2024 | SECTION 125
CAFETERIA PLAN DOCUMENT

Core Documents

SUMMARY OF PLAN SPONSOR RESPONSIBILITIES

As the Plan Sponsor/Administrator, you will have sole responsibility to comply with all plan administration, implementation, amendments, filing, reporting, disclosure and plan compliance requirements imposed by the plan, ERISA, the Internal Revenue Code or any other applicable law, specifically including, but not limited to:

- Reviewing the sample documents (plan, summary plan description, salary redirection agreements and nondiscrimination information) with legal counsel, executing the Plan Adoption Agreement before the first day of the plan year, and distributing the summary plan description to employees on or before their enrollment date.
- Ensuring that only common law employees participate in the plan [employees of companies described in IRC Section 414 (b), (c) or (m) and listed in the plan as participating affiliates may also participate] and ensuring that the terms of its plan document are enforced.
- Conducting initial and annual enrollments, and collecting signed Salary Redirection Agreements from employees prior to their effective date of participation. (In the absence of a valid change in status, currently eligible employees should be enrolled *prior to* the plan effective date.)
- Form 5500 Annual Returns have been suspended for Premium Only Plans. However, you may be required to file a Form *5500* Annual Return for the component benefit plans offered through the Premium Only Plan *(component benefit plans would be any self-funded or partially self-funded health plans sponsored by you through ERISA, Medical Flexible Spending Accounts (FSA) with more than 100 employees are still required to file a Form 5500).*
- Performing nondiscrimination testing required by the Internal Revenue Code (including, but not limited to: ensuring that a nondiscriminatory classification of employees is eligible for the plan, that contributions and benefits do not discriminate in favor of highly compensated employees, and that no more than *25%* of the total pre-tax benefits is received by officers and owners). Additional nondiscrimination testing may be required for the component benefits offered through the cafeteria plan (including insurance and flexible spending account benefits). You will be responsible to perform nondiscrimination testing. Nondiscrimination testing should be performed shortly after enrollment and again if there is a significant change in employee participation.
- Determining whether election changes are permissible in accordance with the provisions of the plan and Internal Revenue Code requirements.
- Ensuring that benefits offered under the plan qualify for inclusion in a Section 125 Premium Only Plan.
- Retaining documentation relating to plan operations that may be requested in an IRS or Department of Labor audit of plan operations - including, but not limited to: nondiscrimination testing information, executed copies of the plan, salary redirection agreements, plan amendments, resolutions adopting the plan, and Form 5500s - for seven years after the close of each plan year.
- Employers with 20 or more employees must provide COBRA continuation of the Health FSA benefits to those employees with a positive FSA Account balance on the date of the COBRA qualifying event.

Section 125 and W-2 Reporting

Where do I report Section 125 Plan benefits on my employees' Form W-2s?

Dependent Care benefits are shown in box 10. Health Savings Account contributions are shown in box 12, code W. Contributions to a medical reimbursement account are not specifically shown. *Effective January 1, 2012, most employers are required to report the cost of employer-sponsored health coverage in box 12, code DD. Refer to IRS Notices 2010-69 and 2011-28, and to your tax professional for more details and proper reporting.*

The Federal and Social Security wages will be decreased by all pre-tax contributions. The State taxable income for most States will be the same as the Federal wage amount. The Local Wage box may not match the Federal amount. Many localities do not recognize these plans, so local tax (if any) might be on unreduced pay, before pre-tax deductions. If so, the Local box will show higher wages than the Federal/Social Security boxes.

Section 125 and State Income Tax

The states generally follow Section 125 federal law in their tax treatment of flex plan contributions. Some states, such as New Jersey, California, Alabama, and Pennsylvania, may not permit some or all pre-taxed salary reduction contributions to be exempt from state income tax. Check with your state Department of Revenue or taxing authority.

Section 125 and Local Income Tax

Some cities and municipalities impose their own income taxes on salary reduction contributions to flex plans. Please contact your accountant for specific flex plan salary reduction local taxation issues.

Section 125 and State Unemployment Tax

Currently, most states impose unemployment taxes on flex plan contributions. Please contact your accountant or tax specialist for information on whether your state unemployment taxes may be exempt on flex plan contributions.

Section 125 and Form 1099 Reporting Requirements

If you pay health care providers directly through a Medical Expense Reimbursement Plan you are required to file a Form 1099-MISC for each health care provider for whom payments exceed $600 per year. Thus, you may want to limit reimbursements to only plan participants.

Company Owners and Section 125?

Question 1: When do owners or shareholders have to be excluded from a Section 125 plan?

Answer: In all cases except for:

1. ownership of shares in a C-Corporation, and
2. ownership of 2% or less in an S-Corporation.

Put another way the partners, members of an LLC, sole proprietors, or greater than 2% shareholders of an S corporation) cannot participate in a Premium Only Plan

Question 2: When can a company owner (whose spouse is also an employee) make use of pre-tax dollars in a Section 125 Plan? The owner holds 100% of the company ownership. Assume that discrimination is not an issue.

Answer: Code §125(d)(1)(a) states that all participants in a cafeteria plan must be employees. The proposed regulations at §1.125-1 define what is meant by "employee."

> The term "employees" includes present and former employees of the employer. All employees who are treated as employed by a single employer under subsections (b), (c), or (m) of section 414 are treated as employed by a single employer for purposes of section 125. The term "employees" does not, however, include self-employed individuals described in section 401(c) of the Code.

Further, it appears that persons who own more than 2 percent of the shares of an S corporation are not considered "employees." (An S corporation is a corporation that has elected to be treated as an "S" corporation for income tax purposes, pursuant to subchapter S of the normal income tax provisions in the Code.) See Code section 1372, which states that for purposes of the "fringe benefits" portions of the Code an S corporation is treated as a partnership and a more than 2 percent shareholder of the S corporation is treated as a partner of such partnership.

Remember to apply the "attribution" rules of Code section 318. The spouse of a 100% owner of an S corporation, or the spouse of an LLC (Limited Liability Company) owner, or a sole proprietorship, who is not employed by the company, would be considered to be the 100% owner as well. In this question, therefore, neither the company owner nor the owner's spouse could participate in the cafeteria plan.

If the corporation is a C corporation for federal income tax purposes, nothing prevents the 100% owner of the corporation's shares from participating. He or she could be an employee and therefore eligible for participation. The spouse of the 100% owner also would be eligible for participation even though attribution would apply to a C corporation owner's spouse.

A sole proprietor who employs his or her spouse (as a bona fide employee!) may not participate in a Section 125 plan, but the spouse may participate. This is because there are no shares to attribute in a sole proprietorship.

Incidentally, this method also applies to family health insurance coverage. The non-owning spouse could elect family coverage (covering, as a dependent, the spouse with 100% ownership of the company.) The health insurance premium would be completely deductible.

SECTION 1

RESOLUTION TO ADOPT

PLACE THIS PAGE AFTER TAB 1

SECTION 1 SHOULD CONSIST OF

1- THE FOLLOWING RESOLUTION TO ADOPT

ROMAN CATHOLIC DIOCESE OF OWENSBORO

RESOLUTION

IRC SECTION 125

FLEXIBLE BENEFITS PLAN

WHEREAS, Roman Catholic Diocese of Owensboro previously determined on January 1, 2018, that it would be in the best interest of its employees to adopt a "Section 125 Flexible Benefits Plan" allowing for pre-taxed insurance and medical benefits, so-called; be it known that a vote was taken to amend and restate said Plan, and all were in favor.

RESOLVED, that Roman Catholic Diocese of Owensboro amend their so-called "Section 125 Flexible Benefits Plan", all in accordance with the specifications annexed hereto; and, be it known that the Roman Catholic Diocese of Owensboro Flexible Benefits Plan Document was executed August 1, 2024.

RESOLVED FURTHER, that the Company undertake all actions necessary to implement and administer said plan.

IN WITNESS WHEREOF, I have executed my name for the above named Company on August 1, 2024.

A True Record

ATTEST:

Mary L Hall
Witness

By: Raymond Purk
Raymond Purk

SECTION 2

SECTION 125 PREMIUM ONLY PLAN DOCUMENT

PLACE ALL PAGES OF THE PLAN DOCUMENT AFTER TAB 2

AUTHORIZED SIGNER SHOULD EXECUTE THE SIGNATURE PAGE
AT THE END OF THE PLAN DOCUMENT

2024 | CORE 125
PREMIUM ONLY PLAN DOCUMENT

Core Documents

ROMAN CATHOLIC DIOCESE OF OWENSBORO

PREMIUM ONLY PLAN

PURPOSE

The Roman Catholic Diocese of Owensboro Premium Only Plan (the "Plan"), adopted by Roman Catholic Diocese of Owensboro effective January 1, 2018 is herein amended and restated effective August 1, 2024. The purpose of the Plan is to allow Employees of Roman Catholic Diocese of Owensboro and other Participating Employers, to choose between at least one permitted taxable benefit, such as cash compensation from existing income and at least one qualified benefit such as health care coverage under medical plan(s) (via salary reduction) sponsored by Roman Catholic Diocese of Owensboro.

Roman Catholic Diocese of Owensboro intends that the Plan qualify as a "cafeteria plan" under section 125 of the Internal Revenue Code of 1986 ("Code") as amended, and that the Medical Insurance Benefits that an Employee elects to receive under the Plan be eligible for exclusion from the Employee's income for federal income tax purposes.

Although this Plan has been reduced to writing in order to comply with section 125 of the Code, the Plan shall also serve as an amendment to each of the health plans described in Schedule A affected by its provisions in order to permit the benefits of this Plan to be fully implemented.

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Section 1

DEFINITIONS

The words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context, and pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural.

"Adoption Agreement" means the written agreement by which an Affiliated Company adopts this Plan.

"Affiliated Company" means:

A. any company which is a member of a controlled group of corporations with the Employer within the meaning of section 1563(a) of the Code, determined without regard to sections 1563(a) (4) and (e) (3) (C);

B. all organizations under common control with the Employer within the meaning of section 414 (c) of the Code:

C. all organizations which are included with the Employer in an affiliated service group within the meaning of section 414 (m) of the Code; or

D. any other entity required to be aggregated with the Employer pursuant to regulations under section 414 (o) of the Code.

"Beneficiary" means the person, persons or trust designated by written revocable designation filed with the Plan Administrator by the Participant to receive payments under this Plan, including the Participant and any dependents of a Participant.

"Cash" for purposes of section 125, cash means cash from current compensation (including salary reduction), payment for annual leave, sick leave, or other paid time off, severance pay, property, and certain after-tax employee contributions.

"Change in Status" has the meaning described in Section 4.3.

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

"Code" means the Internal Revenue Code of 1986 as amended, and the same as may be amended from time to time.

"Dependent" has the meaning described in Section 2.8.

"Effective Date" means January 1, 2018; amended and restated August 1, 2024.

"Eligible Employee" means any non-union Employee regularly scheduled to work 20 or more hours per week for a Participating Employer.

"Employee" means an individual that the Employer classifies as a common-law employee, leased employee, and who is on the Employer's W-2 payroll, but does not include the following: (a) individuals classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual;(e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means Roman Catholic Diocese of Owensboro and any other business organization which succeeds to its business and elects to continue this Plan.

"Enrollment Period" means the calendar month preceding the beginning of any Plan Year.

"Entry Date" means the first day of the month following date of hire as an Eligible Employee.

"ERISA" means the Employee Retirement Income Security Act of 1974, and the same as may be amended from time to time.

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

"Highly Compensated Employee" means any Employee defined as such in section 414(q) of the Code.

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

"Key Employee" means any Employee defined as such in section 416(I) (l) of the Code.

"Medical Insurance Benefits" means a health care coverage option, available from time to time under the Plan, as set forth in Schedule A hereto.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section 2.

"Participating Employer" means Roman Catholic Diocese of Owensboro and any Affiliated Company that adopts this Plan with the consent of the Employer. As of the Effective Date, the Employer is the only Participating Employer.

"Plan" means the Roman Catholic Diocese of Owensboro Premium Only Plan which is described herein and as amended from time to time, and which is intended to constitute a separate, written Plan for the exclusive benefit of Eligible Employees.

"Plan Number" or "PN" assigned by Roman Catholic Diocese of Owensboro is 501.

"Plan Sponsor" means Roman Catholic Diocese of Owensboro.

"Plan Year" means the twelve-month period commencing each January 1 and ending on the subsequent December 31.

"Premium Payment Benefits" means the amount set aside for Medical Insurance Benefits under Section 3.2 and credited to the Participant's Premium Only Account.

"Premium Only Account" means the account established in each Participant's name as provided under Section 3.2 and which is used to record the allocation of Premium Payment Benefits for the expenditure of the Medical Insurance Benefits elected by a Participant.

"Premium Expense" means the expense identified with the Medical Insurance Benefits elected by a Participant in accordance with Section 3.2.

"Qualified Benefits" For purposes of section 125, Qualified Benefit means benefits excludible from an employee's gross income under a specific provision of the Code and must not defer compensation, except as specifically allowed in section 125(d)(2)(B), (C) or (D). Examples of qualified benefits include the following: group-term life insurance on the life of an employee (section 79); or employer-provided accident and health plans. A cafeteria plan may also offer long-term and short-term disability coverage as a qualified benefit (see section 106). See paragraph (q) in Sec. 1.125-1 for nonqualified benefits.

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

"Salary Reduction Agreement" means a voluntary agreement whereby an Employee agrees to reduce his compensation for the forthcoming Plan Year (or, if the agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year) for purposes of obtaining the Medical Insurance Benefits offered by the Plan.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

Section 2

PARTICIPATION IN THE PLAN

2.1 Eligibility to Participate. Each Eligible Employee may elect to participate in the Plan if the Individual satisfies all of the following: (a) is an Employee of a Participating Employer; (b) is working 20 or more hours per week; and (c) has been employed by the Employer for one day. Eligibility shall also be subject to the additional requirements, if any, specified in the Medical Insurance Plan.

Self-employed individuals are not eligible to participate in the Plan. New proposed regulations make clear that:

- sole proprietors,
- partners,
- directors of corporations, and
- 2-percent shareholders of an S corporation

are not employees for purposes of this Plan. (C Corporation owners who are employees and a director of the Corporation are eligible to participate in the Plan in their capacity as an Employee).

2.2 Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by executing a Salary Reduction Agreement under which the Employee agrees to reduce his Compensation for the forthcoming Plan Year (or, if such Salary Reduction Agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year). The Salary Reduction Agreement shall be governed by Section 3 hereof. By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

An Eligible Employee's spouse or dependents can only receive benefits through the Plan if they are named on an Eligible Employee's qualifying policy. Eligible Employee's spouse or dependents can not participate in the Plan independently.

2.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of:

A. the date on which the Plan terminates;
B. the date on which he ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for periods on the terms and subject to the restrictions described in Section 6.4;

C. the first day of any Plan Year for which he has elected not to participate in the Plan;

D. the date on which he revokes his election and elects not to participate in Medical Insurance Benefits, on account of and consistent with a change in family status in accordance with Section 4.3; or

E. the date on which he fails to make a contribution in accordance with Section 3.5.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

Notwithstanding the foregoing, a former Eligible Employee who is absent by reason of sickness, disability, or other authorized leave of absence may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Participating Employer may direct.

2.4 Recommencement of Participation. If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.2. Notwithstanding the above, an election to participate in the Premium Payment Module will be reinstated only to the extent that coverage under the Medical Insurance Plan (here, major medical insurance) is reinstated. If an Employee becomes ineligible for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 2.1 before again becoming eligible to participate in the Plan.

2.5 FMLA Leaves of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical Insurance Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require participants to continue all Medical Insurance Benefit coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are

required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

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

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

If the Employer requires all Participants to continue Medical Insurance Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Medical Insurance Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Medical Insurance Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return

from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

2.6 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 4.4(d) will apply.

2.7 Uniformed Service Under USERRA. A Participant who is absent from employment with the Employer on account of being in "uniformed service", as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period during which he or she is in "uniformed service". The manner in which such payments are made shall be determined by the Plan Administrator, in a manner similar to Section 2.5 (regarding the payment of contributions with respect to FMLA Leave). A Participant whose coverage under the group health insurance plan is terminated on account of his or her being in "uniformed service", and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such group health plan and/or medical savings account, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service".

2.8 Definition of Dependent. Any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (1) a dependent is defined as in Code § 152,

determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) a dependent means any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) a dependent means any child to whom IRS Rev. Proc. 2008-48 applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year), is treated as a dependent of both parents.

The definition of "Dependent" has been revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA). An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer.

The following qualifying criteria now apply to be a "dependent child":

1) The individual has a specific family type relationship to the taxpayer
2) The individual does not provide more than half of his or her own support
3) The individual has the same place of residence as the taxpayer for more than half of the year
4) The individual does not turn age 19 (24 if a full-time student)*, by the end of the Plan Year

In addition, the following qualifying criteria apply to be a "dependent relative":

1) The individual has a specific family type relationship to the taxpayer
2) The individual is not a qualifying child of any other taxpayer
3) The individual receives more than half of his or her support from the taxpayer
4) The individual's annual gross income is less than the Section 151 limit (this criteria does <u>not</u> apply to health plans)

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3)) at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by Employer dependent children may be covered by either spouse, but not by both.

NOTE: the Internal Revenue Service (the "IRS") **Notice 2010-38** (the "**Notice**") provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year. Treasury regulations have been amended retroactively to March 30, 2010, to allow both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid by (or reimbursed

to) the employee for such coverage to be excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. This coverage is provided to such adult child (as defined in Code § 152(f)(1)) regardless of whether the child satisfies the other requirements listed above. The **Notice** provides important guidance and further clarifications with regard to these issues.

Section 3

BENEFITS AND METHODS OF FUNDING

3.1 Benefits Offered. When first eligible or during the Open Enrollment Period as described under Section 2.2, Participants will be given the opportunity to elect Premium Payment Benefits, as described in Section 6. See Schedule A for a complete description of available benefits and refer to specific insurance premium rate sheets for individual maximum elective contribution.

3.2 Premium Payment Benefits. Upon proper election by a Participant in accordance with Section 3.3 herein, there shall be credited to each Participant's Premium Only Account any Premium Payment Benefits that correspond to the Participant's Salary Reduction Agreement determined in accordance with Section 3.3 hereof. Such Premium Payment Benefits shall not exceed the Premium Expense of the Medical Insurance Benefits elected, set forth in Schedule A attached hereto, as it may be revised by the Employer from time to time. The Participant's Premium Payment Benefits shall be credited as and when such sum is redirected from the Participant's compensation pursuant to the Salary Reduction Agreement then in effect. The Premium Payment Benefits shall be used to pay all or part of the Premium Expense of the Medical Insurance Benefits that the Participant has designated pursuant to Section 3.3. The Premium Expense paid on behalf of any Participant shall be a charge to the balance of his Premium Only Account. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

3.3 Election of Benefits. An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits after eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the date in which participation will commence.

Each Eligible Employee shall submit to the Employer, before the close of the Enrollment Period for each Plan Year, or when Employee first becomes eligible, a Salary Reduction Form identifying the Medical Insurance Benefits to be provided by the Employer to or on behalf of the Eligible Employee. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 4.4.

Each election under this Section 3.3 may be modified by the Employer to the extent required to enable the Plan, and payments hereunder, to satisfy the requirements of Section 125 of the Code. If

an Eligible Employee separates from service with a Participating Employer during a period in which he is covered under Medical Insurance Benefits, the Employer may terminate the remaining portion of Medical Insurance Benefits coverage provided by the Plan. Any Participant or newly Eligible Employee who fails to execute an appropriate Salary Reduction Agreement during the Enrollment Period shall be deemed to have elected cash compensation (regular income) to the extent permissible.

3.4 Provision of Benefits. The Participating Employer shall provide the Medical Insurance Benefits the Participant has elected under the Plan. Eligibility for Premium Payment Benefits shall be subject to the additional requirements specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

3.5 Employer and Employee Contributions.

Employer Contributions. For Employees who elect Premium Payment Benefits, the Employer will contribute a portion of the Contributions (if applicable) as provided in the open enrollment materials furnished to Employees and/or on Election Form/Salary Reduction Agreement.

Employee Contributions. Employees who elect any of the Premium Payment Benefits, may pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement, or may pay with after-tax deductions.

If a Participant does not have sufficient Premium Payment Benefits to pay for the Medical Insurance Benefits elected, the Participating Employer is authorized to withhold the additional amounts from a Participant's pay on an after-tax basis to the extent required for said Medical Insurance Benefits.

Participants are required to increase or decrease their payments under the terms of the Plan and as required by the Plan Administrator, if there is an increase or decrease in the premium payments required by an independent, third party provider in order to maintain any Medical Insurance Benefits.

Notwithstanding the foregoing, Medical Insurance Benefits shall cease to be provided to a Participant if said Participant fails to make a contribution required under the terms of the Plan.

3.6 Nondiscrimination. Contributions and benefits under the Plan shall not discriminate in favor of Highly Compensated Employees; nor shall the aggregate cost of the Medical Insurance Benefits provided to Key Employees exceed 25% of the aggregate of such cost for the Medical Insurance Benefits provided to all Employees under the Plan. The Employer may limit or deny any

Employee's Salary Reduction Agreement to the extent necessary to avoid any such discrimination.

3.7 Insurance Contracts. Any dividends or retroactive rates or other refunds which may become payable under any Medical Insurance Benefits due to actuarial error in rate calculation shall be the exclusive property of and shall be retained by a Participating Employer.

3.8 Using Salary Reductions to Make Contributions. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits and for the purposes of this Plan and the Code, are considered to be Employer contributions. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

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

For those Participants who elect to pay their share of the Contributions for any of the Medical Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

3.9 Funding the Plan. All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Section 4

IRREVOCABILITY OF ELECTIONS AND EXCEPTIONS

4.1 Irrevocability of Elections. Except as described in this Article 4, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan;
- Salary Reduction amounts; or
- election of particular Benefit Package Options.

4.2 Procedure for Making New Elections if Exception to Irrevocability Applies.

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 2.1 or during the Open Enrollment Period under Section 2.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.4(d) through 4.4(i), within 30 days after the events described in such Sections, or within 60 days for loss of Medicaid or CHIP coverage or notice of eligibility for a Premium Assistance Subsidy). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 4.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

4.3 Change in Status Defined. A Participant may make a new election upon the occurrence of certain events as described in Section 4.4, including a Change in Status, for the applicable Module. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

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

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; and (4) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents of more than 100 miles.

4.4 Events Permitting Exceptions to Irrevocability Rule for All Benefits. A Participant may change an election as described below upon the occurrence of the stated events for the applicable Module of this Plan:

(a) *Open Enrollment Period* - A Participant may change an election during the Open Enrollment Period in accordance with Section 2.2.

