Plan and any service providers that assist in the administration of Plan claims are required by law and by contract with the Plan (or your Employer) to follow this Notice. A record of your health care claims reimbursed under the Plan is kept for administration purposes only. This Notice applies to all medical records we maintain.

Effective Date of this Notice

This Notice is effective as of August 1, 2020 and will remain effective until changed.

Privacy pledge

We are required by law to (1) make sure PHI identifying you is kept private; (2) give you certain rights with respect to your protected health information; (3) provide this Notice of our legal duties and privacy/security practices concerning protected health information about you; and (4) follow the terms of the Notice currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make a material change to the Notice, we will provide you with a copy of our revised Privacy Notice by posting the updated Notice on the Plan website, and include information about the revised Notice and how you can obtain it in your next eligible participant account statement delivery.

How we may use and disclose PHI about you

The following categories describe various ways we use and disclose PHI. Explanations and examples are provided for each category of uses or disclosures.

Not every use or disclosure is listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

- **For payment (as described in applicable regulations).** We may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from healthcare providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may may share PHI with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments.

- **For healthcare operations (as described in applicable regulations).** We may use and disclose PHI about you for other Plan operations necessary to run the Plan. For example, we may use PHI in connection with conducting quality assessment and improvement activities; other activities relating to Plan coverage; conducting or arranging for legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

- **To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI.

- **As required by law.** We will disclose PHI about you when required to do so by federal, state, or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding such as a malpractice action.

- **To avert a serious threat to health or safety.** We may use and disclose PHI about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person, but only to someone able to help prevent the threat. For example, we may disclose PHI about you in a proceeding regarding the licensure of a physician.

- **To Employers or Plan Sponsors.** For the purpose of administering the Plan, we may disclose PHI to certain employees of your employer or plan sponsor. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise permitted by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Special situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization.

- **Military and veterans.** If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

- **Workers' compensation.** We may release PHI about you for workers' compensation or similar programs providing benefits for work- related injuries or illness.

- **Public health risks.** We may disclose PHI about you for public health activities such as to (1) prevent or control disease, injury or disability; (2) report births and deaths; (3) report child abuse or neglect; (4) report reactions to medications or problems with products; (5) notify people of recalls of products they might be using; (6) notify a person who might have been exposed to a disease or might be at risk for contracting or spreading a disease or condition; or (7) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law).

- **Health oversight activities.** We may disclose PHI to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections, and licensure necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

- **Lawsuits and disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested.

- **Law enforcement.** We may release PHI if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct at the hospital; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

- **National security and intelligence activities.** We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required disclosures

The following is a description of disclosures of your PHI we are required to make.

- **Government audits.** We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

- **Disclosures to you.** When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

Other disclosures

- **Personal representatives.** We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

- **Spouses and other family members.** With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your rights regarding PHI about you"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

- **Authorizations.** Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your rights regarding PHI about you

You have the following rights regarding PHI we maintain about you.

- **Right to inspect and copy.** You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy. To inspect and copy such information, you must submit a written request to our Customer Care Center. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, in which case you may request that the denial be reviewed.

- **Right to amend.** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit a written request to our Customer Care Center including a reason that supports your request. Your request may be denied if it is not in writing or does not include a reason to support the request, or if you ask us to amend information that (1) is not part of the PHI kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

- **Right to an accounting of disclosures.** You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include: (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to our Customer Care Center. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to request restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, healthcare operations, or to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Except as provided later in this paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until

you revoke it or we notify you. We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full. To request restrictions, you must submit a written request to our Customer Care Center detailing (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (i.e., your spouse).

- **Right to request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to our Customer Care Center specifying how or where you wish to be contacted. We will not ask the reason and will accommodate all reasonable requests.

- **Right to be notified of breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured PHI.

- **Right to a paper copy of this Notice.** You have the right to a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. To obtain a paper copy of this Notice, log in to your account at myonebridge.com or contact our Customer Care Center at 1-888-338-4415.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Plan Administrator or your Benefits Coordinator, who will refer you to your Plan's Privacy Official. You will not be penalized or otherwise retaliated against for filing a complaint.

Other uses of PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written permission. Such permission may be revoked, in writing, at any time and we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the service we provided you.

## PLAN INFORMATION SUMMARY

Attached on Following Pages.

# Flexible Spending Account
# Plan Renewal Information Summary

Plan Information Summary

## Employer Information

| | | | |
|---|---|---|---|
| Employer Legal Name: | Benton County Public Utility District | Tax ID Number: | 91-6001045 |
| Address: | 2721 W 10th Avenue | Phone Number: | 509-582-2175 |
| City: | Kennewick | State: WA | Zip Code: 99336 |
| Subject to ERISA: | ○ Yes | ◉ No | |
| Form of Organization: | Government | | |
| Organized in the state of: | Washington | | |
| Employer Affiliates (if any): | N/A | | |

## Employer FSA Benefits Coordinator (Primary Contact)

| | | | |
|---|---|---|---|
| Name: | Jody George | Title: | HR Generalist III |
| Phone Number: | 509-585-5398 | Email: | georgej@bentonpud.org |
| Address same as above: | ◉ Yes | ○ No | If No, enter address below: |
| Address: | | City: | State: Zip Code: |

## Plan Service Provider/Administrator Information

| **OneBridge Benefits<br>170 Franklin St. Suite 700 Buffalo, NY 14202** | |
|---|---|
| Support Phone Number and Hours: | **888-338-4415, Monday-Friday (6 am – 5 pm, Pacific Time)** |
| Employer & Participant Website: | **myonebridge.com** |
| Claims Mailing Address:[1] | **PO Box 80866, Seattle WA 98108** |

1- Claims can also be submitted via the OneBridge Participant Portal and Mobile App.