(b) *Termination of Employment* - A Participant's election will terminate under the Plan upon

termination of employment in accordance with Sections 2.3 and 2.4, as applicable.

(c) *Leaves of Absence* - A Participant may change an election under the Plan upon FMLA leave in accordance with Section 2.5 and upon non-FMLA leave in accordance with Section 2.6.

(d) *Change in Status* - A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 2.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a

result of divorce, annulment, or legal separation).

IRS **Notice 2010-38** states that the applicable Treasury Regulations will be amended retroactively to March 30, 2010, to include Change in Status events covering children under age 27 who do not otherwise qualify as dependent children, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

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

(e) *HIPAA Special Enrollment Rights* - If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or
- a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment

attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

- a Participant or their Dependent becomes eligible for a Premium Assistance Subsidy (60 day special enrollment period provided by CHIP Reauthorization Act effective April 1, 2009).
- a Participant or their Dependent loses Medicaid or CHIP coverage (60 day special enrollment period provided by CHIP Reauthorization Act effective April 1, 2009).

(f) *Certain Judgments, Decrees and Orders* - If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid* - If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid, but coverage for the unaffected Participants may not be canceled or reduced. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

(h) *Change in Cost* - For purposes of this Section 4.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are

considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); and (b) Employees who are otherwise eligible under Section 2.1 may elect the Benefit Package Option that has decreased in cost (such as

the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(i) *Change in Coverage* - The definition of "similar coverage" under Section 4.4(h) applies also to this Section 4.4(i).

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

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either

prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 4.4(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

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

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 2.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively

change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (CHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s). Beginning April 1, 2009, employees and dependents are permitted to enroll in the Employer's group health insurance plan within 60 days of the loss of Medicaid or CHIP coverage.

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

A Participant entitled to change an election as described in this Section 4.4 must do so in accordance with the procedures described in Section 4.2.

4.5 Election Modifications Required by Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits

hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section 5

PLAN ADMINISTRATOR

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

5.2 Powers of the Plan Administrator. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit

consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

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

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

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

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

5.7 Bonding. The Plan Administrator shall be bonded to the extent required by ERISA.

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

amounts are less than aggregate Employer contributions toward such insurance.

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

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

Section 6

PREMIUM ONLY PLAN MODULE

6.1 Benefits. The only Medical Insurance Benefits that are offered under the Premium Payment Module are benefits under the Medical Insurance Plan providing major medical benefits and other ancillary benefits outlined in Schedule A. Notwithstanding any other provision in this Plan, the Medical Insurance Benefits outlined in Schedule A are subject to the terms and conditions of the Medical Insurance Plans, and no changes can be made with respect to such Medical Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Module by electing to pay for his or her share of the Contributions for Medical Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Module and to pay for his or her share of the Contributions, if any, for Medical Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Section 4), such election is irrevocable for the duration of the Period of Coverage to which it relates. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

6.2 Contributions for Cost of Coverage. The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Medical Insurance Benefits Provided Under the Medical Insurance Plan. Medical Insurance Benefits will be provided by the Medical Insurance Plan(s), not this Plan. The types and amounts of Medical Insurance Benefits, the requirements for participating in the Medical Insurance Plan, and the other terms and conditions of coverage and benefits of the Medical Insurance Plans are set forth in the Medical Insurance Plans. All claims to receive benefits under the Medical Insurance Plans shall be subject to and governed by the terms and conditions of the Medical Insurance Plan(s) and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical Insurance Benefits and COBRA. Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the

opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical Insurance Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Medical Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Medical Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

Section 7

MISCELLANEOUS

7.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time. The Employer may amend this Plan retroactively to enable the Plan to qualify as a cafeteria plan under section 125 of the Code. No amendment shall deprive any Participant or Beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made; and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their Beneficiaries, except as may be specifically authorized by statute or regulation.

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

7.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated, except as provided pursuant to a Qualified Medical Child Support Order pursuant to Section 609 of ERISA and Section 7.4 hereof.

7.4 Facility of Payment. If the Employer deems any person incapable of receiving benefits to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by a Participating Employer to disburse it, whose receipt shall be a complete acquittance therefore. Such payments shall, to the extent thereof, discharge all liability of the Participating Employer.

7.5 Proof of Claim. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Plan Administrator may require either directly to the Plan Administrator or to any person delegated by him/her.

7.6 Status of Benefits. The Employer believes that this Plan is in compliance with section 125 of the Code and that it provides certain benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be

available. Any Participant, by accepting benefits under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

7.7 Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Kentucky to the extent not preempted by any federal law.

7.8 Source of Benefits. The Participating Employer and any insurance company contracts purchased or held by a Participating Employer shall be the sole sources of benefits under the Plan. No Employee or Beneficiary shall have any right to, or interest in, any assets of the Participating Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or Beneficiary.

7.9 No Reversion to Employer. At no time shall any part of Plan assets be used for, or diverted to, purposes other than the exclusive benefit of Participants or their Beneficiaries, or for defraying reasonable expenses of administering the Plan.

7.10 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

7.11 Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and Beneficiary.

7.12 Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

7.13 Information to be Furnished. Participants shall provide the Employer and/or Participating Employer with such information and shall complete and sign such forms and documents, as may reasonably be requested from time to time for the Purpose of administration of the Plan.

Executed August 1, 2024

ROMAN CATHOLIC DIOCESE OF OWENSBORO

By: _____ Witness: _____

Raymond Purk

ROMAN CATHOLIC DIOCESE OF OWENSBORO

Schedule A

MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN*:

NAME OF COVERAGE

Group Health Insurance
Dental Insurance
Vision Insurance
Group Term Life Insurance (Employee Only)
Disability Income-Short Term (STD)
Disability Income-Long Term (LTD)
Cancer Insurance
Intensive Care Insurance
Accident Insurance

*The Employee contributions necessary to obtain the coverage options set forth in this Schedule A above will be communicated by the Employer to Eligible Employees at the time of Enrollment and in Schedule B. The required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option above. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

ROMAN CATHOLIC DIOCESE OF OWENSBORO

Schedule B

FORMULA FOR EMPLOYEE CONTRIBUTIONS UNDER THE PLAN

The following description of the Employee Contribution per Participant may be expressed as a percentage of monthly cost, or as a flat monthly dollar amount. If the formula for Employee contributions varies by class of Employees, the Employer Sponsor assumes full responsibility for its Employer contribution design.*

Name of Benefit Plans To Be Offered		Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%

*An asterisk in the premium column means there are multiple rates based on age, sex, or other demographics. Please refer to specific insurance carrier premium rate sheets for individual maximum elective contribution.

In no event shall the existence of any Employer contributions for monthly premium costs, as indicated above, be construed to require the Employer to pay or otherwise be liable for any deductible, coinsurance, co-payment or other cost-sharing amounts related to the applicable medical care coverage option elected by the Participant.

ER = Employer Contribution
EE = Employee Contribution

ROMAN CATHOLIC DIOCESE OF OWENSBORO

Schedule C

PARTICIPATING AFFILIATED EMPLOYERS

(Companies under common ownership)

The following organizations and entities shall be Participating Employers under the Plan:

Name of Participating Employer

None

SECTION 3

SECTION 125 HEALTH FSA PLAN DOCUMENT

PLACE ALL PAGES OF THE PLAN DOCUMENT AFTER TAB 3

AUTHORIZED SIGNER SHOULD EXECUTE THE SIGNATURE PAGE AT THE END OF THE PLAN DOCUMENT

2024 | HEALTH FSA
PLAN DOCUMENT

Core Documents

ROMAN CATHOLIC DIOCESE OF OWENSBORO
HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

PURPOSE

The Roman Catholic Diocese of Owensboro Health FSA (the "Plan"), adopted by Roman Catholic Diocese of Owensboro effective January 1, 2018 is herein amended and restated effective August 1, 2024. The purpose of the Plan is to help provide full and complete medical care for Participants and their Dependents, as defined herein. The Plan is intended to provide reimbursement of medical and hospitalization expenses that exceed the deductible or co-payment limits of any insurance policies covering such costs or which are otherwise not covered by insurance or provided by Roman Catholic Diocese of Owensboro. Roman Catholic Diocese of Owensboro intends that the Plan qualify as an accident and health plan within the meaning of Section 105(e) of the Internal Revenue Code (the "Code"), and Tax Regulation (26 CFR Part 1 from 08-06-07), and that the benefits provided under the Plan be eligible for exclusion from the Participant's income for Federal Income Tax purposes under Section 105(b) of the Code.

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Section 1

DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following rules of interpretation shall apply in reading this instrument:

"Account(s)" means the Health FSA Accounts described in Section 6.5.

"Benefits" means the Health FSA Benefits offered under the Plan.

"Change in Status" has the meaning described in Section 4.3.

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

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

"Contributions" means the amount contributed to pay for the cost of Benefits.

"Committee" means the Benefits Committee appointed by Roman Catholic Diocese of Owensboro.

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

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (1) a dependent is defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child to whom IRS Rev. Proc. 2008-48 applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year), is treated as a dependent of both parents. Notwithstanding the foregoing, the Health FSA Module will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are

includible in gross income for the taxable year.

"Effective Date" means January 1, 2018; amended and restated August 1, 2024.

"Election Form/Salary Reduction Agreement" means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for Health FSA Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 2.1.

"Employee" means an individual that the Employer classifies as a common-law employee, leased employee, or full time life insurance salesmen, and who is on the Employer's W-2 payroll, but does not include the following: (a) individual's classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employee-Only Health FSA Option" has the meaning described in Section 6.3.

"Employer" means Roman Catholic Diocese of Owensboro and any Related Employer that adopts this Plan with the approval of Roman Catholic Diocese of Owensboro.

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

"Entry Date" means the first day of the month following date of hire as an Eligible Employee.

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

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

"General-Purpose Health FSA Option" has the meaning described in Section 6.3.

"Health FSA" means health flexible spending arrangement consisting of the Health FSA Option.

"Health FSA Account" means the account described in Section 6.5.

"Health FSA Benefits" has the meaning described in Section 6.1.

"Health FSA Module" means the Module of this Plan described in Section 6.

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

"Medical Care Expenses" has the meaning defined in Section 6.3.

"Open Enrollment Period" with respect to a Plan Year means the month preceding the beginning of a Plan Year, or such other period as may be prescribed by the Administrator.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Section 2.1. Participants include (a) those who elect Health FSA Benefits and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions on a post-tax basis.

"Participating Employer" means Roman Catholic Diocese of Owensboro and any Affiliated Company that adopts this Plan with the consent of the Employer. As of the Effective Date, the Employer is the only Participating Employer.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 2.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 2.3.

"Plan" means the Roman Catholic Diocese of Owensboro Salary Reduction Plan as set forth herein and as amended from time to time.

"Plan Administrator" means Roman Catholic Diocese of Owensboro. The contact person is Raymond Purk for Roman Catholic Diocese of Owensboro, who has the full authority to act on behalf of the Plan Administrator.

"Plan Year" means the 12-month period commencing January 1 and ending on December 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

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

"Related Employer" means any employer affiliated with Roman Catholic Diocese of Owensboro that, under Code § 414(b), § 414(c), or § 414(m), is treated as a single employer with Roman Catholic Diocese of Owensboro for purposes of Code § 125(g)(4).

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Module, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

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

Section 2

PARTICIPATION IN THE PLAN

2.1 Eligibility to Participate. Each Eligible Employee may elect to participate in the Plan if the Individual satisfies all of the following: (a) is an Employee; (b) is working 20 or more hours per week; and (c) has been employed by the Employer for one day.

Self-employed individuals are not eligible to participate in the Plan. New proposed regulations make clear that:

- sole proprietors,
- partners,
- directors of corporations, and
- 2-percent shareholders of an S corporation

are not employees for purposes of this Plan. (C Corporation owners who are employees and a director of the Corporation are eligible to participate in the Plan in their capacity as an Employee).

2.2 Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by executing a Salary Reduction Agreement under which the Employee agrees to reduce his Compensation for the forthcoming Plan Year (or, if such Salary Reduction Agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year). The Salary Reduction Agreement shall be governed by Section 3 hereof. By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

An Eligible Employee's spouse or dependents can not participate in the Plan independently.

2.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of:

A. the date on which the Plan terminates;
B. the date on which he ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for periods on the terms and subject to the restrictions described in Section 6.8;
C. the first day of any Plan Year for which he has elected not to participate in the Plan;
D. the date on which he revokes his election and elects not to participate in an Health FSA, on account of and consistent with a change in family status in accordance with Section 4.3; or
E. the date on which he fails to make a contribution in accordance with Section 3.3

Termination of participation in this Plan will automatically revoke the Participant's elections.

Notwithstanding the foregoing, a former Eligible Employee who is absent by reason of sickness, disability, or other authorized leave of absence may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Participating Employer may direct.

2.4 Recommencement of Participation. If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.2. If an Employee loses coverage for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 2.1 before again becoming eligible to participate in the Plan.

2.5 FMLA Leaves of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions. An Employer may require participants to continue Health FSA Benefit coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

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

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing

Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

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

2.6 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 4.4(c) will apply.

2.7 Uniformed Service Under USERRA. A Participant who is absent from employment with the Employer on account of being in "uniformed service", as that term is defined by the

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period during which he or she is in "uniformed service". The manner in which such payments are made shall be determined by the Plan Administrator, in a manner similar to Section 2.5 (regarding the payment of contributions with respect to FMLA Leave).

2.8 Definition of "Dependent" revised by the WFTRA of 2005. The definition of "Dependent" has been revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA), effective January 1, 2005. An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer.

The following qualifying criteria now apply to be a "dependent child":

1) The individual has a specific family type relationship to the taxpayer
2) The individual does not provide more than half of his or her own support
3) The individual has the same place of residence as the taxpayer for more than half of the year
4) The individual does not turn age 19 (24 if a full-time student)*, by the end of the Plan Year

In addition, the following qualifying criteria apply to be a "dependent relative":

1) The individual has a specific family type relationship to the taxpayer
2) The individual is not a qualifying child of any other taxpayer
3) The individual receives more than half of his or her support from the taxpayer
4) The individual's annual gross income is less than the Section 151 limit (this criteria does <u>not</u> apply to health plans)

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3)) at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by Employer dependent children may be covered by either spouse, but not by both.

NOTE: the Internal Revenue Service (the "IRS") **Notice 2010-38** (the "**Notice**") provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year. Treasury

regulations have been amended retroactively to March 30, 2010, both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid (or reimbursed) to the employee for such coverage are excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. The **Notice** provides important guidance and further clarifications with regard to these issues.

Section 3

BENEFITS AND METHODS OF FUNDING

3.1 Benefits Offered. When first eligible or during the Open Enrollment Period as described under Section 2.2, Participants will be given the opportunity to elect Health FSA Benefits, as described in Section 6. See Schedule A for a complete description of benefits.

3.2 Health FSA Benefits. Upon proper election by a Participant in accordance with Section 3.2 herein, there shall be credited to each Participant's Health FSA Account any Benefit Credits that correspond to the Participant's Salary Reduction Agreement determined in accordance with Section 3.3 hereof. Such Health FSA Benefits shall not exceed the maximum amount allowable, set forth in Schedule A attached hereto, as it may be revised by the Employer from time to time. The Participant's Health FSA Benefits shall be credited as and when such sum is redirected from the Participant's compensation pursuant to the Salary Reduction Agreement then in effect. The Health FSA Benefits shall be used to pay all or part of the Health FSA Benefits that the Participant has designated pursuant to Section 3.3. The Health FSA Benefits paid on behalf of any Participant shall be a charge to the balance of his or her Health FSA Account.

3.3 Election of Benefits. Each Eligible Employee shall submit to the Employer, before the close of the Enrollment Period for each Plan Year, or when Employee first becomes eligible, a Salary Reduction Agreement identifying the Health FSA Benefits to be provided by the Employer to or on behalf of the Eligible Employee. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 4.4.

Each election under this Section 3.3 may be modified by the Employer to the extent required to enable the Plan, and payments hereunder, to satisfy the requirements of Section 125 of the Code. If an Eligible Employee separates from service with a Participating Employer during a period in which he is covered under a Health FSA, the Employer may terminate the remaining portion of Health FSA coverage provided by the Plan. Any Participant or newly Eligible Employee who fails to execute an appropriate Salary Reduction Agreement during the Enrollment Period shall be deemed to have elected cash compensation to the extent permissible.

3.4 Nondiscrimination. Contributions and benefits under the Plan shall not discriminate in favor of Highly Compensated Employees; nor shall the aggregate cost of the Health FSA provided to Key Employees exceed 25% of the aggregate of such cost for the Health FSA provided to all Employees

under the Plan. The Employer may limit or deny any Employee's Salary Reduction Agreement to the extent necessary to avoid any such discrimination.

3.5 Funding the Plan. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions for Health FSA Benefits, as described in Section 6.2.

3.6 Employer and Employee Contributions.

Employer Contributions. For Employees who elect Health FSA Benefits, the Employer will contribute a portion of the Contributions (if applicable) as provided in the open enrollment materials furnished to Employees and/or on Election Form/Salary Reduction Agreement.

Employee Contributions. Employees who elect any of the Health FSA Benefits, may pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement, or may pay with after-tax deductions.

Notwithstanding the foregoing, Health FSA Benefits shall cease to be provided to a Participant if said Participant fails to make a contribution required under the terms of the Plan.

Section 4

IRREVOCABILITY OF ELECTIONS AND EXCEPTIONS

4.1 Irrevocability of Elections. Except as described in this Article 4, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- Participation in this Plan;
- Salary Reduction amounts; or
- Election of particular Benefit Package Options.

4.2 Procedure for Making New Election If Exception to Irrevocability Applies.

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 2.1 or during the Open Enrollment Period under Section 2.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.4(d) through 4.4(f), within 30 days after the events described in such Sections). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Health FSA Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 4.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed).

4.3 Change in Status Defined. A Participant may make a new election upon the occurrence of certain events as described in Section 4.4, including a Change in Status, for the applicable Module. "Change in Status" means any of the events described below, as well as any other events included

under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

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

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; and (4) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents of more than 100 miles.

4.4 Events Permitting Exception to Irrevocability Rule for All Benefits. A Participant may change an election as described below upon the occurrence of the stated events for the Health FSA Module of this Plan:

(a) *Open Enrollment Period* - A Participant may change an election during the Open Enrollment Period in accordance with Section 2.2.

(b) *Termination of Employment* - A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 2.3 and 2.4, as applicable.

(c) *Leaves of Absence* - A Participant may change an election under the Plan upon FMLA leave in accordance with Section 2.5 and upon non-FMLA leave in accordance with Section 2.6.

(d) *Change in Status* - A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

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

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in

Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 2.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

IRS Notice 2010-38 states that the applicable Treasury Regulations will be amended retroactively to March 30, 2010, to include Change in Status events covering children under age 27 who do not otherwise qualify as dependent children, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

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

(e) *Certain Judgments, Decrees and Orders* - If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(f) *Medicare and Medicaid* - If a Participant or his or her Spouse or Dependent who is

enrolled in a Health FSA under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively cancel the Participant's Health FSA coverage (but not reduce coverage). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

A Participant entitled to change an election as described in this Section 4.4 must do so in accordance with the procedures described in Section 4.2.

4.5 Election Modifications Required by Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section 5

PLAN ADMINISTRATOR

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

5.2 Powers of the Plan Administrator. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit

consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

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

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

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

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

5.7 Bonding. The Plan Administrator shall be bonded to the extent required by ERISA.

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

payment first became due.

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

Section 6

HEALTH FSA MODULE

6.1 Health FSA Benefits. An Eligible Employee can elect to participate in the Health FSA Module by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Section 4), such election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 Contributions for Cost of Coverage of Health FSA Benefits. The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $3,000.00 annual benefit amount is elected, then the annual Contribution amount is also $3,000.00).

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

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

(b) *Medical Care Expenses.* "Medical Care Expenses" will vary depending on which Health FSA coverage option the Participant has elected.

- *General-Purpose Health FSA Option.* For purposes of this Option, "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under Schedule B to this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Section 6.
- *Limited (Vision/Dental/Preventive Care) & Post Deductible Health FSA Option.* For purposes of this combined Option, "Medical Care Expenses" means expenses incurred

by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that such expense is for vision care, dental care, or preventive care (as defined in Code § 223(c)) only, and provided that this term does not include expenses that are excluded under Schedule B to this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Section 6. This option also allows a Participant or his or her Spouse or Dependents to exercise a *Post-Deductible Health FSA option* for Employee participating in an HSA qualified high deductible insurance plan to be reimbursed for medical care expenses, as defined in Code 213(d) after the minimum qualified HSA high deductible is satisfied. HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected.

- *Employee-Only Health FSA Option.* For purposes of this Option, "Medical Care Expenses" means expenses incurred by a Participant (but not by his or her Dependent or Spouse) for medical care as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under Schedule B to this Plan, nor any expenses for which the Participant is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Section 6.

6.4 Maximum and Minimum Benefits for Health FSA.

(a) *Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual

amounts credited to the Participant's Health FSA Account pursuant to Section 6.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 6.8. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section 6 have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $3,000.00, subject to Section 6.5(c) *(effective January 1, 2024, the maximum annual benefit shall not exceed $3,200.00).* The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $10.00 per month, or $120 annually. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Module mid-year or wishes to increase his or her election mid-year as permitted under Section 4.4, then there will be no proration rule - i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Section 4 (other than under Section 4.4(c) for FMLA leave) that increases contributions to the Health FSA Module also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of

such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 4.4(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) *Monthly Limits on Reimbursing OTC Medical Care Items.* Only reasonable quantities of over-the-counter (OTC) medical care items of the same kind may be reimbursed from a Participant's Health FSA Account in a single calendar month; stockpiling is not permitted.

6.5 Establishment of Health FSA Account. The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant who has elected to participate in the Health FSA Module, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 6.6.

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

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

(c) *Available Amount Not Based on Credited Amount.* As described in Section 6.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements during the Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Period of Coverage, the absolute amount of which would not exceed the maximum dollar amount elected by the Participant under this Plan.

6.6 Forfeiture of Health FSA Accounts; Use-It-or-Lose-It Rule. If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making

reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Module during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above. Notwithstanding the above, the Employer has amended the Plan to permit a carryover of up to $610.00 of a Participant's unused FSA account balance to the following Plan Year.

6.7 Reimbursement Claims Procedure for Health FSA.

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

(b) *Claims Substantiation.* An independent third party designated as the PHI Officer will substantiate all claims (see Section 7.4 for PHI Officer designee list). A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the PHI Officer in such form as the Plan Administrator may prescribe, by no later than the 90 days following the close of the Plan Year in which the Medical Care Expense was incurred (except for a Participant who ceases to be eligible to participate, this must be done no later than 90 days after the date that eligibility ceases, as described in Section 6.8) setting forth:

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

- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- as of January 1, 2011, a prescription from the Participant's physician for any OTC drugs and medicines (e.g., Advil, ibuprofen, cough syrup); and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the PHI Officer may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $10. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with IRS guidance.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Section 6.11.

6.8 Reimbursements from Health FSA after Termination of Participation; COBRA. When a Participant ceases to be a Participant under Section 2.3, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under

the Health FSA Module because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Module the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 6.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Module will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

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

6.9 Named Fiduciary for Health FSA. The Employer is the named fiduciary for the Health FSA Module for purposes of ERISA § 402(a).

6.10 Coordination of Benefits with HSA, HRA, etc. Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan. Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, the Participant may choose to seek reimbursement from

either the health FSA or the HSA, but not both. (If the Employer ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the Health FSA must pay first).

6.11 Procedure If Benefits Are Denied Under This Plan. Claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. If a claim for a benefit under the Plan is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to appeal the denial. The rules regarding denied claims for benefits under the Health Expense FSA are set forth, according to ERISA guidelines, in the **Questions and Answers** section of the SPD. The Committee acts on behalf of the Plan Administrator with respect to appeals.

6.12 Advance Orthodontia Payments. Advance payments for orthodontia are permitted if the Participant actually makes payments in advance of the orthodontia services in order to receive the services.

6.13 Debit Cards ***(if applicable).*** New proposed regulations incorporate previous guidance on the use of a debit card to pay, substantiate and reimburse qualified expenses.

- Before a Participant receives a health FSA debit card he/she must agree in writing to the following:
  - That the debit card will only be used to pay for medical expenses (as defined by section 213(d)) of the employee, spouse and/or dependent;
  - That the debit card will not be used for expenses that have already been reimbursed;
  - That he/she will not seek reimbursement under any other health plan for any expense paid with the debit card; and
  - That he/she will acquire and retain sufficient documentation to substantiate any expense paid with the debit card.
- The debit card must contain a statement providing that the above provisions have been agreed to in writing, and are reaffirmed each time the employee uses the card.
- The amount available must equal the employee's annual election (uniform coverage rule applies), and is reduced by amounts paid or reimbursed for medical expenses incurred during the year.
- The card will be automatically cancelled when the employee ceases participation in the Plan.
- The Plan Administrator limits the use of the debit card to:
  - Medical Care Providers (physicians, dentists, hospitals, etc.);
  - Stores with merchant category codes (MCC) for drugstores and pharmacies if such stores

meets the 90% gross receipts test for items that qualify as section 213(d) expenses; and

– Stores that have implemented the inventory information approval system (IIAS).

Please Note: Plan Administrators may limit the use of the debit card to IIAS Merchants to avoid debit card use for ineligible OTC items and may limit debit card use to certain types of expenses to be consistent with the HRA benefit.

• The employer substantiates claims in compliance with the regulations.

• The Plan Administrator will follow proper correction procedures for improper payments as outlined in IRS proposed regulations.

New regulations permit substantiation for expenses that are copay matches (exact multiples of five or fewer), recurring expenses and real-time substantiation. The proposed regulations permit point-of-sale substantiation when the inventory information approval system matches the expense with a list of § 213(d) expenses. The Plan Administrator is responsible to ensure that the inventory information approval system meets the requirements of the new regulations.

Section 7

HEALTH FSA - HIPAA PROVISIONS

7.1 Compliance with HIPAA. This Section 7 shall be interpreted in a manner that permits the Plan to comply with HIPAA and other federal and state laws regarding protection of PHI with respect to the Health FSA.

7.2 Use of Protected Health Information (PHI). The Health FSA will use and disclose protected health information (PHI), as defined in 45 CFR § 160.103, to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Health FSA will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations as defined in the Health FSA HIPAA Privacy Notice (as defined in 45 CFR § 164.520) distributed to Participants and as otherwise permitted by the HIPAA privacy rules.

The Health FSA will disclose PHI, other than enrollment and disenrollment information, summary health information, and information disclosed pursuant to an authorization, to the Employer only upon receipt of a certification from the Employer that the Health FSA plan document has been amended to incorporate the provisions in Section 7.3 and that the Employer agrees to certain conditions regarding the use and disclosure of PHI and the adequate separation between the Health FSA and the Employer and Related Employers.

7.3 Employer's Obligations With Respect to PHI. With respect to PHI, the Employer agrees to certain conditions. The Employer agrees to:

- not use or disclose PHI other than as permitted or required by the Plan document or as required by law;
- ensure that any agents (including a subcontractor) to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;
- report to the Plan any PHI use or disclosure inconsistent with the uses or disclosures provided for in this Section 7 of which it becomes aware;

- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

7.4 Access to PHI Within Employer. Adequate separation will be maintained between the Plan and the Employer. Only the following independent third party individuals or classes of employees shall have access to PHI and may use and disclose PHI: the Vice President of Human Resources; the Benefits Manager; assistants to the Vice President of Human Resources and the Benefits Manager; Human Resources and payroll staff performing Health FSA functions; the Benefits Committee; the Plan Administrator; and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Plan (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). If the persons described herein or any other employees do not comply with the Plan document, then the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Employer shall cooperate with the Plan to correct and mitigate any such noncompliance.

7.5 Privacy Official. The Privacy Official shall be responsible for compliance with the Health FSA's obligations under this Section 7 and HIPAA. Specific rules regarding the Privacy Official follow:

a. *Appointment, Resignation and Removal of Privacy Official*. The Employer shall appoint one or more individuals to act as Privacy Official on matters regarding the Health FSA. The individual appointed as Privacy Official may resign by giving 30 days notice in writing to the Employer. The Employer shall have the power to remove that individual for any or no reason.

b. *Policies and Procedures*. The Privacy Official and the Plan Administrator shall from time to time formulate such policies and procedures as they deem necessary for the Health FSA's compliance with this Article and HIPAA. No policy or procedure, however, shall amend any substantive provision of the Health FSA.

c. *Privacy Notice*. The Privacy Official shall be responsible for arranging with the Employer, the Plan Administrator, and any third-party administrator for the issuance of, and any changes to, the Privacy Notice under the Health FSA.

d. *Complaint Contact Person.* The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this Article and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the Health FSA HIPAA Privacy Notice.

7.6 HIPAA Security Rule. The Employer, as the Plan sponsor, shall comply with the plan document requirements of the HIPAA security regulations found at 45 CFR § 164.314(b).

a. *Electronic Protected Health Information*. "Electronic Protected Health Information" shall mean individually identifiable health information that is transmitted by electronic media or maintained in electronic media by the Plan.

b. *Employer Agreement.* The Employer agrees to:

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transits on behalf of the Plan.

(ii) Ensure that the adequate separation between the Plan and the Employer as required by the Privacy Rule is supported by reasonable and appropriate security measures.

(iii) Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Heath Information agrees to implement reasonable and appropriate security measures to protect such Electronic Protected Health Information; and

(iv) Report to the Plan Administrator any security incident of which it becomes aware.

Section 8

MISCELLANEOUS

8.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time. The Employer may amend or modify this Plan retroactively to enable the Plan to provide non-taxable medical expense reimbursement benefits under section 105 of the Code. No amendment shall deprive any Participant or beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their beneficiaries, except as may be specifically authorized by statute or regulation.

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

8.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated, except as provided pursuant to a Qualified Medical Child Support Order pursuant to Section 609 of ERISA.

8.4 Facility of Payment. If the Employer deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be complete acquittance therefore. Such payments shall, to the extent thereof, discharge all liability of the Employer.

8.5 Proof of Claim. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Employer may require (either directly to the Employer or to any person delegated by it).

8.6 Status of Benefits. The Employer believes that this Plan is written in accordance with section 105 of the Code and that it provides certain benefits to Employees which are free from Federal income tax under the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be available. Any

Participant, by accepting a benefit under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

8.7 Code and ERISA Compliance. It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all regulations issued thereunder. (ERISA applies to the Medical Insurance Plan and the Health FSA Module but not to the HSA Module) This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

8.8 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

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

8.10 Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Kentucky to the extent not pre-empted by any federal law.

8.11 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

8.12 Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

8.13 Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

8.14 Gender and Form. Unless the context clearly indicates otherwise, pronouns shall be interpreted so that the masculine pronoun shall include the feminine, and the singular shall include the plural.

8.15 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

8.16 Terms. The primary meaning of terms set forth in this Plan shall be as defined in Section 1 (Definitions).

8.17 Source of Payments. The Employer shall be the sole source of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Company upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or beneficiary.

Executed August 1, 2024.

ROMAN CATHOLIC DIOCESE OF OWENSBORO

By: _____ Witness: _____
Raymond Purk

ROMAN CATHOLIC DIOCESE OF OWENSBORO

SCHEDULE A

HEALTH FSA EMPLOYEE CONTRIBUTION LIMITATIONS

	Minimum*	Maximum*
HEALTH FLEXIBLE SPENDING ACCOUNT	**$10.00**	**$250.00**

*Monthly, based on a 12 month Plan Year; Health FSA annual maximum is $3,000.00

A list of qualifying Health Flexible Spending Account expenses is available at: www.coredocuments.com/expenses.php.

ROMAN CATHOLIC DIOCESE OF OWENSBORO

SCHEDULE B

HEALTH FSA EXCLUSIONS
MEDICAL EXPENSES NOT REIMBURSEABLE

The Roman Catholic Diocese of Owensboro Health FSA Plan document contains the general rules governing what expenses are reimbursable. This Schedule B, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA—that is, expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under the regulations governing Health FSAs.

This Schedule B does not apply to HSAs. As described in the Plan, terms and conditions of coverage and benefits under the HSA (including eligible medical expenses and exclusions) will be provided by and are set forth in the HSA, not this Plan.

Exclusions: *The following expenses are not reimbursable from the Health FSA*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs:

• Dual purpose products, items for general well-being, or items not typically medically necessary (such as <u>Acupuncture,</u> <u>Supplements,</u> <u>Vitamins,</u> <u>Massage Therapy,</u> <u>Dermatology Products,</u> and <u>Weight Loss Programs</u>) are excluded from reimbursement unless accompanied by a letter of medical necessity. The letter of medical necessity must be from a Physician and must include a diagnosis, duration of treatment, and description of treatment plan. • Health insurance premiums for any other plan (including a plan sponsored by the Employer). • Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. • Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework). • Long-term care services.	• Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods. • Social activities, such as dance lessons (even if recommended by a physician for general health improvement). • Bottled water. • Cosmetics, toiletries, toothpaste, etc. • Uniforms or special clothing, such as maternity clothing. • Automobile insurance premiums. • Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician. • Any item that does not constitute "medical care" as defined under Code § 213(d). • Any item that is not reimbursable under Code § 213(d) due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations. • The salary expense of a nurse to care for a healthy newborn at home. • Custodial care. • Funeral and burial expenses.

SECTION 4

SUMMARY PLAN DESCRIPTION (SPD)

PLACE ALL PAGES OF THE SUMMARY PLAN DESCRIPTION AFTER TAB 4

COMPLETE SCHEDULES A, B AND C AND DISTRIBUTE SPD TO ALL EMPLOYEES

ROMAN CATHOLIC DIOCESE OF OWENSBORO
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION
WITH
SECTION 125 FLEXIBLE BENEFITS PLAN

PLAN PURPOSE

The Roman Catholic Diocese of Owensboro Flexible Benefits Plan is a benefit program that allows you to use pre-tax benefit dollars through payroll deduction to pay for insurance premium(s) and unreimbursed medical expenses. Section 125 of the Internal Revenue Code permits Roman Catholic Diocese of Owensboro to offer you the opportunity to participate in designing your own personalized benefit plan on a tax-favored (pretax) basis. This Summary does not describe every detail of the Flexible Benefits Plan. If there is a conflict between the Plan Document and the Summary, the Plan Documents will control.

WHO IS ELIGIBLE TO ENROLL IN THE PLAN

If you are an employee regularly scheduled to work 20 or more hours per week for Roman Catholic Diocese of Owensboro ("Employer"), or any affiliate of the Employer which adopts the Plan ("Participating Employer"), then you are eligible to participate in the Plan.

For purposes of the Premium Only Module your spouse or dependent(s) can only receive benefits through the Plan if they are named on your qualifying policy. Your spouse or dependent(s) can not participate in the Plan independently.

Self-employed individuals are not eligible to participate in the Plan, however C Corporation owners who are also W2 employees can participate.

HOW TO ENROLL

After you become eligible, you must select which benefits you would like to purchase through the Plan. Your decision must be made during the month preceding the Plan Year for which it will be in effect. Each year, Roman Catholic Diocese of Owensboro will provide you with a written election form that will enable you to identify the benefits in which you wish to participate and the portion of your salary reduction that may be applied to provide each benefit.

If for some reason, as a newly eligible Employee, you fail to complete an election form, then you will be deemed to have elected cash compensation to the extent permissible (your normal paycheck

will not be voluntarily reduced). If you are already a Plan participant and you fail to complete an election form for the upcoming Plan Year, then you will be able to maintain the medical and dental benefit options, if any, that you elected for the prior year, but will not be eligible to participate in the Health Flexible Spending Account (FSA).

You may build a completely new plan each year. Keep in mind that your choices are in effect for the entire Plan Year. Generally, you cannot change the elections you have made after the beginning of the Plan Year.

If, for any reason, you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pretax payment of premiums until the next Plan Year.

WHEN YOU ARE ELIGIBLE TO ENROLL

You may enroll in the Plan effective on the first day of the month following date of hire as an Eligible Employee.

SCHEDULE OF FLEXIBLE BENEFITS

Benefits may be purchased through the Flexible Benefits Plan with pretax income. Details relative to the cost per pay period for each benefit and the minimum and maximum amounts you may contribute to the Spending Accounts are provided by Roman Catholic Diocese of Owensboro on the enrollment form and outlined in Schedule B and Schedule D of this Summary Plan Description.

The benefits from which you may choose include:

- medical plan(s) outlined in Premium Election Form
- a Health Flexible Spending Account (Health FSA)

Each benefit under the Flexible Benefits Plan has separate rules governing benefits and plan administration. These rules are explained in more detail in the plan documents that have been prepared solely for the purpose of each particular benefit. A copy of all this information is available from Raymond Purk at Roman Catholic Diocese of Owensboro.

OPTIONAL BENEFITS

Briefly, the Optional Benefits from which you may choose are as follows:

1. **Health Insurance Plan(s)**

You may purchase the above coverage for yourself and your family through the Flexible Benefits Plan. You may pay for this coverage using pretax dollars that are automatically deducted per pay period. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

2. Health Flexible Spending Account (FSAs)

There are some expenses you know you'll have to pay for in the coming year; for instance, new eyeglasses, and possibly medical and dental care expenses not covered by the health plan. Normally you'd pay for expenses like these with after-tax income. And, because taxes reduce the value of your dollar, you'd have to earn considerably more than $100 to pay for $100 of expenses.

If you are eligible to participate, the Roman Catholic Diocese of Owensboro Flexible Benefits Plan allows you to contribute pretax income to create a special account in order to reimburse yourself on a pretax basis for payment of certain medical expenses. It's like getting a discount on these bills since you don't have to earn as much money to pay for them. The money you contribute to a spending account by automatic payroll deduction is not subject to federal or Social Security taxes but, depending on your residence, may be subject to state and local income taxes.

How Health FSAs Work

You may establish an FSA spending account to reimburse predictable out-of-pocket medical care expenses. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, a portion of that amount may be paid for with pretax pay, deposited on a period basis to the spending account. The minimum amount you may defer is $120.00 per Plan Year. The maximum pretax deferral for the Health FSA is outlined in Schedule D attached to this Summary. The Internal Revenue Code Section 125 states that this balance cannot be used for purposes other than for which they were originally intended.

To receive reimbursement, you must complete a claim form and submit it along with your paid bills to the Benefits Administrator of Roman Catholic Diocese of Owensboro or the designated claims administration representative. Once the claims administrator receives the claims all claims will be processed for reimbursement on a monthly basis. Upon submission of a claim to your Health FSA, you will be reimbursed the full amount of your eligible expenses up to your elected Health FSA pretax deferral amount. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), you will be required to comply with substantiation procedures established by your Plan Administrator in accordance with IRS guidance. You must

acquire and retain sufficient documentation to substantiate any expense paid with the debit card.

Under the Health FSA category are expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary," with substantiated claims and allowable as deductions under Code Section 213. Covered expenses do not include premiums paid for other health plan coverage, including plans maintained by the employer of your spouse or dependents, or expenses for non-reconstructive cosmetic surgery; nor do they include expenses for personal mileage. More detailed information about what is eligible and what is not eligible for reimbursement will be provided later in this Summary.

You must determine before the Plan Year starts how much you will possibly spend in out-of-pocket medical expenses. One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs, because the tax law requires unused amounts in your spending accounts to be forfeited at the end of each Plan Year.

Flexible Spending Accounts - Other Facts to Consider

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on flexible spending accounts:

- Salary redirection authorized for medical care expense reimbursement is in effect for the entire year unless you have a change in status such as those listed under "How To Enroll" and "Election Changes" in this Summary Plan Description.
- You must use all of the funds in your spending accounts by the end of the Plan Year or you will lose them; the balances cannot be combined, carried over into the next year, or converted to cash. So, if you choose to open a Health FSA, it is wise to be conservative in your estimate of future reimbursable expenses. Your has amended the Health FSA Plan to permit up to $610.00 of unused funds from a prior Plan Year to carryover to the next Plan Year.
- You may request statements periodically to remind you how much money is left in your account. This money must be used for expenses incurred before the end of the Plan Year or be forfeited. You may continue to submit claims up to three months after the Plan Year ends for prior year's expenses. Employees who terminate employment during the Plan Year will be given three months from their date of termination in which to submit expenses incurred prior to their termination.

HEALTH FSA OPTIONS AND COORDINATION WITH HSA PLANS

You may receive reimbursements for Medical Care Expenses incurred during the Period of Coverage for which an election is in force under one of the following options:

- *General-Purpose Health FSA Option*. For purposes of this Option, "Medical Care Expenses" means expenses incurred by you or your Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under Schedule D to this Summary, nor any expenses for which you or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan.
- *Limited (Vision/Dental/Preventive Care) or Post Deductible Health FSA Option*. This is the only Health FSA option available to employees participating in a Health Savings Account. For purposes of this Option, "Medical Care Expenses" means expenses incurred by you or your Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that such expense is for vision care, dental care, or preventive care (as defined in Code § 223(c)) only, and provided that this term does not include expenses that are excluded under Schedule D to this Summary, nor any expenses for which you or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan. Once the HSA Plan deductible has been met "Medical Care Expenses" shall mean post deductible expenses incurred by you or your Spouse or Dependents for medical care as defined in Code § 213(d). The Post Deductible Health FSA option allows you to be reimbursed for qualifying medical expenses outlined in IRS Code 213(d) in excess of high deductible of the qualifying HSA insurance plan. **Health Savings Accounts (HSA) Benefits cannot be elected with Health FSA Benefits unless the Limited Health FSA Option is selected (reimburses <u>only</u> Vision/Dental/Preventive Care or Post Deductible expenses).**

- *Employee-Only Health FSA Option*. For purposes of this Option, "Medical Care Expenses" means expenses incurred by you (but not by your Dependent or Spouse) for medical care as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under Schedule D to this Summary, nor any expenses for which you are reimbursed through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan.

ELECTION CHANGES

You generally cannot change your election to participate in this Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but that will apply only for the upcoming Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule, known as "Change in Election Events." Participants can change their elections under the Salary Reduction Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Changes in Election Event: Leaves of absence, including FMLA leave; Changes in Status; Certain Judgments, Decrees, and Orders; Medicare and Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note that the Change in Election Events do not apply for all Benefits - applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence. A special HIPAA enrollment period of no more than 60 days is provided as of April 1, 2009 for Employees and their Dependents for loss of Medicaid or CHIP coverage; or upon becoming eligible for a Premium Assistance Subsidy. The 60 day special enrollment period applies to Insurance Plans only, not to Health FSA enrollment. If the change involves a loss of your Spouse's or Dependent's eligibility for

Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. Leaves of Absence. You may change an election under the Salary Reduction Plan upon FMLA, non-FMLA, and USERRA leaves of absence.

2. Change in Status. If one or more of the following Changes in Status 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. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment). "Spouse" means the person who is legally married to you and is treated as a spouse under the Internal Revenue Code ("the Code");
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). "Dependent" means your tax dependent under the Code;
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefits eligibility under a cafeteria plan (including this Salary Reduction Plan) or other employee benefit plan of you, 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; switching from salaried to hourly-paid; union to non-union; or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance).
- a change in your, your Spouse's or your Dependent's place of residence of more than 100 miles.

3. Change in Status—Other Requirements. If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. 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.

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age). But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. For example, assume that you elected to contribute $100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of $700. If a Change in Status Event occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of $700 for the year. In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For accident and health benefits (here, the Medical Insurance Plan and the Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election 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.

  However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you

remain a Participant under the terms of this Salary Reduction Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gains 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 Salary Reduction Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

IRS Notice 2010-38 states that the applicable Treasury Regulations have been amended retroactively to March 30, 2010, to include Change in Status events covering children under age 27 who do not otherwise qualify as dependent children, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage. Both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid by (or reimbursed to) the employee for such coverage are excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. The Notice provides important guidance and further clarifications with regard to these issues.

4. Special Enrollment Rights. *(Applies to Medical Insurance Benefits, but Not to Health FSA.)* In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. When a special enrollment right applies to your Medical Insurance Benefits, you may change your election under the Salary Reduction Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders. *(Applies to Medical Insurance Benefits and Health FSA Benefits.)* If a judgment, decree, or order from a divorce, separation, annulment or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child if such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. *(Applies to Medical Insurance Benefits, to Health FSA Benefits as Limited Below.)* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan, and/or your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Medical Insurance Benefits and/or Health FSA Benefits, as applicable). Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act for you or your Dependent's loss of health coverage under Medicaid. The 60 day special enrollment period applies to Insurance Plans only, not to Health FSA enrollment.

7. Eligibility for Premium Assistance Subsidy. Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act if you become eligible for a Premium Assistance Subsidy. The 60 day special enrollment period applies to Insurance Plans only, not to Health FSA enrollment.

8. Change in Cost. *(Applies to Medical Insurance Benefits, but Not to Health FSA Benefits.)* If the cost charged to you for your Medical Insurance Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefits package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefits package option provides similar coverage. (Note that, for purposes of this definition, (a) the Health FSA is not similar coverage with respect to the Medical Insurance Benefits; (b) an HMO and a PPO are considered to be similar coverage (the Employer currently offers an HMO and a PPO); and (c) coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.)

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of Medical Insurance benefits.

9. Change in Coverage. *(Applies to Medical Insurance Benefits, but Not to Health FSA Benefits.)* You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Medical Insurance Benefits coverage is

significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefits package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefits package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage. The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage.