## Plan Dates

| Plan Year | Plan Year Run Date | | | Open Enrollment Dates | | |
|---|---|---|---|---|---|---|
| 2023 | 01/01 | to | 12/31 | 10/31/2022 | to | 11/18/2022 |

Each successive Plan Year will use the same run and enrollment dates, as well as all Plan Details listed below unless modified via a written amendment.

## Health FSA Plan Details[2]

| Election Amounts: | |
|---|---|
| Allowed Maximum Election | Required Minimum Election |
| $ 3,050.00 | $ 120.00 |

| Grace Period[3]: | |
|---|---|
| Grace Period Adopted | Grace Period Number of Days |
| Yes | 75 |

| Carryover[3]: | | | | |
|---|---|---|---|---|
| Carryover Adopted | Carryover Maximum | Carryover Minimum | Enrollment Required in Next Plan Year | Carryover Limited to Next Plan year |
| No | | | N/A | N/A |

| Runout Period (End of Plan Year): | |
|---|---|
| Runout Period Adopted | Runout Period Number of Days |
| Yes | 90 |
| Include Runout as part of Grace Period? | Yes |

| Runout Period (for Terminated Employees): | |
|---|---|
| Terminated Runout Adopted | Runout Period Number of Days |
| Yes | 90 |
| Runout Begins at Term Date | Yes |
| Runout Begins at | N/A |

| Qualified Reservist Distribution (QRD) | |
|---|---|
| QRD Adopted | Yes |

### Eligible Expenses

The IRS Code 213 eligible and ineligible expense list will be used to determine eligible expenses for reimbursement on Health FSA accounts. https://www.irs.gov/publications/p502

2- In order to remain eligibility to make contributions to an HSA, employees may elect a limited-scope health FSA when enrolling.

3- IRS Plan rules only allow for either a Carryover or Grace Period option to be included.

## Dependent Care FSA Plan Details

| Election Amounts: | |
|---|---|
| Allowed Maximum Election | Required Minimum Election |
| $ 5,000.00 | $ 120.00 |

| Grace Period: | |
|---|---|
| Grace Period Adopted | Grace Period Number of Days |
| No | N/A |

| Runout Period (End of Plan Year): | |
|---|---|
| Runout Period Adopted | Runout Period Number of Days |
| Yes | 90 |
| Include Runout as part of Grace Period? | N/A |

| Runout Period (for Terminated Employees): | |
|---|---|
| Terminated Runout Adopted | Runout Period Number of Days |
| Yes | 90 |
| Runout Begins at Term Date | Yes |
| Runout Begins at | N/A |

| Spend Down Option (for Terminated Employees) | |
|---|---|
| Spend Down Option Adopted | No |

**Dependent Care Expenses**

All "work related" expenses defined by IRS Publication 503, Child and Dependent Care Expenses, will be used to determine eligible expenses for reimbursement on DCAP accounts. https://www.irs.gov/publications/p503

## Eligibility Requirements

**The following employees are eligible to participate in the FSA Plan:[4]**

○ All ○ Full-time Employees Only ◉ Other(s): Employees who average 30 hours/week or 130 hours/month and are eligible for the group medical plan

4- Eligible Employees must be eligible for the Employer's major medical coverage to participate in the Health FSA; however, they're not required to elect major medical.

**The following employees are not eligible to participate in the FSA Plan:**

☐ Part-time Employees ☐ Seasonal/Temporary Employees ☐ Union (Collectively Bargained)

☑ Other(s): Anyone who does not meet the above stated eligibility requirements.

**What is the service period employees must complete before being eligible to participate in the Plan?**

◉ As of the Date of Hire (DOH) ○ Number of days after DOH:

○ Number of months after DOH: ○ Other:

| When can eligible employees begin to participate in the Plan? | |
|---|---|
| First day of | (●) Pay period following the date employee becomes eligible |
| | ( ) Month following the date employee becomes eligible |
| | ( ) Quarter following the date employee becomes eligible |

## OneBridge Benefits Card[5]

All FSA participants will be automatically enrolled in the debit card program when electing to participant in the FSA program. If a participant has an existing OneBridge Benefits Card for their OneBridge administered HRA account, their FSA account funds will be automatically added to their existing card when the plan becomes effective, and as according to the specific rules of the FSA benefit type.

For participants with a single stacked debit card for both HRA and FSA accounts, their Health FSA account will typically be used first for a qualifying medical expense—please refer to the HRA Plan documents for additional reference.

5- The OneBridge Visa® Benefits Card is issued by the Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card can be used for qualified expenses wherever Visa Debit Cards are accepted. See cardholder agreement for details.

## Other Pre-tax (Qualified Benefit) Deductions[6]

In addition to Health and Dependent Care FSA benefits, listed below are all other pre-tax qualified benefit deductions available to employees under our Cafeteria plan?

| | | |
|---|---|---|
| [✓] Medical | [✓] Prescription | [ ] HSA contributions |
| [✓] Vision | [ ] Short-term Disability | [ ] Voluntary Life Insurance |
| [✓] Dental | [ ] Long-term Disability | [ ] Voluntary Critical Illness |
| [ ] Others: | | |

6- Eligibility to make Pre-tax Contributions for the applicable Benefit Options may be subjected to eligibility requirement(s) or waiting period(s), as well as additional terms of eligibility and participation specific to these Benefits. You may confirm with your employer's Benefits Coordinator if other governing documents for these Benefits exist, and if so, how to obtain a copy of these documents.

## Health FSA COBRA Administrator

| | | | | | |
|---|---|---|---|---|---|
| Name: | Rehn & Associates | | | | |
| Address: | 1322 N Post St | | | | |
| City: | Spokane | State: | WA | Zip Code: | 99201 |