- *Addition or Significant Improvement of Salary Reduction Plan Option.* If the Salary Reduction Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs). Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act for you or your Dependent's loss of health coverage under CHIP.
- *Change in Election Under Another Employer Plan.* 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 a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Salary Reduction Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from

the period of coverage under the other cafeteria plan or qualified benefits plan.

For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Salary Reduction Plan to replace the dropped coverage.

10. Change in HSA Elections. If you have enrolled in the Plan during Open Enrollment and have elected HSA Benefits, then you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. No other benefits package option election changes can be made as a result of a change in your HSA Benefits election. For example, generally you would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described above for Health FSA Benefits otherwise applied (such as a change in status).

11. Modifications Required by the Plan Administrator. The Plan Administrator may modify your election(s) downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Code), if necessary to prevent the Salary Reduction Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Salary Reduction Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

MEDICAL CARE EXPENSES THAT MAY BE REIMBURSED FROM THE HEALTH FSA

For Health FSAs, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code § 213(d). Under the tax laws, "Medical Care Expenses" now includes expenses for over-the-counter (OTC) drugs and medicines, as well as expenses for prescription drugs. Your Health FSA Account may reimburse reasonable quantities of over-the-counter (OTC) medical care items of the same kind purchased in a single calendar month; stockpiling is not permitted.

Schedule E of this Summary specifies certain expenses that are not reimbursable, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions on Schedule E will still not be reimbursable if such expenses do not meet the definition of "medical care" under Code § 213(d) and other requirements for reimbursement under the Health FSA.

For more information about what items are—and are not—Medical Care Expenses, consult IRS Publication 502 ("Medical and Dental Expenses") under the headings "What Medical Expenses Are Deductible?" and "What Expenses Are Not Deductible?" But use the Publication with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some of the statements in the Publication aren't correct when determining whether that same expense is reimbursable from your Health FSA. This is because there are several fundamental differences between what is deductible as medical care (under Code §§ 213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code § 213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. (For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from your Health FSA.) And not all expenses that are reimbursable under a Health FSA are deductible. (For example, Health FSAs may reimburse OTC drugs that are prescribed by a physician if they qualify as medical care under Code § 213(d), but they are still not deductible under Code §§ 213(a) and 213(b).)

Ask the Plan Administrator if you need further information about which expenses are - and are not - likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

COVERAGE FOR OVER-THE-COUNTER DRUGS AND OTHER PRODUCTS

The Coronavirus Aid, Relief and Economic Security (CARES) Act eliminated provisions that exclude the use of funds from HSAs and Health FSAs to purchase over-the-counter drugs without a prescription. The CARES Act also allows tax-free funds from these accounts to pay for menstrual care products. These changes apply to expenses that the Employee has incurred retroactive to January 1, 2020. This amendment will continue after December 31, 2020 for as long as allowed by law.

With the new law, eligible Employees are now able to purchase, or be reimbursed for, over-

the-counter medications (examples: Tylenol, Motrin, cough suppressants; items that used to require a prescription) using your Health FSA without a prescription.

In addition, any menstrual hygiene products (tampons, sanitary napkins, liners, etc.) may also be purchased or reimbursed using Health FSA funds with this new law.

The law is retroactive to January 1, 2020, meaning any over-the-counter medications or menstrual products purchased since January 1, 2020 can be reimbursed from a Participant's Health FSA, if the expense has not already been reimbursed previously using a prescription benefit.

An eligible Employee may begin to use their Health FSA funds for over-the-counter medications and menstrual hygiene products as of January 1, 2020. This new law also has no expiration date, meaning you may continue to purchase these items with Health FSA funds for the entire Plan Year and beyond.

Employees with qualifying purchases on or after January 1, 2020 can submit a claim to be reimbursed from their Health FSA for over-the-counter medications not previously reimbursed with a prescription benefit, as well as menstrual hygiene products. You will need to provide a copy of your receipt that shows proof of purchase date and item purchased (Health FSA).

FMLA LEAVES OF ABSENCE *(Applicable to groups of 50+ employees)*

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Medical Insurance Benefits, HSA Benefits, and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Medical Insurance Benefits and Health FSA Benefits coverage while you are on paid leave (so long as 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, on a pre-tax salary-reduction basis). If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Medical Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused

sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Medical Insurance Benefits and Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to. If your Medical Insurance Benefits or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave. If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

NON-FMLA LEAVES OF ABSENCE

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

A Participant who takes an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA Leave"), may revoke his election to participate under any benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the USERRA leave commences, as other Plan Participants.

ABOUT TAXES

Social Security taxes are not deducted from the amount you pay in premiums on a pretax basis. This could result in a small reduction in the Social Security benefit you receive at retirement. This is because Social Security benefits are based on what you earned while you were working, up to the Taxable Wage Base (TWB). The TWB is adjusted annually. If your compensation is above the TWB, your Social Security benefit is not likely to be affected. If you are below the TWB, the benefit would be reduced. The tax advantages you gain through the Flexible Benefits Plan may offset any possible reduction in Social Security benefits.

FUTURE OF THE FLEXIBLE BENEFITS PLAN

The Flexible Benefits Plan is based on Roman Catholic Diocese of Owensboro's understanding of the current provisions of the Internal Revenue Code. The Employer reserves the right to amend or

discontinue the Plan if changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order". Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan.

MATERNITY AND NEWBORN COVERAGE

Since this Plan could offer maternity and newborn coverage under the Health FSA and one or more of the Health Insurance Plan(s), you are advised that under Federal law, this Plan and the insurers may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from this Plan or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods.

REVISED DEFINITION OF "DEPENDENT" BY WFTRA

The definition of “Dependent” has been revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005, effective January 1, 2005. An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer.

The following four criteria must be met to be a qualifying child:

- The individual has a specific family type relationship to the taxpayer
- The individual does not provide more than half of his or her own support
- The individual has the same place of residence as the taxpayer for more than half of the year
- The individual does not turn age 19 (24 if a full-time student)*, by the end of the Plan Year

In addition the following four criteria must be met to be a qualifying relative:

- The individual has a specific family type relationship to the taxpayer
- The individual is not a qualifying child of any other taxpayer
- The individual receives more than half of his or her support from the taxpayer
- The individual's annual gross income is less than the Section 151 limit (this criteria does not apply to health plans)

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3)) at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by Employer dependent children may be covered by either spouse, but not by both.

NOTE: the Internal Revenue Service (the "IRS") Notice 2010-38 (the "Notice") provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year. Treasury regulations have been amended retroactively to March 30, 2010, to permit both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid (or reimbursed) to the employee for such coverage to be excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. The Notice provides important guidance and further clarifications with regard to these issues.

YOUR PRIVACY RIGHTS UNDER HIPAA

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the Health FSA Plan from using or disclosing certain health information about you that is created or received by the Health FSA Plan without your written authorization. For additional information about your privacy rights, please either refer to the Plan's Privacy Notice or contact the Plan's Privacy Official: Raymond Purk.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), defines **Protected Health Information (PHI)** as information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health

care to a participant; or the past, present or future payment of the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The HIPAA definition of PHI applies to this plan and it restricts a Plan Administrator's use and disclosure of PHI. The Plan Administrator shall have access to PHI from the Plan only as permitted under this plan or as otherwise required or permitted by HIPAA, subject to the conditions of permitted disclosure and after obtaining written certification. The Plan may disclose PHI to the Plan Administrator, provide that the Plan Administrator uses or discloses the PHI for Plan administration purposes only. Plan Administration Purposes include administrative functions performed by the Plan Administrator on behalf of the Plan, such as, claims processing, auditing, and monitoring.

The Plan may disclose to the Plan Administrator information on whether the individual is participating in the plan, or is enrolled in or has disenrolled from the Plan.

With respect to PHI disclosed by The Plan to the Plan Administrator, the Plan Administrator shall:

1. Not use or disclose the PHI other than is permitted or required by the Plan or by law.
2. Not use or disclose the PHI for employment-related actions and decisions.
3. Ensure that any agents, or subcontractors to whom PHI is provided, agrees to the same privacy restrictions and conditions that apply to the employer and the Plan Administrator.
4. Report to The Plan any use or disclosure of PHI that is any violation of the HIPAA Privacy Rule.
5. Make available PHI to comply with the HIPAA right to access in accordance with the law.
6. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
7. Return or destroy all PHI received from the Plan that the employer or Plan Administrator still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, if feasible.
8. Satisfy the requirement of adequate separation between the Plan and the employer.

The employer shall allow only the PHI Officer and other designated persons, access to PHI. These specified employees, or classes of employees, shall only have access to and use PHI to the extent necessary to perform the Flexible Benefits Plan administration functions that the Plan

Administrator performs for the Plan. Any of these specified employees who do not comply with the provisions of this Section, shall be subject to disciplinary action by the employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

COBRA CONTINUATION COVERAGE *(Generally applicable to groups of 20+ employees)*

If you terminate employment, under Federal law, you, your spouse, and/or your covered dependents lose coverage under this Plan. You, your spouse, and/or your covered dependents may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if we (and any related companies) employed twenty (20) or more employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three (3) years for any of the other reasons given in (b) and (c) below. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, coverage under another employer's plan (whether as an employee or otherwise, provided the other employer's health plan does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary unless the pre-existing condition limit does not apply to, or is satisfied by, the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act), termination of our health plan, a "for cause" termination of coverage for reasons such as fraud, or you (or the person entitled to continued coverage) become enrolled in Medicare. However, if you become enrolled in Medicare, your covered dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a "similarly situated" employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage

after expiration of the initial 18-month period.

(a) If you would otherwise lose your health plan coverage under this Plan because of a termination of employment or a reduction in hours, you may continue the health plan coverage provided under this Plan. However, this will not be a tax-deductible expense to you, absent unusual circumstances.

(b) Your spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.

(c) Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a dependent child under the Plan.

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is our responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, the Employer's bankruptcy, or Medicare eligibility.

"*Medicare*" means the Health Insurance For the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

COMPLIANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The information furnished herein constitutes the Summary Plan Description required by federal law. To comply with the law, the following additional information is also furnished. Note: Dependent care assistance plans are not covered under the Employee Retirement Income Security Act (ERISA).

ERISA RIGHTS STATEMENT

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to help assure that all employer-sponsored group benefit programs conform to standards set by Congress. An employee who is a Participant in the Plan is entitled to certain rights and protections under ERISA, which

provides that all Participants will be entitled to: (1) examine, without charge, at the Plan Administrator's office and at other appropriate locations, all Plan documents and copies of documents filed with the U.S. Department of Labor, such as copies of the latest annual reports (Form 5500), if any, and Plan descriptions; (2) obtain copies, upon written request to the Plan Administrator copies of all Plan documents and other Plan information governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series) and updated summary plan description, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report. Plan records are kept on a Plan Year basis.

In addition to creating rights for plan Participants, ERISA imposes duties upon those responsible for the operation of the Plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of Participants and Beneficiaries. If a claim for a benefit under the Plan is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Under ERISA, there are steps the Employee covered under the Plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require the company to provide the materials and pay the person up to $110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the Employer's control.

If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if the Employee covered under the Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the claimant is successful, the court may order the person sued to pay these costs and fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration (PWBA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, 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.

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

This is a Summary Plan Description only. Your specific rights to benefits under the plan are governed solely, and in every respect, by the Roman Catholic Diocese of Owensboro Health FSA Plan Document, a copy of which is available from Raymond Purk upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan Document, the language of the Plan Document shall govern.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and Roman Catholic Diocese of Owensboro or a Participating Employer. Roman Catholic Diocese of Owensboro's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Plan Definition and Funding

This is a Section 125 flexible benefits plan classified as a "cafeteria" plan by the Internal Revenue Code. It includes a Section 105 Health Flexible Spending Account, classified by the Department of Labor as a "welfare" plan. The Plan is funded by employee contributions.

General Information

- Name: Roman Catholic Diocese of Owensboro Flexible Benefits Plan (501).
- Plan Number: 501
- Effective Date: January 1, 2018; amended and restated August 1, 2024
- Plan Year: January 1 to December 31

Type of Plans

Section 125 Premium Only Plan
Health Flexible Spending Account

Participants

The plan provides benefits for all employees of Roman Catholic Diocese of Owensboro who meet the eligibility requirements described herein.

Employer/Plan Sponsor Information

Roman Catholic Diocese of Owensboro
600 Locust Street
Owensboro, KY 42301
Phone: (270) 683-1545

Employer Identification Number (EIN): 45-3848250

Plan Administrator Information

Roman Catholic Diocese of Owensboro
600 Locust Street
Owensboro, KY 42301
Phone: (270) 683-1545

Named Fiduciary and Agent for Service of Legal Process

Roman Catholic Diocese of Owensboro
600 Locust Street
Owensboro, KY 42301
Phone: (270) 683-1545

ROMAN CATHOLIC DIOCESE OF OWENSBORO
FLEXIBLE BENEFITS PLAN
QUESTIONS AND ANSWERS

INTRODUCTION

As part of our efforts to keep your medical benefit costs as affordable as possible, Roman Catholic Diocese of Owensboro (referred to in these questions and answers as the "Company") is pleased to sponsor the Roman Catholic Diocese of Owensboro Flexible Benefits Plan (the "Plan").

The Plan provides each eligible employee with the opportunity to set aside part of his or her pay on a *pre-tax* basis to:

(1) pay for his or her share of health insurance premiums under the health care program(s) sponsored by the Company; and,

(2) provide for reimbursement of unreimbursed medical and dental expenses on a *tax-free* basis.

The Plan helps you because the benefits you elect are nontaxable. In addition, you save Social Security and income taxes on the amount of your salary reduction used to pay for these expenses.

Following are commonly asked questions and answers describing the basic features of the Plan and how it operates. Please review these questions and answers carefully, and do not hesitate to ask questions. This is *your* benefit, and it is important that you understand how it works and how it can help you. However, you should note that the questions and answers address only the key parts of the Plan. Consult the Plan documents or summary plan description for more details. Or, contact Raymond Purk at the Company.

QUESTIONS & ANSWERS

1. What is the purpose of the Plan?

The purpose of the Plan is to permit eligible employees to elect to defer part of their pay on a pre-tax basis to defray their health insurance expenses and unreimbursed medical expenses.

2. What benefits are offered through the Plan?

Two kinds of benefits are offered under the Plan: a "Premium Only Plan" and a "Health FSA Benefit". These benefits are explained in more detail below.

3. Who may participate in the Plan?

With respect to the Premium Only Plan, you are eligible to become a participant in the Plan after completing one day of active employment with the Company.

With respect to the Health FSA, if you regularly work 20 or more hours per week with the Company, you are eligible to participate in the Plan after the completion of one day of active employment with the Company.

4. What is the Premium Only Plan Benefit?

The Premium Only Plan allows you to pay your share of the health insurance premiums and other ancillary benefits with *pre-tax* dollars. If you do not elect to receive pre-tax benefits under the Premium Only Plan, you still will have to pay your share of the health insurance premiums under the Company's health care program(s), but on an *after-tax* basis. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

5. How does the Health FSA Benefit help me?

It is likely that you will have some medical expenses that you will have to pay for in the coming year. For example, you or your family may have medical expenses that are subject to deductible or co-payment limits under a health plan. Or you may incur expenses that are not reimbursed at all. Normally, you would pay for these expenses with after-tax income. And, because taxes reduce the value of a dollar, you would have to earn considerably more than $100 to pay for $100 of expenses.

The Health FSA Benefit under the Plan permits eligible employees to contribute *pre-tax* income to a Health FSA on your behalf. The Health FSA will reimburse you on a pre-tax basis for your unreimbursed medical expenses. It's like getting a discount on these bills so you don't have to earn as much to pay for them.

6. How does the Health FSA Benefit work?

Once you have determined your annual predictable medical expenses for the plan year (or part thereof, if you first become eligible to participate in the middle of a plan year), you may elect to defer a portion of your salary into a Health FSA maintained on your behalf. You should take into account your health insurance deductibles and copayments, as well as uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary" as covered under Section 213 of the IRS code. Do not take into account premiums paid for health insurance coverage provided by the Company (since this is covered under the Premium Only Plan). Also, do not take into account other health insurance coverage, such as that of your spouse, or expenses for cosmetic surgery.

7. How much may I contribute to my Health FSA?

The maximum amount you may elect to defer into a Health FSA for a year is outlined in Schedule D attached to this Summary.

8. What is an "eligible expense" under the Health FSA?

An "eligible expense" means any items for which you can claim a medical expense covered under the Code Section 213 (with some limitations, see the Summary Plan Description for complete details) of the IRS. It is an expense for which you have not otherwise been reimbursed from insurance or some other source.

Please review the list of eligible medical expenses provided in your Roman Catholic Diocese of Owensboro Summary Plan Description for assistance in determining what is an "eligible expense".

9. How do I receive medical expense reimbursements under the Plan?

To receive reimbursement, you must complete a claim form and attach any other information as the Plan Administrator may require. The Plan Administrator will instruct you as to how to file the form. When the claim is approved, you will be reimbursed the full amount of your eligible expenses, up to your elected Health FSA limit.

10. What happens to the money in my Spending Account(s) should I terminate?

You may submit claims on expenses incurred before the date of your termination, up until three months after you leave. If applicable, you may elect continuation coverage through COBRA you may continue to use your Health FSA.

11. How long do I have after the Plan Year ends to submit my claims?

You will have three months after the Plan Year ends to submit claims on expenses incurred in that Plan Year, unless you terminate your employment. A terminated employee has three months from their date of termination to submit claims incurred in that Plan Year.

12. What else should I know about the Health FSA Benefit?

The IRS imposes certain restrictions on Health FSAs including the following:

- Authorized salary reductions into your Health FSA may not be changed for the rest of the year unless you terminate employment or have a change in status. Changes in status are discussed in detail in the Summary Plan Description.
- Generally, you will forfeit all unused funds in your Health FSA at the end of the year. This is the "use it or lose it" rule. Unused balances may not be carried over to the next year or converted to cash. For this reason, you should estimate your anticipated medical expenses for the year

conservatively. Notwithstanding the above, your Employer has amended the Plan to permit a carryover of up to $610.00 of a Participant's unused FSA account balance to the following Plan Year.

- You may request periodic statements to remind you how much money is left in your Health FSA. As indicated above, these amounts must be used by the end of the year or they will be lost. Claims may be submitted up to three months after the end of the plan year in which the expenses were incurred. If you terminate employment, you may submit claims up to three months after you terminate employment.

13. Are my Plan benefits taxable?

Under current law, the benefits you receive under the Plan are not currently taxable to you, nor are the benefits subject to federal income tax withholding and Social Security (FICA) withholding taxes.

14. Will the Health FSA claims I submit to my plan administrator be kept private?

Yes, the HIPAA Rule, requires that Protected Health Information (PHI) given to the plan administrator be kept completely confidential. See the Summary Plan Description for the complete Privacy Statement regarding PHI.

15. When and how do I elect the Plan benefits?

You will be provided a form when you first become eligible to participate. This form will notify you of your eligibility for participation in the Plan, upon which you may elect the Premium Only Plan and/or the Health FSA Benefit. If you elect the Premium Only Plan, the health insurance premiums you are already making will be converted to a pre-tax basis.

In future years, you will be furnished a new form by the first day of the annual enrollment period and be given the opportunity to confirm or change your existing choices for the coming calendar year.

16. The Plan sounds too good to be true. Are there any reasons why I shouldn't participate?

As discussed above, salary you elect to use to pay for Plan benefits is free from income and FICA taxes. This is a valuable benefit. However, because amounts deferred under the Plan are not counted as wages when determining your Social Security benefit, it is possible that there may be a reduction in your Social Security benefits. If your salary is above the Social Security Taxable Wage Base you probably will not be affected. If your salary is below the Social Security Taxable Wage Base, your Social Security benefits might be reduced. You should consult your own financial or tax advisor to determine the effects of electing to participate in the Plan. If you are using the Plan for reimbursement of insurance premium, it is specifically your responsibility not to request anything

that could violate the terms of your insurance policy.

17. How does the Plan save me money?

The following example illustrates how the Plan saves you money. Assume that your monthly share of the health insurance premium is $400 per month, your monthly income is $4,000, and you are in the 28-percent federal income tax bracket and the 7.5-percent state tax bracket. Assume also that you expect to have $2,400 in uninsured medical expenses during the year. If you pay your health insurance premiums using the Premium Only Plan and your uninsured medical expenses using the Health FSA Benefit, you will save $259 per month, or $3,108 per year. These amounts are computed as follows:

Your Salary	**Pre-Tax Medical Plan $4,000**	**No Pre-Tax Medical Plan $4,000**
LESS YOUR:		
Health Insurance Premium	(400)	0
Uninsured Medical Expenses	(200)	0
Taxable Income	**3,400**	**4,000**
LESS YOUR:		
Federal Income Tax at 28%	(952)	(1,120)
State Income Tax at 7.5%	(255)	(300)
Social Security (FICA) at 7.65%	(260)	(306)
Health Insurance Premium	0	(400)
Uninsured Medical Expenses	0	(200)
Net Take Home Pay	1,933	1,674
Monthly Tax Savings	**259**	-----
Annual Tax Savings With This Plan	**3,108**	-----

18. Can I change my election during the Plan Year?

Generally, you may not change or vary your elections during the Plan Year. However, you may change your elections during the annual enrollment period for the coming Plan Year. The Plan Administrator will advise you when you may elect to change your elections for the upcoming plan year.

There is an important exception to this general rule: You may change or revoke your election at any time during the Plan Year if you have a qualifying change in status (which generally includes a change in your legal marital status or change in the number of dependents). See the qualifying changes in status listed under "**Election Changes**" in this Summary.

19. Who holds the funds I have set aside under the Plan?

The insurance companies providing the benefits under the Plan will receive all amounts withheld from your paycheck for payment of premiums. Amounts contributed under the Health FSA will be retained by the Company but earmarked to pay for Health FSA Benefits. Separate bookkeeping entries will be maintained to keep track of your Health FSA.

20. When will my participation in the Plan cease?

If you elect to participate in the Plan, your participation will continue until you separate from service with the Company or elect to stop making contributions under the Plan. Also, with respect to this Plan, if your employment status changes so that you regularly work less than 20 hours per week, your participation in the Plan will cease. However, you may be eligible for continuation coverage under this Plan.

21. What is continuation coverage?

If you, your spouse, and/or your covered dependents lose coverage under this Plan, you may be entitled to COBRA continuation of health care coverage, including the Health FSA. Generally, if the Employer has employed twenty (20) or more employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a specific period of time. The Administrator will inform you of these rights if you lose coverage and you are entitled to continuation coverage.

22. Will I have any administrative costs under the Plan?

No. The Company will pay the entire cost of administering the Plan.

23. How long will the Plan remain in effect?

The Company has the right to modify or terminate the program at any time, or to elect not to continue sponsorship of the Plan.

24. What happens if my claim for benefits is denied?

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the Health FSA are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Plan Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Administrator will make the decision based on the information that it has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Administrator will include the following information:

- The specific reason for the denial;
- A reference to the specific Health FSA provision(s) on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Health FSA's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA § 502(a) following a denial on review; and
- If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to appeal the Plan Administrator's denial of your claim.

D. What are the requirements of my appeal?

Your appeal must be in writing, must be provided to the Plan Administrator, and must include the following information:

• Your name and address;
• The fact that you are disputing a denial of a claim or the Administrator's act or omission;
• The date of the notice that the Administrator informed you of the denied claim; and
• The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

E. Is there a deadline for filing my appeal?

Yes. Your appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission.

If you do not file your appeal within this 180-day period, you lose your right to appeal.

Your appeal will be heard and decided by the Committee.

F. How will my appeal be reviewed?

Anytime before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and other information to the Committee. The Health FSA is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Health FSA who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination.

G. When will I be notified of the decision on my appeal?

The Committee must notify you of the decision on your appeal within 60 days after receipt of your request for review.

H. What information is included in the notice of the denial of my appeal?

If your appeal is denied, the notice that you receive from the Committee will include the following information:

• The specific reason for the denial upon review;

- A reference to the specific Health FSA provision(s) on which the denial is based;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to bring a civil action under ERISA § 502(a).

No action may be brought against the Plan, the Employer, the Plan Administrator, or any other entity to whom administrative or claims processing functions have been delegated until you first follow the above claim procedures and receive a final determination from the Plan Administrator.

25. Will I be able to file claims for over-the-counter drugs from the Health FSA?

Effective January 1, 2020 the Coronavirus Aid, Relief and Economic Security (CARES) Act law allows eligible Employees to purchase, or be reimbursed for, over-the-counter medications (examples: Tylenol, Motrin, cough suppressants; items that used to require a prescription) using your Health FSA without a prescription. In addition, any menstrual hygiene products (tampons, sanitary napkins, liners, etc.) may also be purchased or reimbursed using Health FSA funds with this new law.

The law is retroactive to January 1, 2020, meaning any over-the-counter medications or menstrual products purchased since January 1, 2020 can be reimbursed from a Participant's Health FSA, if the expense has not already been reimbursed previously using a prescription benefit.

26. Can I request an external review if my appeal is denied?

If the Health FSA is an excepted benefit, it is not subject to external review requirements. To be an excepted benefit, the Health FSA must satisfy two conditions:

1. Maximum Benefit Condition. The maximum benefit payable under the Health FSA to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the Health FSA for the year (or, if greater, the amount of the participant's salary reduction election for the Health FSA for the year, plus $500).
2. Availability Condition. Other nonexcepted group health plan coverage (e.g., major medical coverage) must be made available for the year to the class of participants by reason of their

employment.

If the Health FSA is not an excepted benefit, it is subject to external review requirements. If the denial of your claim is not related to your (or your beneficiary's) failure to meet the requirements for eligibility under the terms of your employer's HRA, you may be eligible to request an external review. View current procedures and timeline relevant to the external review request at http://www.dol.gov/ebsa or call the Employee Benefits Security Administration, 866-444 EBSA (3272).

ROMAN CATHOLIC DIOCESE OF OWENSBORO

Schedule A

MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN*:

NAME OF COVERAGE

Group Health Insurance
Dental Insurance
Vision Insurance
Group Term Life Insurance (Employee Only)
Disability Income-Short Term (STD)
Disability Income-Long Term (LTD)
Cancer Insurance
Intensive Care Insurance
Accident Insurance

*The Employee contributions necessary to obtain the coverage options set forth in this Schedule A above will be communicated by the Employer to Eligible Employees at the time of Enrollment and in Schedule B. The required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option above. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

<u>ROMAN CATHOLIC DIOCESE OF OWENSBORO</u>

Schedule B

FORMULA FOR EMPLOYEE CONTRIBUTIONS UNDER THE PLAN

The following description of the Employee Contribution per Participant may be expressed as a percentage of monthly cost, or as a flat monthly dollar amount. If the formula for Employee contributions varies by class of Employees, the Employer Sponsor assumes full responsibility for its Employer contribution design.*

Name of Benefit Plans To Be Offered		Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%

*An asterisk in the premium column means there are multiple rates based on age, sex, or other demographics. Please refer to specific insurance carrier premium rate sheets for individual maximum elective contribution.

In no event shall the existence of any Employer contributions for monthly premium costs, as indicated above, be construed to require the Employer to pay or otherwise be liable for any deductible, coinsurance, co-payment or other cost-sharing amounts related to the applicable medical care coverage option elected by the Participant.

ER = Employer Contribution
EE = Employee Contribution

ROMAN CATHOLIC DIOCESE OF OWENSBORO

Schedule C

PARTICIPATING AFFILIATED EMPLOYERS

(Companies under common ownership)

The following organizations and entities shall be Participating Employers under the Plan:

Name of Participating Employer

None

ROMAN CATHOLIC DIOCESE OF OWENSBORO

SCHEDULE D

HEALTH FSA EMPLOYEE CONTRIBUTION LIMITATIONS

	Minimum*	Maximum*
HEALTH FLEXIBLE SPENDING ACCOUNT	**$10.00**	**$250.00**

*Monthly, based on a 12 month Plan Year; Health FSA annual maximum is $3,000.00

A list of qualifying Health Flexible Spending Account expenses is available at: www.coredocuments.com/expenses.php.

ROMAN CATHOLIC DIOCESE OF OWENSBORO

SCHEDULE E

HEALTH FSA EXCLUSIONS
MEDICAL EXPENSES NOT REIMBURSEABLE

The Roman Catholic Diocese of Owensboro Health FSA Plan document contains the general rules governing what expenses are reimbursable. This Schedule E, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA—that is, expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under the regulations governing Health FSAs.

This Schedule E does not apply to HSAs. As described in the Plan, terms and conditions of coverage and benefits under the HSA (including eligible medical expenses and exclusions) will be provided by and are set forth in the HSA, not this Plan.

Exclusions: *The following expenses are not reimbursable from the Health FSA*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs:

• Dual purpose products, items for general well-being, or items not typically medically necessary (such as Acupuncture, Supplements, Vitamins, Massage Therapy, Dermatology Products, and Weight Loss Programs) are excluded from reimbursement unless accompanied by a letter of medical necessity. The letter of medical necessity must be from a Physician and must include a diagnosis, duration of treatment, and description of treatment plan. • Health insurance premiums for any other plan (including a plan sponsored by the Employer). • Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. • Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework). • Long-term care services.	• Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods. • Social activities, such as dance lessons (even if recommended by a physician for general health improvement). • Bottled water. • Cosmetics, toiletries, toothpaste, etc. • Uniforms or special clothing, such as maternity clothing. • Automobile insurance premiums. • Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician. • Any item that does not constitute "medical care" as defined under Code § 213(d). • Any item that is not reimbursable under Code § 213(d) due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations. • The salary expense of a nurse to care for a healthy newborn at home. • Custodial care. • Funeral and burial expenses.

Roman Catholic Diocese of Owensboro
Premium Election Form

- ❑ Correction
- ❑ Change of personal information
- ❑ Change of Family Status
- ❑ Transfer
  Effective Date_____
- ❑ Termination
- ❑ Waive Participation _____ (initial)

Personal Information

Last Name	First Name	Middle Initial	Social Security Number

Home Address	Street	City	State	Zip

Date of Birth: / / Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married Date of Hire: / /

Benefit Elections (Circle coverage elected and enter appropriate amount on total cost per month line.)

Name of Benefit Plans To Be Offered	**Employee Only** (**Employee Cost Per Month***)	**Employee & Child(ren)**	**Employee & Spouse**	**Employee & Family**
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____

* Amount after employer contribution is deducted **Total Cost Per Month $_____**

Salary Reduction Agreement

I have read and understand the explanation I have received regarding my options under the Roman Catholic Diocese of Owensboro Premium Only Plan. I understand I have the right to have the company redirect my salary on a pretax basis during the plan year and apply this amount toward the purchase of the medical coverage I have designated above. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I acknowledge that my election is irrevocable unless there is a change in my status. A change in status includes: marriage; divorce; death of a spouse or dependent; birth of a dependent; birth or adoption of a child; change in number of dependents; termination of employment or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; or any change in employment status that affects eligibility; a change in residence for me, my spouse or children; or my dependent either satisfies or ceases to satisfy requirements for coverage due to change in age, student status, or any similar circumstances; or a change in my or my spouse's employment status.

It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy. I understand that subsidized insurance premiums can only be deducted on a post-tax basis.

I hereby apply for the options listed above. If necessary, I authorize Roman Catholic Diocese of Owensboro to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from January 1 until December 31, unless my family status changes.

_____ _____
Employee Signature Date

_____ _____
Company Representative Date

ROMAN CATHOLIC DIOCESE OF OWENSBORO
HEALTH FSA ELECTION FORM

(Please Print)

1. PERSONAL DATA **PLAN YEAR**_____ Effective Date_____

Name_____ Waive Participation_____ (initial)
(Last) (First) (MI)

Marital Status:_____ Date of Hire_____ Soc. Sec. _____ - ___ -_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

Email _____ Work Phone_____Home/Cell Phone _____
I prefer to be contacted regarding my FSA Account via Email ____, Wk Ph____, Hm/Cell Ph_____, 1st Class Mail_____

DEPENDENT INFORMATION (Must List ALL eligible Dependents Affected by Enrollment)

Last Name	First Name	Relationship (Self/Spouse/Child)	M/F	SS#	Date of Birth
Employee		*Self*			
Dependent					
Dependent					
Dependent					
Dependent					

2. FLEXIBLE SPENDING ACCOUNT CONTRIBUTIONS

HEALTH FLEXIBLE SPENDING ACCOUNT - Employer Contribution ☐ NO ☐ YES $_____Annual Benefit

PAYROLL SCHEDULE ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

EMPLOYEE ELECTION $_____/Per Pay Period $_____/Annually (from <u>your</u> Effective Date until December 31)

TYPE OF PLAN: ☐GENERAL PURPOSE ☐LIMITED PURPOSE / POST DEDUCTIBLE ☐EMPLOYEE ONLY

3. AUTHORIZATION AND ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs. Changes must be submitted within 30 days of the qualifying event.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits from my Insurance Provider, itemized bill, etc.) for out-of-pocket Medical, Dental, Vision expenses before I can be reimbursed.

I understand that the plan provisions will require that all Health FSA participants who have a positive balance (taking into account all claims submitted prior to termination) at the time of terminating employment will be provided with information regarding their COBRA options, if applicable (see your Summary Plan Description regarding COBRA qualifications). If the continuation for the Health FSA is not elected, I realize that I will not be reimbursed for any expenses incurred after the date employment terminates.

I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize Roman Catholic Diocese of Owensboro to make pretax deductions from my salary on the payroll schedule I have elected above. I understand that to stop such deduction, I must notify Roman Catholic Diocese of Owensboro Benefits office in writing with my request, and revoke this authorization.

Any unused dollars remaining in my Flexible Spending Account at the end of the year will be forfeited. Expenses/claims must be incurred during the time that I participate in the plan in order to be eligible for reimbursement**.**

Employee's Signature _____ Date: _____

ROMAN CATHOLIC DIOCESE OF OWENSBORO
HEALTH FSA
REIMBURSEMENT CLAIM FORM

PERSONAL DATA (Please Print)

Name	SS# (Last four digits only) X X X – X X –
Home Address	Address Change: ☐Yes ☐No
City	State / Zip
Phone: Work ( ) Home/Cell ( )	Email: I prefer to be contacted by Email, Wk Ph, Hm Ph, Mail (***circle one***)

You must provide a receipt showing the date of service, amount of service, description of service, name of service provider, and name of patient or other evidence the expense was incurred (such as an EOB from your Insurance Provider). If this form is incomplete your claim could be denied. Print or type the information requested, then sign and date the form.

	Name of Medical Provider (Doctor, Pharmacy, etc.)	Date Medical Care Provided*	Patient Name	Relationship (Self, Spouse, Child)	Amount that is your responsibility	General Medical Expense Description.
1					$	
2					$	
3					$	
4					$	
5					$	
6					$	
7					$	
8					$	
9					$	
10					$	
		Total Medical Amount Requested →				$

Please arrange documentation in order listed above.

***Claims for future services will not be accepted**

I request payment from my **Health Flexible Spending Account** (FSA) as indicated above for the expenses listed. I certify that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while I was enrolled in the employer's FSA with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I certify that these expenses will not be claimed as an income tax deduction. I fully understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I authorize my **FSA** to reimburse me by the amount requested.

☐ **I am funding an HSA for this Plan Year** ☐ **I am NOT funding an HSA for this Plan Year**

Employee Signature_____ Date_____

SUBMIT YOUR COMPLETED CLAIM FORM TO:

Roman Catholic Diocese of Owensboro
600 Locust Street
Owensboro, KY 42301

ROMAN CATHOLIC DIOCESE OF OWENSBORO
FLEXIBLE BENEFITS PLAN
CHANGE AND REVOCATION FORM

(Please Print)

PERSONAL DATA **PLAN YEAR**_____ Soc. Sec. #_____

Name_____ Home Phone #_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

CHANGE OR REVOCATION OF SALARY REDUCTION AGREEMENT

Please indicate the change in your Salary Reduction Agreement in the area below. If there is a status change event, change in cost/coverage or other-type change (judgment decrees, etc.) that is permitted under the Internal Revenue Code and Regulations, and which justifies a change in your Salary Reduction Agreement, you may change or revoke your Salary Reduction Agreement. However, once you make the change indicated on this form, you may not reinstate or revise your Salary Reduction Agreement as of a date before the first day of the next Plan Year unless there is another status change event, change in cost/coverage or other-type allowable change (judgments, decrees, etc.). Please Note: In most circumstances, you must submit the Change and Revocation Form within **30 days** of qualifying event.

Premium-type Benefits

If you are changing from one level of coverage, from single to family coverage for example, mark "Revoke" for your current coverage (e.g. single) and mark "New Enrollment" for the new coverage (e.g. family).

If you are ending participation in the Plan, mark "Revoke".

Current Election	Revoke/ Suspend	New Enrollment	Effective Date
**** Health Insurance ****			
[ ] Employee Only	[ ]	[ ]	___/___/___
[ ] Employee Plus Dependents	[ ]	[ ]	___/___/___
**** Dental ****			
[ ] Employee Only	[ ]	[ ]	___/___/___
[ ] Employee Plus Dependents	[ ]	[ ]	___/___/___
** _____ **			
[ ] Employee Only	[ ]	[ ]	___/___/___
[ ] Employee Plus Dependents	[ ]	[ ]	___/___/___

Flexible Spending Arrangements

If you are reducing or increasing your salary reductions, please indicate the new amount PER PAY PERIOD under "New Enrollment". If you are ending participation in the Plan, mark "Revoke".

Current Election	Revoke/ *Suspend*	New Enrollment Salary Reduction	Effective Date
[ ] Medical Expense FSA	[ ]	_____.__	___/___/___

*Reason for Election Change – **please mark [X] the appropriate election change event(s) that justifies the change(s) or revocation(s) on this form and enter the date(s) of the event(s)***

1. Status Change Events

a. Change in Marital Status

[ ] Marriage on ___/___/___
[ ] Divorce on ___/___/___
[ ] Annulment on ___/___/___
[ ] Legal Separation on ___/___/___
[ ] Death of Spouse on ___/___/___

b. Change in Number of Tax Dependents

[ ] Birth on ___/___/___
[ ] Adoption on ___/___/___
[ ] Other – Gain Tax Dependent on ___/___/___
[ ] Death of Dependent on ___/___/___
[ ] Death of Spouse on ___/___/___

Reason for Election Change *(continued)*

c. Change in Employment Status With Gain or Loss of Eligibility -

Change relates to: *[ ] Employee* *[ ] Spouse or Dependent*

[ ] Termination of Employment on ___/___/___ [ ] Full-time to Part-time on ___/___/___
[ ] Commencement of Employment on ___/___/___ [ ] Part-time to Full-time on ___/___/___
[ ] Commencement of Unpaid Leave on ___/___/___ [ ] Return from Unpaid Leave on ___/___/___
[ ] Other (hourly to salary, union to non union, etc.) on ___/___/___

Provide Details: _____

_____

d. Change in Dependent Eligibility Under an Employer's Plan

[ ] Lost Eligibility (age, student status, attainment of age 13 for Dependent Care FSA, COBRA event, etc.) on ___/___/___
[ ] Gain Eligibility (e.g., age, student status, etc.) on ___/___/___

e. Change of Residence Affecting Eligibility – Date of change ___/___/___

Change relates to: *[ ] Employee* *[ ] Spouse or Dependent*

2. Special Enrollment Rights – HIPAA *(applies to Premium benefits only)*

[ ] Loss of other group health plan coverage on ___/___/___
[ ] Acquired new spouse or dependent (marriage, birth, etc.) on ___/___/___
[ ] Eligible for Premium Assistance Subsidy on ___/___/___

3. Certain Judgments, Decrees and Orders *(applies to Premium and Health FSA benefits only)*

[ ] Court order requiring coverage for Dependent on ___/___/___

4. Medicare or Medicaid *(applies to Premium and Health FSA benefits only)*

[ ] Became eligible for Medicare or Medicaid on ___/___/___
[ ] Became ineligible for Medicare or Medicaid on ___/___/___

5. Change in Cost *(applies to Premium)*

[ ] Significant cost increase in coverage on ___/___/___
[ ] Significant cost decrease in coverage on ___/___/___

6. Change in Coverage *(applies to Premium)*

[ ] Change in dependent care provider on ___/___/___
[ ] Significant curtailment of coverage on ___/___/___
[ ] Addition or significant improvement of a plan option on ___/___/___
[ ] Loss of group health coverage under plan of a governmental or educational institution on ___/___/___
[ ] Change in coverage under an employer's plan on ___/___/___

Signature

I have examined this authorization to modify my Salary Reduction Agreement and to the best of my knowledge, it is true, correct and complete. I understand that the election change I have requested must be on account of and consistent with the status change or other election change event (s) I have checked above. I understand that the status and participation changes must comply with the Plan and that the Plan Administrator has the sole discretion in making this determination. I further understand that I may be required to provide documentation regarding the change(s) I have checked above.

_____ _____
Participant's Signature Date

Sec 132 and Sec 125 FSAs must indicate the LAST PAY DATE affected (may differ from actual Termination Date): _____/_____/_____

Denied by _____ on _____
Reason for Denial _____
Action to be taken_____
*Plan Administrator*_____ _____
Agreed and accepted by the Employer's Representative Date

SECTION 5

ADMINISTRATION GUIDE &

NON-DISCRIMINATION TESTING

PLACE ALL PAGES AFTER TAB 5

RETAIN TO REFERENCE NEW REGULATIONS AS NEEDED

ROMAN CATHOLIC DIOCESE OF OWENSBORO
AMENDMENT ADDING HEALTH FSA CARRYOVER
IRC SECTION 125 CAFETERIA PLAN
As Permitted by IRS Notice 2013-71

WHEREAS, Roman Catholic Diocese of Owensboro has determined that it would be in the best interests of its employees to adopt the Health FSA Carryover for their "Section 125 Health Flexible Spending Account" as permitted by IRS Notice 2013-71, so-called; be it known that a vote was taken, and all were in favor to amend said Plan herein, to be effective for the current Plan Year.

RESOLVED, that Roman Catholic Diocese of Owensboro amend its so-called "Section 125 Health FSA Plan", all in accordance with the specifications annexed hereto; and, be it known that the amended "Health FSA Plan" Document was executed AUGUST 1, 2024. These amendments shall apply notwithstanding any other statements in the Plan, the summary plan description (SPD), or any other documents for the current Plan Year.

RESOLVED FURTHER, that Roman Catholic Diocese of Owensboro undertake all actions necessary to implement and administer said amendment. The undersigned hereby certifies that he/she is qualified by Roman Catholic Diocese of Owensboro, a company duly formed pursuant to the laws of the State of Kentucky, and that the foregoing is a true record of an amendment duly adopted, and that said amendment is now in full force and effect without modification or rescission for the current Plan Year.

IN WITNESS WHEREOF, I have executed my name for Roman Catholic Diocese of Owensboro on AUGUST 1, 2024.

ATTEST:

Mary L Hall
Witness

By: Raymond Purk
Raymond Purk

ROMAN CATHOLIC DIOCESE OF OWENSBORO
HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) CARRYOVER
SUMMARY OF MATERIAL MODIFICATIONS

PURPOSE

The Health FSA (the "Plan"), adopted by Roman Catholic Diocese of Owensboro on January 1, 2018, is herein amended effective AUGUST 1, 2024 to adopt the Health FSA Carryover for the current Plan Year. The Health FSA Carryover option will begin on January 1, 2025 and will end on December 31, 2025. The Health FSA Carryover option will allow up to $610.00 of unused amounts remaining in your Health FSA Account on December 31, 2024, to be used to reimburse you for eligible medical expenses incurred in the following Plan Year.

A. Plan Amendments

1. The Health FSA Carryover option for Health FSA Component:
Amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during subsequent Plan Years under the following conditions:

(a) Applicability.
In order for an individual to be reimbursed for Medical Care Expenses from amounts remaining in his or her Health FSA Account at the end of the Plan Year, he or she must be either (1) an eligible Employee; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

(b) No Cash-Out or Conversion.
Unused Health FSA balances may not be cashed out or converted to any other taxable or nontaxable benefit. For example, unused Health FSA Amounts may not be used to reimburse Dependent Care Expenses.

(c) Reimbursement of Health FSA expenses.
The unused Health FSA balance at the end of the prior Plan Year may be used for expenses incurred in the prior Plan Year if claimed during the Plan's run-out period, or to expenses that are incurred at any time in the current Plan Year. Medical Care Expenses incurred during the current Plan Year and approved for reimbursement in accordance with the Plan's claims procedure for the Health FSA Component will be reimbursed and charged first against the current Plan Year Health FSA Amounts. All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

(d) Run-Out Period and Forfeitures.
Claims for reimbursement of Medical Care Expenses incurred during a Plan Year must be submitted no later than 90 days following the close of the Plan Year in order to be reimbursed from the prior Plan Year Health FSA Amounts. Any prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year shall be carried over to reimburse the Participant for expenses incurred in the following Plan Year. The Participant will forfeit all rights with respect to

HOW TO ADOPT THE HEALTH FSA CARRYOVER OF UNUSED BENEFITS

The IRS allows Employers to modify the Health FSA "use it or lose it" rule by amending their Health FSA to allow a carryover of up to $610.00 of unused FSA balances from one Plan Year to the next Plan Year, provided the Health FSA does not also include the Grace Period rule. If the Health FSA Carryover is adopted, participants with an FSA balance remaining at the end of the Plan Year will be able to use those unused funds for the reimbursement of qualifying medical expenses incurred in the next Plan Year. The carryover option does not affect the maximum amount of salary reduction contributions the participant is permitted to make under the Health FSA Plan.

An Employer is not required to adopt the Health FSA Carryover, but Employers who wish to adopt the Health FSA Carryover for their current Plan Year must amend their Plan before the end of that Plan Year.

The template on the following page can be used to Amend your Plan to adopt the Health FSA Carryover for the current Plan Year.

Should you choose to amend your Plan to adopt the Health FSA Carryover:

1. Complete the "Amendment Adopting Health FSA Carryover" and place it in Section 1 of your Plan Document, in front of the Resolution to Adopt the Plan and any previous Amendments.
2. Complete the Summary of Material Modifications (SMM); distribute a copy to each eligible Employee; place a copy at the end of your Plan Document and at the end of your Summary Plan Description. **You must notify Plan participants of the Health FSA Carryover prior to the end of the Plan Year.**

ROMAN CATHOLIC DIOCESE OF OWENSBORO

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) CARRYOVER

SUMMARY OF MATERIAL MODIFICATIONS

PURPOSE

The Health FSA (the "Plan"), adopted by Roman Catholic Diocese of Owensboro on January 1, 2018, is herein amended effective _____, 20__ to adopt the Health FSA Carryover for the current Plan Year. The Health FSA Carryover option will begin on January 1, 20__ and will end on December 31, 20__. The Health FSA Carryover option will allow up to $610.00 of unused amounts remaining in your Health FSA Account on December 31, 20__, to be used to reimburse you for eligible medical expenses incurred in the following Plan Year.

A. Plan Amendments

1. The Health FSA Carryover option for Health FSA Component:

Amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during subsequent Plan Years under the following conditions:

(a) Applicability.

In order for an individual to be reimbursed for Medical Care Expenses from amounts remaining in his or her Health FSA Account at the end of the Plan Year, he or she must be either (1) an eligible Employee; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

(b) No Cash-Out or Conversion.

Unused Health FSA balances may not be cashed out or converted to any other taxable or nontaxable benefit. For example, unused Health FSA Amounts may not be used to reimburse Dependent Care Expenses.

(c) Reimbursement of Health FSA expenses.

The unused Health FSA balance at the end of the prior Plan Year may be used for expenses incurred in the prior Plan Year if claimed during the Plan's run-out period, or to expenses that are incurred at any time in the current Plan Year. Medical Care Expenses incurred during the current Plan Year and approved for reimbursement in accordance with the Plan's claims procedure for the Health FSA Component will be reimbursed and charged first against the current Plan Year Health FSA Amounts. All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

(d) Run-Out Period and Forfeitures.

Claims for reimbursement of Medical Care Expenses incurred during a Plan Year must be submitted no later than 90 days following the close of the Plan Year in order to be reimbursed from the prior Plan Year Health FSA Amounts. Any prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year shall be carried over to reimburse the Participant for expenses incurred in the following Plan Year. The Participant will forfeit all rights with respect to

such balance, upon termination of employment, unless FSA COBRA coverage has been selected. Unused Health FSA balances in excess of $610.00 will be forfeited.

(e) **Debit Cards** *(if applicable).*
If a Debit Card is provided to access your Health FSA funds, verify with your Plan Administrator whether you may use your Debit Card to access amounts available from the Prior Plan Year Health FSA.

Caution Regarding Impact of Health FSA Carryover on Eligibility to Contribute to a Health Savings Account (HSA).

Under IRS rules regarding Health FSA and an Employee's ability to contribute to a Health Savings Account (HSA), the Employee may be restricted to Health FSA reimbursement of eligible dental, vision, or preventive care expenses only, unless the HSA compatible health insurance plan statutory minimum deductible amount has been met. The Employee should check with their HSA Administrator and/or Plan Administrator.

Please attach this document to your SPD for future reference.

If you have questions, please contact the Plan Administrator.

Roman Catholic Diocese of Owensboro

600 Locust Street

Owensboro, KY 42301

Tel. (270) 683-1545

Plan Sponsor: Roman Catholic Diocese of Owensboro

Sponsor's EIN: 45-3848250

Plan Name: Roman Catholic Diocese of Owensboro Health FSA

Plan Number: 501

Plan Year: January 1 to December 31

Employee Benefits--Cafeteria Plans; Proposed Rule
REG-142695-05 – August 6, 2007

Department of the Treasury
Internal Revenue Service
26 CFR Part 1
REG-142695-05
Employee Benefits--Cafeteria Plans
AGENCY: Internal Revenue Service (IRS), Treasury.
ACTION: Withdrawal of prior notices of proposed rulemaking, notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains new proposed regulations providing guidance on cafeteria plans. This document also withdraws the notices of proposed rulemaking relating to cafeteria plans under section 125 that were published on May 7, 1984, December 31, 1984, March 7, 1989, November 7, 1997 and March 23, 2000. In general, these proposed regulations would affect employers that sponsor a cafeteria plan, employees that participate in a cafeteria plan, and third party cafeteria plan administrators.

Explanation of Provisions

Overview
The new proposed regulations are organized as follows: general rules on qualified and nonqualified benefits in cafeteria plans (new proposed Sec. 1.125-1), general rules on elections (new proposed Sec. 1.125-2), general rules on flexible spending arrangements (new proposed Sec. 1.125-5), general rules on substantiation of expenses for qualified benefits (new proposed Sec. 1.125-6) and nondiscrimination rules (new proposed Sec. 1.125-7). The new proposed regulations, new Proposed Sec. Sec. 1.125-1, 1.125-2, 1.125-5, 1.125-6 and Sec. 1.125-7, consolidate and restate Proposed Sec. 1.125-1 (1984, 1997, 2000), Sec. 1.125-2 (1989, 1997, 2000) and Sec. 1.125-2T (1986). Unless otherwise indicated, references to "new proposed regulations" or "these proposed regulations" mean the proposed section 125 regulations being published in this document.

The new proposed regulations reflect changes in tax law since the prior regulations were proposed, including: the change in the definition of dependent (section 152) and the addition of the following as qualified benefits: adoption assistance (section 137), additional deferred compensation benefits described in section 125(d)(1)(B), (C) and (D), Health Savings Accounts (HSAs) (sections 223, 125(d)(2)(D) and 4980G), and qualified HSA distributions from health FSAs (section 106(e)). Other changes include the prohibition against long-term care insurance and long-term care services (section 125(f)) and the addition of the key employee concentration test in section 125(b)(2).

The prior proposed regulations, Sec. Sec. 1.125-1 and 1.125-2, provide the basic framework and requirements for cafeteria plans and elections under cafeteria plans. The prior proposed regulations also outlined the most significant rules for benefits under a health flexible spending arrangement (health FSA) offered by a cafeteria plan--the requirement that the maximum reimbursement be available at all times during the coverage period (the uniform coverage rule), the requirement of a 12-month period of coverage, the requirement that the health FSA only reimburse medical expenses, the requirement that all medical expenses be substantiated by a third party before reimbursement, the requirement that expenses be incurred during the period of coverage, and the prohibition against deferral of compensation (including the use-or-lose rule). The prior proposed regulations also provided guidelines for dependent care FSAs, and the application of section 125 to paid vacation days offered under a cafeteria plan. These remain substantially unchanged in the new proposed regulations, with certain clarifications. Finally, the prior proposed regulations included a number of Q & As addressing transitional issues relating to the enactment of section 125, as well as the application of the now-repealed section 89 (special nondiscrimination rules with respect to certain employee benefit plans). These provisions are omitted from the new proposed regulations.

I. New Proposed Sec. 1.125-1--Qualified and Nonqualified Benefits in Cafeteria Plans Section 125 Exclusive Noninclusion Rule
Section 125 provides that, except in the case of certain discriminatory benefits, no amount shall be included in the gross income of a participant in a cafeteria plan (as defined in section 125(d)) solely because, under the plan, the participant may choose among the benefits of the plan. The new proposed regulations clarify and amplify the general rule in the prior proposed regulations that section 125 is the exclusive means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice itself resulting in inclusion in gross income by the

employees. When employees may elect between taxable and nontaxable benefits, this election results in gross income to employees, unless a specific Internal Revenue Code (Code) section (such as section 125) intervenes to prevent gross income inclusion. Thus, except for an election made through a cafeteria plan that satisfies section 125 or another specific Code section (such as section 132(f)(4)), any opportunity to elect among taxable and nontaxable benefits results in inclusion of the taxable benefit regardless of what benefit is elected and when the election is made. This interpretation of section 125 is consistent with the legislative history of section 125. The legislative history begins with the interim ERISA rules for cafeteria plans:

Under * * * ERISA, an employer contribution made before January 1, 1977, to a cafeteria plan in existence on June 27, 1974, is required to be included in an employees' gross income only to the extent that the employee actually elects taxable benefits. In the case of a plan not in existence on June 27, 1974, the employer contribution is required to be included in an employee's gross income to the extent the employee could have elected taxable benefits. S. Rep. No. 1263, 95th Cong., 2d Sess. 74 (1978), reprinted in 1978 U.S.C.C.A.N. 6837; H. R. Rep. No. 1445, 95th Cong., 2d Sess. 63 (1978); H.R. Conf. Rep. No. 1800, 95th Cong., 2d Sess. 206 (1978).

The legislative history also provides:

Generally, employer contributions under a written cafeteria plan which permits employees to elect between taxable and nontaxable benefits are excluded from the gross income of an employee to the extent that nontaxable benefits are elected. S. Rep. No. 1263, 95th Cong., 2d Sess. 75 (1978), reprinted in 1978 U.S.C.C.A.N. 6838; H. R. Rep. No. 1445, 95th Cong., 2d Sess. 63 (1978). See also H.R. Conf. Rep. No. 1800, 95th Cong., 2d Sess. 206 (1978).

The legislative history to the 1984 amendments to section 125 continues:

The cafeteria plan rules of the Code provide that a participant in a nondiscriminatory cafeteria plan will not be treated as having received a taxable benefit offered under the plan solely because the participant has the opportunity, before the benefit becomes available, to choose among the taxable and nontaxable benefits under the plan. H.R. Conf. Rep. No. 861, 98th Cong., 2d Sess. 1173 (1984), reprinted in 1984 U.S.C.C.A.N. 1861. See also H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 295, reprinted in 1996 U.S.C.C.A.N. 2108.

The new proposed regulations provide that unless a plan satisfies the requirements of section 125 and the regulations, the plan is not a cafeteria plan. Reasons that a plan would fail to satisfy the section 125 requirements include: Offering nonqualified benefits; not offering an election between at least one permitted taxable benefit and at least one qualified benefit; deferring compensation; failing to comply with the uniform coverage rule or use-or-lose rule; allowing employees to revoke elections or make new elections during a plan year, except as provided in Sec. 1.125-4; failing to comply with substantiation requirements; paying or reimbursing expenses incurred for qualified benefits before the effective date of the cafeteria plan or before a period of coverage; allocating experience gains (forfeitures) other than as expressly allowed in the new proposed regulations; and failing to comply with grace period rules.

Definition of a Cafeteria Plan

The new proposed regulations provide that a cafeteria plan is a separate written plan that complies with the requirements of section 125 and the regulations, that is maintained by an employer for employees and that is operated in compliance with the requirements of section 125 and the regulations. Participants in a cafeteria plan must be permitted to choose among at least one permitted taxable benefit (for example, cash, including salary reduction) and at least one qualified benefit. A plan offering only elections among nontaxable benefits is not a cafeteria plan. Also, a plan offering only elections among taxable benefits is not a cafeteria plan. See Rev. Rul. 2002-27, Situation 2 (2002-1 CB 925), see Sec. 601.601(d)(2)(ii)(b). Finally, a cafeteria plan must not provide for deferral of compensation, except as specifically permitted in section 125(d)(2)(B), (C), or (D).

Written Plan

Section 125(d)(1) requires that a cafeteria plan be in writing. The cafeteria plan must be operated in accordance with the written plan terms. The new proposed regulations require that the written plan specifically describe all benefits, set forth the rules for eligibility to participate and the procedure for making elections, provide that all elections are irrevocable (except to the extent that the plan includes the optional change in status rules in Sec. 1.125-4), and state how employer contributions may be made under the plan (for example, salary reduction or nonelective employer contributions), the maximum amount of elective contributions, and the plan year. If the plan includes a flexible spending arrangement (FSA), the written plan must include provisions complying with the uniform coverage rule and the use-or-lose rule. Because

section 125(d)(1)(A) states that a cafeteria plan is a written plan under which "all participants are employees", the new proposed regulations require that the written cafeteria plan specify that only employees may participate in the cafeteria plan. The new proposed regulations also require that all provisions of the written plan apply uniformly to all participants.

Individuals Who May Participate in a Cafeteria Plan
All participants in a cafeteria plan must be employees. See section 125(d)(1)(A). These proposed regulations provide that employees include common law employees, leased employees described in section 414(n), and full-time life insurance salesmen (as defined in section 7701(a)(20)). These proposed regulations further provide that former employees (including laid-off employees and retired employees) may participate in a plan, but a plan may not be maintained predominantly for former employees. See Rev. Rul. 82-196 (1982-2 CB 53); Rev. Rul. 85-121 (1985-2 CB 57), see Sec. 601.601(d)(2)(ii)(b). All employees who are treated as employed by a single employer under section 414(b), (c) or (m) are treated as employed by a single employer for purposes of section 125. See section 125(g)(4). A participant's spouse or dependents may receive benefits through a cafeteria plan although they cannot participate in the cafeteria plan. Self-employed individuals are not treated as employees for purposes of section 125. Accordingly, the new proposed regulations make clear that sole proprietors, partners, and directors of corporations are not employees and may not participate in a cafeteria plan. In addition, the new proposed regulations clarify that 2-percent shareholders of an S corporation are not employees for purposes of section 125. The new proposed regulations provide rules for dual status individuals and individuals moving between employee and non-employee status. A self-employed individual may, however, sponsor a cafeteria plan for his or her employees.

Election Between Taxable and Nontaxable Benefits
The new proposed regulations require that a cafeteria plan offer employees an election among only permitted taxable benefits (including cash) and qualified nontaxable benefits. See section 125(d)(1)(B). For purposes of section 125, cash means cash from current compensation (including salary reduction), payment for annual leave, sick leave, or other paid time off, severance pay, property, and certain after-tax employee contributions. Distributions from qualified retirement plans are not cash or taxable benefits for purposes of section 125. See Rev. Rul. 2003-62 (2003-1 CB 1034) (distributions to former employees from a qualified employees' trust, applied to pay health insurance premiums, are includible in former employees' gross income under section 402), see Sec. 601.601(d)(2)(ii)(b).

Qualified Benefits
In general, in order for a benefit to be a qualified benefit for purposes of section 125, the benefit must be excludible from employees' gross income under a specific provision of the Code and must not defer compensation, except as specifically allowed in section 125(d)(2)(B), (C) or (D). Examples of qualified benefits include the following: group-term life insurance on the life of an employee (section 79); employer-provided accident and health plans, including health flexible spending arrangements, and accidental death and dismemberment policies (sections 106 and 105(b)); a dependent care assistance program (section 129); an adoption assistance program (section 137); contributions to a section 401(k) plan; contributions to certain plans maintained by educational organizations, and contributions to HSAs. Section 125(f), (d)(2)(B), (C), (D). See Notice 97-9 (1997-2 CB 35) (adoption assistance), see Sec. 601.601(d)(2)(ii)(b); Notice 2004-2, Q & A-33 (2004-1 CB 269) (HSAs), see Sec. 601.601(d)(2)(ii)(b). A cafeteria plan may also offer long-term and short-term disability coverage as a qualified benefit (see section 106). However, see paragraph (q) in Sec. 1.125-1 for nonqualified benefits.

Group-Term Life Insurance
An employer may provide group-term life insurance through a combination of methods. Generally, under section 79(a), the cost of $50,000 or less of group-term life insurance on the life of an employee provided under a policy (or policies) carried directly or indirectly by an employer is excludible from the employee's gross income. (Special rules apply to key employees if the group-term life insurance plan does not satisfy the nondiscrimination rules in section 79(d)). However, if the group-term life insurance provided to an employee by an employer or employers exceeds $50,000 (taking into account all coverage provided both through a cafeteria plan and outside a cafeteria plan), the cost of coverage exceeding coverage of $50,000 is includible in the employee's gross income. For this purpose, the cost of group-term life insurance is shown in Sec. 1.79-3(d)(2), Table I (Table I). The Table I cost of the excess group-term life insurance (minus all after-tax contributions by the employee for group-term life insurance coverage) is includible in each covered employee's gross income. The new proposed regulations provide that the cost of group-term life insurance on the life of an employee, that either is less than or equal to the amount excludible from gross income under section 79(a) or provides coverage in excess of that amount, but not combined with any permanent benefit, is a qualified benefit that may be offered in a cafeteria plan. The new proposed regulations also provide that the entire amount of salary reduction and employer flex credits for group-term life insurance coverage on the life of an employee is excludible from an employee's gross income.

The rule in the new proposed regulations differs from Notice 89-110 (1989-2 CB 447), see Sec. 601.601(d)(2)(ii)(b). Notice 89-110 provides that an employee includes in gross income the greater of the Table I cost of group-term life insurance coverage exceeding $50,000 or the employee's salary reduction and employer flex-credits for excess group term life insurance coverage. The new proposed regulations provide instead that the employee includes in gross income the Table I cost of the excess coverage (minus all after-tax contributions by the employee for group-term life insurance coverage) and that the entire amount of salary reduction and employer flex-credits for group-term life insurance coverage on the life of the employee is excludible from the employee's gross income. As noted in this preamble, taxpayers may rely on the new proposed regulations for guidance pending the issuance of final regulations.

Employer-Provided Accident and Health Plan
Coverage under an employer-provided accident and health plan that satisfies the requirements of section 105(b) may be provided as a qualified benefit through a cafeteria plan and is excludible from employees' gross income. Section 106; Sec. 1.106-1. The nondiscrimination rules under section 105(h) apply to self-insured medical reimbursement arrangements (including health FSAs).

The new proposed regulations specifically permit a cafeteria plan (but not a health FSA) to pay or reimburse substantiated individual accident and health insurance premiums. See Rev. Rul. 61-146 (1961-2 CB 25), see Sec. 601.601(d)(2)(ii)(b). In addition, a cafeteria plan may provide for payment of COBRA premiums for an employee. For employer-provided accident and health plans and medical reimbursement plans, the definition of dependents is the definition in section 105(b) as amended by the Working Families Tax Relief Act of 2004 (WFTRA), Public Law 108-311, section 207(9) (118 Stat. 1166) (that is, a dependent as defined in section 152, determined without regard to section 152(b)(1), (b)(2), or (d)(1)(B)). See Notice 2004-79 (2004-2 CB 898), see Sec. 601.601(d)(2)(ii)(b). For purposes of the exclusion from employees' gross income for accident and health plans and for medical reimbursement under sections 105(b) and 106, the spouse or dependent of a former employee (including a retired employee or a laid-off employee) or of a deceased employee is treated as a spouse or dependent. See Rev. Rul. 82-196 (1982-2 CB 53); Rev. Rul. 85-121 (1985-2 CB 57), see Sec. 601.601(d)(2)(ii)(b).

Dependent Care Assistance Programs and Adoption Assistance Programs
If the requirements of section 129 are satisfied, up to $5,000 of employer-provided assistance for amounts paid or incurred by employees for dependent care is excludible from employees' gross income. The new proposed regulations outline the general requirements for providing dependent care assistance programs and adoption assistance programs under section 137 through a cafeteria plan. See Notice 97-9, section II (1997-2 CB 35), see Sec. 01.601(d)(2)(ii)(b) Cafeteria Plan Year. The new proposed regulations require that a cafeteria plan year must be 12 consecutive months and must be set out in the written cafeteria plan. A short plan year (or a change in plan year resulting in a short plan year) is permitted only for a valid business purpose. A change in plan year resulting in a short plan year, for other than a valid business purpose, is disregarded. If a principal purpose of a change in plan year is to circumvent the rules of section 125, the change in plan year is ineffective.

No Deferral of Compensation
Qualified benefits must be current benefits. In general, a cafeteria plan may not offer benefits that defer compensation or operate to defer compensation. Section 125(d)(2)(A). In general, benefits may not be carried over to a later plan year or used in one plan year to purchase benefits to be provided in a later plan year. For example, life insurance with a cash value build-up or group-term life insurance with a permanent benefit (within the meaning of Sec. 1.79-0) defers the receipt of compensation and thus is not a qualified benefit.

The new proposed regulations clarify whether certain benefits and plan administration practices defer compensation. For example, the regulations permit an accident and health insurance policy to provide certain benefit features that apply for more than one plan year, such as reasonable lifetime limits on benefits, level premiums, premium waiver during disability, guaranteed renewability of coverage, coverage for specified accidental injury or specific diseases, and the payment of a fixed amount per day for hospitalization. But these insurance policies must not provide an investment fund or cash value to pay premiums, and no part of the premium may be held in a separate account for any beneficiary. The new proposed regulations also provide that the following benefits and practices do not defer compensation: a long-term disability policy paying benefits over more than one plan year; reasonable premium rebates or policy dividends; certain two-year lock-in vision and dental policies; certain advance payments for orthodontia; salary reduction contributions in the last month of a plan year used to pay accident and health insurance premiums for the first month of the following plan year; reimbursement of section 213(d) expenses for durable medical equipment; and allocation of experience gains (forfeitures) among participants.

Paid Time Off
Under the prior proposed regulations, permitted taxable benefits included various forms of paid leave. Since the prior proposed regulations were issued, many employers have recharacterized and combined vacation days, sick leave and personal days into a single category of "paid time off." The new proposed regulations use the term "paid time off"' to refer to vacation days and other types of paid leave. The new proposed regulations contain the same ordering rule for elective and nonelective paid time off as set forth in Prop. Sec. 1.125-1, Q & A-7 (1984). A plan offering an election solely between paid time off and taxable benefits is not a cafeteria plan.

Grace Period
The new proposed regulations allow a written cafeteria plan to provide an optional grace period immediately following the end of each plan year, extending the period for incurring expenses for qualified benefits. A grace period may apply to one or more qualified benefits (for example, health FSA or dependent care assistance program) but in no event does it apply to paid time off or contributions to section 401(k) plans. Unused benefits or contributions for one qualified benefit may only be used to reimburse expenses incurred during the grace period for that same qualified benefit. The amount of unused benefits and contributions available during the grace period may be limited by the employer. A grace period may extend to the fifteenth day of the third month after the end of the plan year (but may be for a shorter period). Benefits or contributions not used as of the end of the grace period are forfeited under the use-or-lose rule. The grace period applies to all employees who are participants (including through COBRA), as of the last day of the plan year. Grace period rules must apply uniformly to all participants. The grace period rules in these proposed regulations are based on Notice 2005-42 (2005-1 CB 1204), modified in Notice 2007-22 (2007-10 IRB 670), see Sec. 601.601(d)(2)(ii)(b), amplified in Notice 2005-86 (2005-2 CB 1075), amplified in Notice 2007-22 (2007-10 IRB 670), see Sec. 601.601(d)(2)(ii)(b). For eligibility to contribute to a Health Savings Account (HSA) during a grace period, see Notice 2005-86 (2005-2 CB 1075), see Sec. 601.601(d)(2)(ii)(b). For Form W-2 reporting for unused dependent care assistance used for expenses incurred during a grace period, see Notice 2005-61 (2005-2 CB 607), see Sec. 601.601(d)(2)(ii)(b).

Contributions to Section 401(k) Plans Through a Cafeteria Plan
A cafeteria plan may include contributions to a section 401(k) plan. Section 125(d)(2)(B). The new proposed regulations clarify the interactions between section 125 and section 401(k). Contributions to a section 401(k) plan expressed as a percentage of compensation are permitted. Pursuant to Sec. 1.401(k)-1(a)(3)(ii), elective contributions to a section 401(k) plan may be made through automatic enrollment (that is, when the employee does not affirmatively elect cash, the employee's compensation is reduced by a fixed percentage, which is contributed to a section 401(k) plan).

Nonqualified Benefits
A cafeteria plan must not offer any of the following benefits: scholarships (section 117); employer-provided meals and lodging (section 119); educational assistance (section 127); fringe benefits (section 132); long-term care insurance. See section 125(f). Long-term care services are nonqualified benefits, H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 29, reprinted in 1996 U.S.C.C.A.N. 2109. (An HSA funded through a cafeteria plan may, however, be used to pay premiums for long-term care insurance or for long-term care services.) The new proposed regulations clarify that contributions to Archer Medical Savings Accounts (sections 220, 106(b)), group term life insurance for an employee's spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits. A plan offering any nonqualified benefit is not a cafeteria plan. A cafeteria plan may not offer a health FSA that provides for the carryover of unused benefits. See Notice 2002-45, Part I (2002-2 CB 93); Rev. Rul. 2002-41 (2002-2 CB 75), see Sec. 601.601(d)(2)(ii)(b).

After-Tax Employee Contributions
The new proposed regulations allow a cafeteria plan to offer after-tax employee contributions for qualified benefits or paid time off. A cafeteria plan may only offer the taxable benefits specifically permitted in the new proposed regulations. Nonqualified benefits may not be offered through a cafeteria plan, even if paid with after-tax employee contributions.

Employer Contributions Through Salary Reduction
Employees electing a qualified benefit through salary reduction are electing to forego salary and instead to receive a benefit which is excludible from gross income because it is provided by employer contributions. Section 125 provides that the employee is treated as receiving the qualified benefit from the employer in lieu of the taxable benefit. A cafeteria plan may also impose reasonable fees to administer the cafeteria plan which may be paid through salary reduction. A cafeteria plan is not required to allow employees to pay for any qualified benefit with after-tax employee contributions.

II. New Prop. Sec. 1.125-2--Elections in Cafeteria Plans

Making, Revoking and Changing Elections

Generally, a cafeteria plan must require employees to elect annually between taxable benefits and qualified benefits. Elections must be made before the earlier of the first day of the period of coverage or when benefits are first currently available. The determination of whether a taxable benefit is currently available does not depend on whether it has been constructively received by the employee for purposes of section 451. Annual elections generally must be irrevocable and may not be changed during the plan year. However, Sec. 1.125-4 permits a cafeteria plan to provide for changes in elections based on certain changes in status. An employer that wishes to permit such changes in elections must incorporate the rules in Sec. 1.125-4 in its written cafeteria plan. These proposed regulations omit the rule in Q & A-6(b) in Prop. Sec. 1.125-2 (1989) (cessation of required contributions), because the change in status rules in Sec. 1.125-4 superseded this provision of the 1989 proposed regulations.

If HSA contributions are made through salary reduction under a cafeteria plan, employees may prospectively elect, revoke or change salary reduction elections for HSA contributions at any time during the plan year with respect to salary that has not become currently available at the time of the election.

A cafeteria plan is permitted to include an automatic election for new employees or current employees. Rev. Rul. 2002-27 (2002-1 CB 925), see Sec. 601.601(d)(2)(ii)(b). A new rule also permits a cafeteria plan to provide an optional election for new employees between cash and qualified benefits. New employees avoid gross income inclusion if they make an election within 30 days after the date of hire even if benefits provided pursuant to the election relate back to the date of hire. However, salary reduction amounts used to pay for such an election must be from compensation not yet currently available on the date of the election. Also, this special election rule for new employees does not apply to any employee who terminates employment and is rehired within 30 days after terminating employment (or who returns to employment following an unpaid leave of absence of less than 30 days).

New elections and revocations or changes in elections can be made electronically. The safe harbor for electronic elections in Sec. 1.401(a)-21 is available. Only an employee can make an election or revoke or change his or her election. An employee's spouse or dependent may not make an election under a cafeteria plan and may not revoke or change an employee's election.

III. New Prop. Sec. 1.125-5--Flexible Spending Arrangements

Overview

In general, a flexible spending arrangement (FSA) is a benefit designed to reimburse employees for expenses incurred for certain qualified benefits, up to a maximum amount not substantially in excess of the salary reduction and employer flex-credits allocated for the benefit. The maximum amount of reimbursement reasonably available must be less than five times the value of the coverage. Employer flex-credits are non-elective employer contributions that an employer makes available for every employee eligible to participate in the cafeteria plan, to be used at the employee's election only for one or more qualified benefits (but not as cash or other taxable benefits). The three types of FSAs are dependent care assistance, adoption assistance and medical care reimbursements (health FSA).

Uniform Coverage Rule

The new proposed regulations retain the rule that the maximum amount of reimbursement from a health FSA must be available at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements). The uniform coverage rule does not apply to FSAs for dependent care assistance or adoption assistance.

Use-or-Lose Rule

An FSA must satisfy all the requirements of section 125, including the prohibition against deferring compensation. In general, as discussed under "no deferral of compensation", in order to satisfy this requirement of section 125, all benefits and contributions must be used by the end of the plan year (or grace period, if applicable), or are forfeited. The new proposed regulations continue the use-or-lose rule.

Period of Coverage

The required period of coverage for all FSAs continues to be twelve months, with an exception for short plan years that satisfy the conditions in the new proposed regulations. The period of coverage and the plan year need not be the same. The beginning and end of a period of coverage is clarified. The new proposed regulations also clarify that FSAs for

different qualified benefits need not have the same coverage period. See also “Grace period”, discussed in this preamble. The new proposed regulations also continue to provide that expenses are incurred when services are provided. Expenses incurred before or after the period of coverage may not be reimbursed.

Health FSA
A health FSA may only reimburse certain substantiated section 213(d) medical care expenses incurred by the employee, or by the employee’s spouse or dependents. A health FSA may be limited to a subset of permitted section 213(d) medical expenses (for example, a health FSA is permitted to exclude reimbursement of over-the-counter drugs described in Rev. Rul. 2003-102 (2003-2 CB 559), see Sec. 601.601(d)(2)(ii)(b)). Similarly, a health FSA may be an HSA compatible limited-purpose health FSA or post-deductible health FSA. Rev. Rul. 2004-45 (2004-1 CB 971), see Sec. 601.601(d)(2)(ii)(b), amplified, Notice 2005-86 (2005-2 CB 1075). A health FSA may not reimburse premiums for accident and health insurance or long-term care insurance. See section 125(f).

A health FSA must satisfy all requirements of section 105(b), Sec. Sec. 1.105-1 and 1.105-2. The section 105(h) nondiscrimination rules apply to health FSAs. All medical expenses must be substantiated before expenses are reimbursed. See Incurring and reimbursing expenses for qualified benefits, discussed in this preamble. The new proposed regulations also clarify when medical expenses are incurred.\1\ A cafeteria plan may limit enrollment in a health FSA to those employees who participate in the employer’s accident and health plan.

\1\ See Rev. Rul. 2005-55 (2005-2 CB 284) and Rev. Rul. 2005-24 (2005-1 CB 892), see Sec. 601.601(d)(2)(ii)(b) (section 105(b) exclusion only applicable to reimbursements for medical expenses incurred by employee, or by the employee’s spouse or dependents); Rev. Rul. 2002-3 (2002-1 CB 316) (purported reimbursements to employees of health insurance premiums not paid by employees and therefore impermissible); Rev. Rul. 2002-80 (2002-2 CB 925), see Sec. 601.601(d)(2)(ii)(b) (so-called advance reimbursements and purported loans are impermissible); Rev. Rul. 2003-43 (2003-1 CB 935), see Sec. 601.601(d)(2)(ii)(b); Notice 2006-69 (2006-31 IRB 107) (substantiation requirements for debit cards), amplified in Notice 2007-2 (2007-2 IRB 254), see Sec. 601.601(d)(2)(ii)(b).

Qualified HSA Distributions
Section 106(e), enacted in section 302 of the Health Opportunity Patient Empowerment Act of 2006, Public Law 109-432 (120 Stat. 2922 (2006)) allows “qualified HSA distributions” from health FSAs to HSAs. Section 106(e) applies to distributions between December 20, 2006 and December 31, 2011. The proposed regulations incorporate the rules on qualified HSA distributions set forth in Notice 2007-22 (2007-10 IRB 670). See Sec. 601.601(d)(2)(ii)(b).

The distribution must not be more than the lesser of the balance in the health FSA on September 21, 2006, or the date of the distribution. If you were not covered by a health FSA on September 21, 2006, you cannot elect to make a qualified HSA distribution from the health FSA. If you were covered by a health FSA with an employer on September 21, 2006, but change employers after that date, you cannot elect to make a qualified HSA distribution from your second employer's health FSA.

The following conditions must be met to make a qualified HSA distribution.
-The plan must have been amended to allow these distributions.
-You must elect to make the rollover.
-The year-end balance in the health FSA must be frozen.
-The funds must be transferred within 2½ months after the end of the health FSA's plan year and result in a zero balance in the health FSA.
-The distribution must be contributed directly to the HSA trustee by the employer.

Only one qualified HSA distribution is allowed for each health FSA. If you do not remain an eligible individual for HSA purposes during the testing period, the distribution is included in your income and is subject to a 10% additional tax. For more information, see Notice 2007-22, 2007-10 I.R.B. 670

Dependent Care Assistance After Termination
A new optional rule permits an employer to reimburse a terminated employee’s qualified dependent care expenses incurred after termination through a dependent care FSA, if all section 129 requirements are otherwise satisfied.

Experience Gains
If an employee fails to use all contributions and benefits for a plan year before the end of the plan year (and the grace period, if applicable), those unused contributions and benefits are forfeited under the use-or-lose rule. Unused amounts are also known as experience gains. The new proposed regulations retain the forfeiture allocation rules in the 1989 proposed regulations, and clarify that the employer sponsoring the cafeteria plan may retain forfeitures, use forfeitures to defray expenses of administering the plan or allocate forfeitures among employees contributing through salary reduction on a reasonable and uniform basis.

FSA Administrative Rules
Salary reduction contributions may be made at whatever interval the employer selects, including ratably over the plan year based on the employer's payroll periods or in equal installments at other regular intervals (for example, quarterly installments). These rules must apply uniformly to all participants.

IV. New Prop. Sec. 1.125-6--Substantiation of Expenses for All Cafeteria Plans

Incurring and Reimbursing Expenses for Qualified Benefits
The new proposed regulations provide that only expenses for qualified benefits incurred after the later of the effective date or the adoption date of the cafeteria plan are permitted to be reimbursed under the cafeteria plan. Similarly, if a plan amendment adds a new qualified benefit, only expenses incurred after the later of the effective date or the adoption date are eligible for reimbursement.\2\ This rule applies to all qualified benefits. Similarly, a cafeteria plan may pay or reimburse only expenses for qualified benefits incurred during a participant's period of coverage.

\2\ See American Family Mut. Ins. Co. v. United States, 815 F. Supp. 1206 (W.D. Wis. 1992); Wollenberg v. United States, 75 F. Supp.2d 1032 (D. Neb. 1999); Rev. Rul. 2002-58 (2002-2 CB 541), see Sec. 601.601(d)(2)(ii)(b); Notice 97-9, section II (adoption assistance).

Substantiation and Reimbursement of Expenses for Qualified Benefits
The new proposed regulations provide, after an employee incurs an expense for a qualified benefit during the coverage period, the expense must first be substantiated before the expense may be paid or reimbursed. All expenses must be substantiated (substantiating only a limited number of total claims, or not substantiating claims below a certain dollar amount does not satisfy the requirements in the new proposed regulations). See Sec. 1.105-2; Rul. 2003-80; Rev. Rul. 2003-43 (2002-1 CB 935), see Sec. 601.601(d)(2)(ii)(b); Notice 2006-69 (2006-31 IRB 107), Notice 2007-2 (2007-2 IRB 254). FSAs for dependent care assistance and adoption assistance must follow the substantiation procedures applicable to health FSAs.

Debit Cards
The new proposed regulations incorporate previously issued guidance on substantiating, paying and reimbursing expenses for section 213(d) medical care incurred at a medical care provider when payment is made with a debit card. Rev. Rul. 2003-43 (2003-1 CB 935), amplified, Notice 2006-69 (2006-31 IRB 107), Notice 2007-2 (2007-2 IRB 254); Rev. Proc. 98-25 (1998-1 CB 689), see Sec. 601.601(d)(2)(ii)(b). Among the permissible substantiation methods are copayment matches, recurring expenses, and real-time substantiation. The new proposed regulations also allow point-of sale substantiation through matching inventory information with a list of section 213(d) medical expenses. The employer is responsible for ensuring that the inventory information approval system complies with the new regulations and with the recordkeeping requirements in section 6001. Rev. Rul. 2003-43 (2003-1 CB 935), amplified, Notice 2006-69 (2006-31 IRB 107), Notice 2007-2 (2007-2 IRB 254); Rev. Proc. 98-25 (1998-1 CB 689), see Sec. 601.601(d)(2)(ii)(b). The new proposed regulations also provide rules under which an FSA may pay or reimburse dependent care expenses using debit cards.

Pursuant to prior guidance (in Notice 2006-69 (2006-31 IRB 107), amplified, Notice 2007-2 (2007-2 IRB 254)), for plan years beginning after December 31, 2006, the recordkeeping requirements described in paragraph (f) in Sec. 1.125-6 apply (that is, responsibility of employers relying on the inventory information approval system for health FSA debit cards to ensure that the system complies with the new proposed recordkeeping requirements, including Rev. Proc. 98-25 (1998- 1 CB 689), Notice 2006-69 (2006-31 IRB 107), amplified, Notice 2007-2 (2007-2 IRB 254). For health FSA debit card transactions occurring on or before December 31, 2007, all supermarkets, grocery stores, discount stores and wholesale clubs that do not have a medical care merchant category code (as described in Rev. Rul. 2003-43 (2003-2 CB 935) are nevertheless deemed to be an "other medical provider"' as described in Rev. Rul. 2003-43. (For a list of

merchant category codes, see Rev. Proc. 2004-43 (2004-2 CB 124).) During this time period, mail-order vendors and web-based vendors that sell prescription drugs are also deemed to be an "other medical provider" as described in Rev. Rul. 2003- 43. After December 31, 2008, health FSA debit cards may not be used at stores with the Drug Stores and Pharmacies merchant category code unless (1) the store participates in the inventory information approval system described in Notice 2006-69, or (2) on a store location by store location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care under section 213(d). Notice 2006-69 (2006-31 IRB 107), amplified, Notice 2007-2 (2007-2 IRB 254).

V. New Prop. Sec. 1.125-7--Nondiscrimination Rules

Discriminatory benefits provided to highly compensated participants and individuals and key employees are included in these employees' gross income. See section 125(b), (c). The new proposed regulations reflect changes in tax law since Prop. Sec. 1.125-1, Q & A-9 through 13 and 19 were proposed in 1984, including the key employee concentration test, statutory nontaxable benefits (enacted in the Deficit Reduction Act of 1984 (DEFRA), Public Law 98-369, section 531(b), (98 Stat. 881(1984)), and the change in definition of dependent in WFTRA.

The new proposed regulations provide additional guidance on the cafeteria plan nondiscrimination rules, including definitions of key terms, guidance on the eligibility test and the contributions and benefits tests, descriptions of employees allowed to be excluded from testing and a safe harbor nondiscrimination test for premium-only-plans.

Specifically, the new proposed regulations define several key terms, including highly compensated individual or participant (consistent with the section 414(q) definition of highly compensated employee), officer, five percent shareholder, key employee and compensation. The new proposed regulations also provide guidance on the non-discrimination as to eligibility requirement by incorporating some of the rules under section 410(b) (specifically the rules under Sec. 1.410(b)-4(b) and (c) dealing with reasonable classification, the safe harbor percentage test and the unsafe harbor percentage component of the facts and circumstances test).

The new proposed regulations also provide additional guidance on the contributions and benefits test and, unlike the prior proposed regulations, the new proposed regulations provide an objective test to determine when the actual election of benefits is discriminatory. Specifically, the new proposed regulations provide that a cafeteria plan must give each similarly situated participant a uniform opportunity to elect qualified benefits, and that highly compensated participants must not actually disproportionately elect qualified benefits. Finally, the new rules provide guidance on the safe harbor for cafeteria plans providing health benefits and create a safe harbor for premium-only-plans that satisfy certain requirements.

The example in Prop. Sec. 1.125-1, Q & A-11 (1984) is deleted because it concerns a qualified legal services plan, which is no longer a qualified benefit.

Other Issues

These proposed regulations provide guidance under section 125 (26 U.S.C. 125). Other statutes may impose additional requirements (for example, the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. 1000), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), (sections 9801-9803); and the continuation coverage requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (section 4980B).

Proposed Effective Date

With the exceptions noted in the "Effect on other documents" section of this preamble and under the "Debit cards" section of the preamble, it is proposed that these regulations apply for plan years beginning on or after January 1, 2009. Taxpayers may rely on these regulations for guidance pending the issuance of final regulations. Prior published guidance on qualified benefits under sections 79, 105, 106, 129, 137 and 223 that is affected by these proposed regulations remains applicable through the effective date of the final regulations (except as modified in "Effect on other documents" section of this preamble).

Effect on Other Documents

Notice 89-110 (1989-2 CB 447), see Sec. 601.601(d)(2)(ii)(b), states that where group-term life insurance provided to an employee by an employer exceeds $50,000, the employee includes in gross income the greater of the cost of group-term life insurance shown in Sec. 1.79-3(d)(2), Table I (Table I) on the excess coverage or the employee's salary reduction and employer flex-credits for excess coverage. Notice 89-110 is modified, effective as of the date the proposed regulations are published in the Federal Register.

Published guidance under Sec. 105(b) states that if any person has the right to receive cash or any other taxable or nontaxable benefit under a health FSA other than the reimbursement of section 213(d) medical expenses of the employee, employee's spouse or employee's dependents, then all distributions made from the arrangement are included in the employee's gross income, even amounts paid to reimburse medical care. See Rev. Rul. 2006-36 (2006-36 IRB 353); Rev. Rul. 2005-24 (2005-1 CB 892); Rev. Rul. 2003-102 (2003-2 CB 559); Notice 2002-45 (2002-2 CB 93); Rev. Rul. 2002-41 (2002-2 CB 75); Rev. Rul. 69-141 (1969-1 CB 48). New section 106(e) provides that a health FSA will not fail to satisfy the requirements of sections 105 or 106 merely because the plan provides for a qualified HSA distribution. Amounts rolled into an HSA may be used for purposes other than reimbursing the section 213(d) medical expenses of the employee, spouse or dependents. Accordingly, Rev. Rul. 2006-36, Rev. Rul. 2005-24, Rev. Rul. 2003-102, Notice 2002-45, Rev. Rul. 2002-41, and Rev. Rul. 69-141 are modified with respect to qualified HSA distributions described in section 106(e). See Notice 2007-22 (2007-10 IRB 670), see Sec. 601.601(d)(2)(ii)(b).

Special Analyses
It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this regulation. It is hereby certified that the collection of information in this regulation will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the regulations will only minimally increase the burdens on small entities. The requirements under these regulations relating to maintaining a section 125 cafeteria plan are a minimal additional burden independent of the burdens encompassed under existing rules for underlying employee benefit plans, which exist whether or not the benefits are provided through a cafeteria plan. In addition, most small entities that will maintain cafeteria plans already use a third-party plan administrator to administer the cafeteria plan. The collection of information required in these regulations, which is required to comply with the existing substantiation requirements of sections 105, 106, 129 and 125, and the recordkeeping requirements of section 6001, will only minimally increase the third-party administrator's burden with respect to the cafeteria plan. Therefore, an analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Internal Revenue Code, this proposed regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing

Simple Cafeteria Plan

After December 31, 2010, eligible employers meeting contribution requirements and eligibility and participation requirements can establish a simple cafeteria plan. Simple cafeteria plans are treated as meeting the nondiscrimination requirements of a cafeteria plan and certain benefits under a cafeteria plan.

Eligible Employer
You are an eligible employer if you employ an average of 100 or fewer employees during either of the two preceding years. If your business was not in existence throughout the preceding year, you are eligible if you reasonably expect to employ an average of 100 or fewer employees in the current year. If you establish a simple cafeteria plan in a year that you employ an average of 100 or fewer employees, you are considered an eligible employer for any subsequent year as long as you do not employ an average of 200 or more employees in a subsequent year.

Eligibility and Participation Requirements
These requirements are met if all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate and each employee eligible to participate in the plan may elect any benefit available under the plan. You may elect to exclude from the plan employees who:

1. Are under age 21 before the close of the plan year,
2. Have less than 1 year of service with you as of any day during the plan year,
3. Are covered under a collective bargaining agreement, or
4. Are nonresident aliens working outside the United States whose income did not come from a U.S. source.

Contribution Requirements
You must make a contribution to provide qualified benefits on behalf of each qualified employee in an amount equal to:

1. A uniform percentage (not less than 2%) of the employee's compensation for the plan year, or
2. An amount which is at least 6% of the employee's compensation for the plan year or twice the amount of the salary reduction contributions of each qualified employee, whichever is less.

If the contribution requirements are met using option (2) above, the rate of contribution to any salary reduction contribution of a highly compensated or key employee can not be greater than the rate of contribution to any other employee.

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-If you have less than 100 employees;
-If employees that work 1,000 hours or more per year are eligible;
-If any eligible employee may choose any benefit available under the plan;
-If employees that have been employed by you one year (or less) are eligible;
-If employees over 21 are not excluded; and
-If you contribute either

1. A uniform percentage (not less than 2%) of the employee's compensation for the plan year, **or**
2. An amount which is at least 6% of the employee's compensation for the plan year or twice the amount of the salary reduction contributions of each qualified employee, whichever is less. HCE salary reduction contribution cannot be greater than that of any other employee.

Then you have a **Simple Cafeteria Plan**! There is no need to perform Nondiscrimination testing.

Nondiscrimination

The proposed rules, for the first time in more than twenty years, try to elaborate on the application of various non-discrimination rules to cafeteria plans. Cafeteria plans cannot favor highly compensated individuals (HCIs) as to eligibility, or favor highly compensated participants as to contributions and benefits (Treas. Reg. §1.125-7). In applying this eligibility test, certain individuals are allowed to be disregarded, including COBRA qualified beneficiaries. In other words, the test is run based on the active employee population.

The rules apply to cafeteria plans generally, and specifically to HSAs offered through a cafeteria plan and health FSAs.

Under the safe harbor provisions, plans that meet certain criteria fall within a safe harbor, that is, are deemed nondiscriminatory.

Definitions
Under the new proposed rules, an HCI means an individual who is:

1) an officer;
2) a 5-percent shareholder; or
3) highly compensated (Treas. Reg. §1.125-7(a)(3)(i)).

Spouses and dependents of HCIs also are HCIs (Treas. Reg. §1.125-7(a)(3)(ii)).

A highly compensated participant (HCP) means an HCI who is eligible to participate in a cafeteria plan (Treas. Reg. §1.125-7(a)(4)).

An "officer" for the nondiscrimination test means an individual or participant who for the preceding year was an officer. Status as an officer depends on the source of the individual's authority, the term of his or her election or appointment, and the nature and extent of duties. Generally, the term "officer" means an administrative executive who is in regular and continued service. The officer title without authority is not an "officer" for the rules' nondiscrimination purposes (Treas. Reg. §1.125-7(a)(7)).

A "key employee" is defined as under pension provisions (Code Section 416) as an employee who is an:

1) officer with compensation above a defined threshold (indexed) for the plan year as defined in the Section 415(b)(1)(A));
2) a 5-percent owner of the employer; or
3) a 1-percent owner having annual compensation from the employer of more than a threshold amount as defined in Section 416 (Treas. Reg. §1.125-7(a)(10)).

Eligibility test
Cafeteria plans cannot discriminate as to eligibility in favor of HCIs. The proposed cafeteria plan rules incorporate the pension plan safe-harbor percentage test for eligibility from Treas. Reg. §1.410. Under this test, a certain minimum percentage of nonhighly compensated individuals must be benefiting under the plan relative to a certain percentage of HCIs (Treas. Reg. §1.125-7(b)).

If enough rank-and-file employees benefit relative to the number of HCIs benefiting, the plan falls within what is called a safe harbor - or a zone of ratios automatically deemed not to discriminate (Treas. Reg. §1.125-7(b)).

If the ratio of rank-and-file employees benefiting in the cafeteria plan relative to the HCIs is too low, then the plan is deemed discriminatory. However, a plan that fails the ratios test may yet qualify under another part of the test referred to as the facts-and-circumstances test (Treas. Reg. §1.125-7(b)). For example, there may be a legitimate business reason for discriminatory eligibility, such as rank-and-file employees residing outside an HMO service area who thus do not qualify for plan coverage.

Contributions and benefits test
Under another test, a cafeteria plan cannot discriminate in favor of HCPs regarding contributions and benefits (Treas. Reg. §1.125-7(c)(1)). A plan must give each similarly situated participant a uniform chance to elect qualified benefits, and the HCPs must not in disproportionate numbers actually elect those benefits (Treas. Reg. §1.125-7(c)(2)).

Under the benefits test, disproportionate election exists if the aggregate qualified benefits that HCPs elect, measured as a percentage of their aggregate compensation, exceeds the aggregate qualified benefits that nonhighly compensated participants elect, measured as a percentage of their aggregate compensation (Treas. Reg. §1.125-7(c)(2)).

> **Example.** Contel's cafeteria plan meets eligibility requirements. HCPs in the plan elect aggregate qualified benefits equaling 5 percent of aggregate compensation; nonhighly compensated participants elect aggregate qualified benefits equaling 10 percent of aggregate compensation. Contel's cafeteria plan passes the contributions and benefits test.

Key employees test

There also is a key employees test. If nontaxable benefits provided to key employees exceed 25 percent of the aggregate nontaxable benefit provided for all employees through the cafeteria plan, each key employee includes in gross income an amount equaling the maximum taxable benefits that he or she could have elected for the plan year (Treas. Reg. §1.125-7(d)(1)).

However, there is a safe harbor for POPs under which a POP passes the contributions and benefits test and the key employee test if it meets the safe harbor percentage test for eligibility described above (Treas. Reg. §1.125-7(f)(1)).

To illustrate the key employees test:

> **Example.** Employer Durango's cafeteria plan offers all employees an election between taxable benefits (such as cash) and qualified benefits (such as excludable health benefits) and meets the eligibility test. Durango has two key employees and four nonhighly compensated employees. Key employees each elect $2,000 of qualified benefits. Each nonhighly compensated employee also elects $2,000 of qualified benefits.

Key employees receive $4,000 of nontaxable benefits and nonhighly compensated employees receive $8,000 of nontaxable benefits, for a total of $12,000. Key employees receive 33 percent of nontaxable benefits. Because the plan provides more than 25 percent of aggregate nontaxable benefits to key employees, the plan fails the key employee concentration test (Treas. Reg. §1.125-7(d)(2)).

To illustrate the POP safe harbor:

> **Example.** Employer Fox's written POP offers one health plan and offers all employees the election to salary reduce the same amount or same percentage of the premium for self-only or family coverage. All key employees and all highly compensated employees elect salary reduction for the health plan, but only 20 percent of nonhighly compensated employees elect the health plan (Treas. Reg. §1.125-7(f)(2)(i)).

The POP satisfies the eligibility and contributions and benefits tests (Treas. Reg. §1.125-7(f)(2)(ii)).

Health plan safe harbor

In addition, there is a contributions and benefits test safe harbor for group health plans — but not dental or health FSAs. The safe harbor applies if the contribution on behalf of each participant equals 100 percent of the cost of health coverage of the majority of similarly situated HCPs, or at least equals 75 percent of the cost of health coverage of the similarly situated participant with the highest cost health coverage under the plan (Treas. Reg. §1.125-7(e)(1)).

Aggregation

Employers that sponsor more than one cafeteria plan have the option to aggregate plans for nondiscrimination testing purposes, which could provide flexibility particularly to employers in industries with high turnover or low participation rates, for example (Treas. Reg. §1.125-7(g)(2)).

Plans are required to do nondiscrimination testing annually. Tests must be done as of the last day of the plan year (Treas. Reg. §1.125-7(j)(1)).

> **Example**. Employer Hoopla has three employees and maintains a calendar year cafeteria plan. During 2009 Jay was an employee the entire year, Kay was an employee from May 1 through Aug. 31, 2009, and Lai was an employee from Jan. 1 to April 15, 2009.

Nondiscrimination testing must be done for the 2009 plan year and must be performed on Dec. 31, 2009, taking into account employees Jay, Kay and Lai's compensation in the preceding year (Treas. Reg. §1.125-7(j)(2)).

Section 125 Plan Non-discrimination Testing
Instructions and Forms

The discrimination rules described in the IRC Section 125 are applied to all benefits provided in a cafeteria plan in the aggregate.

The discrimination rules applicable to cafeteria plans are found in Section 125 of the Internal Revenue Code. Under these rules, a plan cannot discriminate in favor of highly compensated employees or participants for purposes of the Eligibility Test or discriminate in favor of highly compensated participants for purposes of the Contributions and Benefits Test. A plan also cannot discriminate in favor of key employees for purposes of the Key Employee Concentration Test. The required tests are as follows:

Eligibility Test: A plan cannot discriminate in favor of highly compensated employees (defined in #1 below) as to eligibility to participate.

Contributions and Benefits Test: A plan cannot discriminate in favor of highly compensated participants (defined in #1 below) as to contributions and benefits.

Concentration Test: Benefits to key employees (defined in #2 below) under the plan cannot exceed 25% of the aggregate benefits provided to all employees under the plan.

1. For purposes of the **Eligibility, Contributions and Benefits Tests**, who are "highly compensated employees"?

   A highly compensated employee is an employee who is:
   - An officer;
   - A shareholder owning more than 5% of the voting power or value of all classes of stock of the employer;
   - Highly compensated [*interpreted to mean a "highly compensated employee" as defined in Code section 414(q)]. For 2013, it includes any employee earning over $120,000 in 2017*; or
   - A spouse or dependent of one of the above.

2. For purpose of the **Concentration Test**, who is a "key employee"?

   A key employee is an employee who is:
   - An officer with annual compensation more than $175,000 (for 2017), as indexed;
   - A more than 5% owner; or
   - A more than 1% owner with compensation over $150,000, not indexed.

What nondiscrimination rules apply to Premium Only Plans?
A Premium Only Plan that pays medical premiums on a pre-tax basis is governed by Section 106 of the Code, which does not provide any rules regarding nondiscrimination. Thus, the rules above under Item 1 will apply to Premium Only Plans for medical premiums. If all employees are eligible to have their salary reduced pre-tax to pay medical premiums, and the amount of premium does not vary (except for levels of coverage), the plan should pass the nondiscrimination tests. In addition, if a Premium Only Plan also involves the payment of group life insurance premiums, it will be subject to the nondiscrimination rules under Item 1 above.

Consequences of Test Failures

What happens if the plan discriminates in favor of either highly compensated employees or key employees?
If either the **Eligibility Test** or **Contribution and Benefits Test** fail, all highly compensated employees participating in the plan must claim the amount of benefit that they COULD have received from the plan as income on their taxes for that year. If the **Concentration Test** fails, all key employees participating in the plan must claim the amount of benefit that they COULD have received from the plan as income on their taxes for that year.
Some employees can be excluded when determining the top paid group. These include employees who:

1. Have not completed 6 months of service.
2. Normally work less than 17 ½ hours per week.

3. Normally work not more than 6 months per year.

Compensation includes taxable compensation and salary reductions under cafeteria plans, 401(k) plans, and tax sheltered annuities. Stock owned by an employee's spouse, children, grandchildren, or parents is treated as owned by the employee. (See IRC Section 318)

Excluded Employees
Section 125 provides no specific authority to exclude a group of employees. However, plan administrators have routinely "borrowed" exclusions from other code sections and applied them to cafeteria plans in general. Check the plan document for details on excluded employees.

Eligibility Discrimination
A plan will not be treated as discriminatory as to eligibility, if the plan:

1. Benefits a group of employees who qualify under a classification established by the employer and found by the IRS not to be discriminatory in favor of highly compensated employees (see IRC Section 410(b)(20(A)(I)); and
2. Meets the requirements of (a) and (b) below:
   a. No employee is required to complete more than 3 years of employment with the employer or employers maintaining the plan as a condition of participating in the plan, and the employment requirement for each employee is the same.
   b. An employee who has satisfied the employment requirement of (a) above, and who is otherwise entitled to participate in the plan, commences participation no later than the first day of the first plan year beginning after the date the employment requirement was satisfied unless the employee was separated from service before the first day of that plan year.

Contributions and Benefits
A plan will not be discriminatory as to contributions and benefits if total benefits and nontaxable benefits do not discriminate in favor of highly compensated employees. Generally this determination will be made on the basis of facts and circumstances.

Section 125(c) provides a safe harbor. It provides that a cafeteria plan does not discriminate as to contributions and benefits if the qualified benefits and total benefits (or employer contributions allocable to qualified benefits and employer contributions for total benefits) do not discriminate in favor of highly compensated participants. The regulations under Reg. Section 1.125-1 Q & A 19 states that: "a plan must satisfy section 125(c) with respect to both benefit availability and benefit selection. Thus, a plan must give each participant an equal opportunity to select nontaxable benefits, and the actual selection of nontaxable benefits under the plan must not be discriminatory, i.e., highly compensated participants do not disproportionately select nontaxable benefits while other participants select taxable benefits."

The regulations merely provide that the utilization non disproportionately favor highly compensated participants. Unfortunately, there is no guidance as to what this means.

For example, suppose an employer allows salary redirections to a cafeteria plan to pay for dependent coverage for health insurance. All highly compensated eligible employees (100%) elect coverage. Does this satisfy IRC Section 125(c)? Presumably this plan disproportionately favors highly compensated participants.

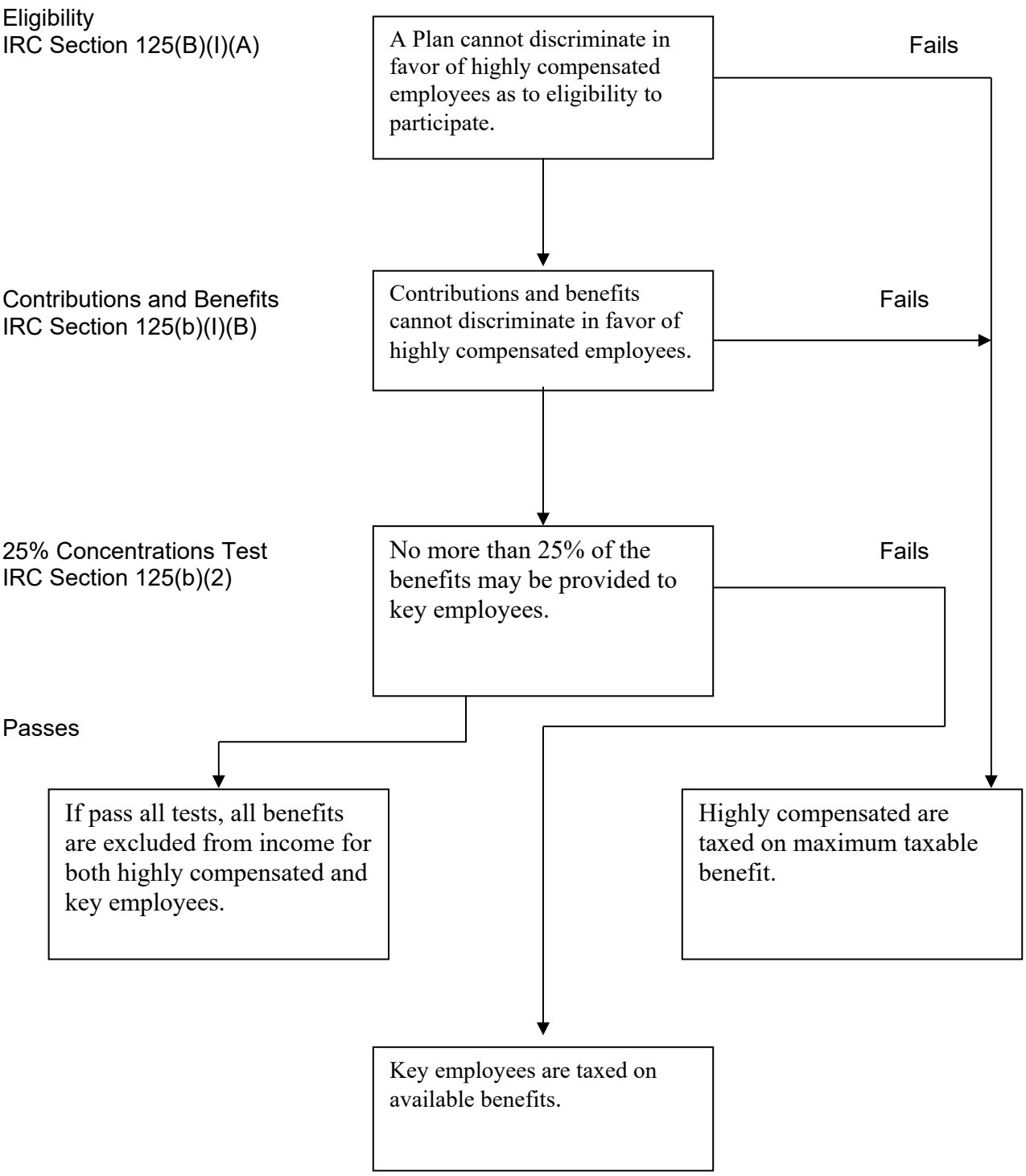
Eligibility
IRC Section 125(B)(I)(A)
A Plan cannot discriminate in favor of highly compensated employees as to eligibility to participate.
Fails
Contributions and Benefits
IRC Section 125(b)(I)(B)
Contributions and benefits cannot discriminate in favor of highly compensated employees.
Fails
25% Concentrations Test
IRC Section 125(b)(2)
No more than 25% of the benefits may be provided to key employees.
Fails
Passes
If pass all tests, all benefits are excluded from income for both highly compensated and key employees.
Highly compensated are taxed on maximum taxable benefit.
Key employees are taxed on available benefits.

Table I

Safe/Unsafe Harbor Table

Non-highly Compensated Employee Concentration Percentage	Safe Harbor Percentage	Unsafe Harbor Percentage
0-60%	50.00%	40.00%
61	49.25%	39.25%
62	48.50%	38.50%
63	47.75%	37.75%
64	47.00%	37.00%
65	46.25%	36.25%
66	45.50%	35.50%
67	44.75%	34.75%
68	44.00%	34.00%
69	43.25%	33.25%
70	42.50%	32.50%
71	41.75%	31.75%
72	41.00%	31.00%
73	40.25%	30.25%
74	39.50%	29.50%
75	38.75%	28.75%
76	38.00%	28.00%
77	37.25%	27.25%
78	36.50%	26.50%
79	35.75%	25.75%
80	35.00%	25.00%
81	34.25%	24.25%
82	33.50%	23.50%
83	32.75%	22.75%
84	32.00%	22.00%
85	31.25%	21.25%
86	30.50%	20.50%
87	29.75%	20.00%
88	29.00%	20.00%
89	28.25%	20.00%
90	27.50%	20.00%
91	26.75%	20.00%
92	26.00%	20.00%
93	25.25%	20.00%
94	24.50%	20.00%
95	23.75%	20.00%
96	23.00%	20.00%
97	22.25%	20.00%
98	21.50%	20.00%
99	20.75%	20.00%

Eligibility Classification Test

(All Plans) Reg. Section 410(b)

_____

(Company Name)

Plan Year Ended _____

		Total Employees	Highly Compensated	Non-highly Compensated
1.	Total employees	_____	_____	_____
2.	Employees ineligible under the plan	_____	_____	_____
3.	Total eligible employees (Subtract line 2 from line 1)	_____ (A)	_____	_____(B)
4.	Total employees excluded from benefiting	_____	_____	_____
5.	Total employees eligible to benefit (Subtract line 4 from line 3)	_____	_____	_____(C)
6.	Concentration of non-highly compensated employees (Divide Non-highly compensated (B) by Total Employees (A))			_____%
7.	Safe Harbor percentage			_____%
8.	Unsafe Harbor percentage			_____%
9.	Percentage of non-excluded, non-highly compensated employees eligible to benefit under the plan. (Divide Non-highly Compensated (C) by Non-highly Compensated (B))			_____%

Conclusion:

If line 9 is less than line 7, then it fails the Nondiscriminatory Classification Test.

IRC Section 125 — Cafeteria Plan

Highly Compensated Employees (HCE) — IRC 125(e) (All Plans)

This Form Just Helps You Identify and Document HCEs

_____
(Company Name)

Plan Year Ended_____

This page simply helps you identify and list Highly Compensated Employees in your group.

List all employees who fit into one or more of the following categories. An employee may be classified as highly compensated on the basis of more than one category. When listing highly compensated employees, list each employee only once.

1. List all employees at any time during the **current plan year** with more than 5% ownership.

_____ _____

_____ _____

_____ _____

2. List all employees who, during the **current plan year**, were officers.

_____ _____

_____ _____

_____ _____

3. List all employees who are a spouse or dependent (within the meaning of IRC Section 152) of any individual listed in 1 or 2 above.

_____ _____

_____ _____

_____ _____

4. List all employees who are highly compensated within the meaning of IRC Section 414(q) $130,000 in 2021, as indexed annually.

_____ _____

_____ _____

_____ _____

IRC Section 125 — Cafeteria Plan

Key Employees — IRC 416(i)(1)(A) - (All Plans)
This Form Simply Helps You Identify and Document Key Employees

_____
(Company Name)

Plan Year Ended_____

This page simply helps you identify and list all the key employees in your group.

List all employees who, at any time during the current plan year or for any of the 4 preceding plan years, fit into one or more of the following 4 categories. An employee may be classified as a key employee on the basis of more than one category. When listing key employees, list each employee only once.

1. Any officer with annual compensation more than $185,000 (for 2021), as indexed annually:

_____ _____
_____ _____
_____ _____
_____ _____

2. Employees with more than 5% ownership:

_____ _____
_____ _____
_____ _____
_____ _____

3. Employees with more than 1% ownership and annual compensation greater than $150,000:

_____ _____
_____ _____
_____ _____
_____ _____

Concentration Test

IRC Section 125 — Cafeteria Plan

25% Concentration IRC 125(b)(2) (All Plans)

_____

(Company Name)

Plan Year Ended_____

Total nontaxable benefits paid to all participants who are key employees _____(A)

Total nontaxable benefits paid to all other participants _____

Total nontaxable benefits paid _____(B)

Percent of nontaxable benefits paid to participants who are key employees (A / B) _____(C)

Conclusion:

If (C) is greater than 25%, participants who are key employees will include in income any "nontaxable benefits" received for the plan year.

IRC SECTION 105 (h)

(Health FSA) Medical Expense Reimbursement Plans Percentage Test

A plan is not discriminatory as to eligibility if it satisfies one of the following percentage tests.

The medical expense reimbursement plan benefits:

A. 70% or more of all employees.

or

B. 80% or more of all the employees who are eligible to benefit under the plan if 70% or more of all employees are eligible to benefit under the plan.

1. Total employees _____

2. Total ineligible (employees that do not meet eligibility requirements) _____

3. Employees eligible under the plan (subtract (2) from (1)) _____

4. Employees excluded from benefiting (i.e., S Corp. owner, seasonal/temporary EEs, EEs that have waived participation) _____

5. Employees eligible to benefit (subtract (4) from (3)) _____

6. Number of employees participating in plan _____

7. Percent of eligible nonexcluded employees who participate (divide (6 by (3)). If ≥ 70% *stop*. Do not complete the remainder of this form. _____

Complete (8) only if (7) is less than 70% and complete (9) only if (8) is 70% or more:

8. Percent of nonexcluded employees who are eligible to participate (divide (5) by (3)) _____

9. Percent of eligible employees who are participating (divide (6) by (5)) _____

Conclusion:

If line (7) is ≥ 70%, the plan has satisfied requirement A above.
If line (8) is ≥ 70% **and** line (9) is 80% or more, the plan has satisfied requirement B above.