

#17

DEC 11 2014



MEMORANDUM

DATE: December 2, 2014

TO: Mayor and City Council

THRU: Rich Dlugas, City Manager *RD*
Debra Stapleton, Human Resources Director *DS*

FROM: Rae Lynn Nielsen, Benefits and Labor Relations Administrator *RN*

SUBJECT: Resolution 4830 - Authorizing and Adopting the Amended and Restated City of Chandler Section 125 Flexible Benefit Plan (Cafeteria Plan)

RECOMMENDATION:

Approve Resolution 4830 authorizing and adopting the amended and restated City of Chandler Section 125 Flexible Benefit Plan ("the Plan") which renames the former City of Chandler Flexible Spending Account Program, adds provisions allowing for pre-tax contributions to Health Savings Accounts (HSAs) and continuous (evergreen) benefit elections, and makes clarifying changes to promote the efficient administration of the Plan.

BACKGROUND DISCUSSION:

A Cafeteria Plan under Section 125 of the Internal Revenue Code of 1986, as amended (26 U.S.C.A. § 125), allows employers to offer employees a choice among a variety of nontaxable benefits and cash. A Cafeteria Plan allows employees to purchase certain qualified benefits with pre-tax dollars.

The City of Chandler adopted a Cafeteria Plan for its employees effective January 1, 1996. A restatement of the Cafeteria Plan became effective January 1, 2004, as the City of Chandler Flexible Spending Account Program.

The proposed amendment and restatement of the Cafeteria Plan renames the former Flexible Spending Account Program as the City of Chandler Section 125 Flexible Benefit Plan (the "Plan") to clarify its status as a Cafeteria Plan and eliminate confusion with the Flexible Spending Account ("FSA") benefit, which is only a single component of the Plan. The restated and amended Plan also incorporates into the body of the Plan two previously approved amendments to the Health FSA effective as of January 1, 2010; adds provisions allowing employees to make pre-tax contributions to a Health Savings Account (HSA) through salary reduction if they otherwise qualify; and permits certain types of benefit elections to apply automatically to a subsequent Benefit Plan Year without an affirmative election by the employee.

The City Council's approval of the proposed Amended and Restated Plan is required for the changes to apply to the Benefit Plan Year commencing on January 1, 2015.

PROPOSED MOTION:

Move to approve Resolution 4830 authorizing and adopting the Amended and Restated City of Chandler Section 125 Flexible Benefit Plan which renames the former City of Chandler Flexible Spending Account Program, adds provisions allowing for pre-tax contributions to Health Savings Accounts and continuous (evergreen) benefit elections, and makes clarifying changes to improve administration of the Plan.

RESOLUTION NO. 4830

A RESOLUTION OF THE CITY OF CHANDLER, MARICOPA COUNTY, ARIZONA, AUTHORIZING AND ADOPTING THE AMENDED AND RESTATED CITY OF CHANDLER SECTION 125 FLEXIBLE BENEFIT PLAN TO RENAME THE FORMER CITY OF CHANDLER FLEXIBLE SPENDING ACCOUNT PROGRAM, ADD PROVISIONS ALLOWING FOR PRE-TAX CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS AND CONTINUOUS (EVERGREEN) BENEFIT ELECTIONS, AND MAKE CLARIFYING CHANGES TO IMPROVE ADMINISTRATION OF THE PLAN

WHEREAS, the City of Chandler ("the City") adopted a Cafeteria Plan under Section 125 of the Internal Revenue Code effective as of January 1, 1996, which was amended and restated as the City of Chandler Flexible Spending Account Program, effective January 1, 2004 ("the Plan"), to provide certain welfare and other benefits to its employees on a taxable or nontaxable basis; and

WHEREAS, the adoption of a Cafeteria Plan allows the City to provide employees with a choice among a variety of benefits and cash and to pay for qualified benefits with pre-tax dollars; and

WHEREAS, the City is authorized, pursuant to Section 10.1 of the Plan, to adopt amendments to the Plan; and

WHEREAS, the City Council approved amendments to the Plan in October 2009 which made changes to the Health Care Reimbursement Benefit (Health FSA) to provide for a grace period and reflect changes in the applicable law and such amendments require incorporation into the body of the Plan; and

WHEREAS, the City has determined that additional amendments are required to allow Participants to make pre-tax salary reduction contributions to Health Savings Accounts, authorize the use of automatic continuing (Evergreen) elections for certain types of benefits, and clarify provisions to promote the Plan's successful operation and administration;

NOW, THEREFORE, BE IT RESOLVED by the Council of the City of Chandler, as follows:

SECTION 1. The Mayor and City Council hereby approve and adopt the Amended and Restated City of Chandler Section 125 Flexible Benefit Plan effective for the Plan Year commencing January 1, 2015, attached hereto as Exhibit A.

SECTION 2. The Mayor is authorized to execute, on behalf of the City, the Amended and Restated City of Chandler Section 125 Flexible Benefit Plan effective for the Plan Year commencing January 1, 2015.

SECTION 3. The City's officers and employees are authorized and directed to take such actions as are deemed necessary and proper to give effect to this Resolution and implement the Plan.

PASSED AND ADOPTED by the City Council of the City of Chandler, Arizona, this _____ day of _____, 2014.

ATTEST:

CITY CLERK

MAYOR

CERTIFICATION

I HEREBY CERTIFY that the above and foregoing Resolution No. 4830 was duly passed and approved by the City Council of the City of Chandler, Arizona, at a regular meeting held on the _____ day of _____, 2014, and that a quorum was present thereat.

CITY CLERK

APPROVED AS TO FORM:

CITY ATTORNEY (*RECEIVED*)

**CITY OF CHANDLER
SECTION 125 FLEXIBLE BENEFIT PLAN**

Effective as of January 1, 1996
Amended and Restated as of January 1, 2015

TABLE OF CONTENTS

ARTICLE I
DEFINITIONS

ARTICLE II
PARTICIPATION

2.1	ELIGIBILITY	4
2.2	EFFECTIVE DATE OF PARTICIPATION	4
2.3	APPLICATION TO PARTICIPATE	4
2.4	TERMINATION OF PARTICIPATION	4
2.5	TERMINATION OF EMPLOYMENT.....	5
2.6	DEATH	5

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1	SALARY REDIRECTION	6
3.2	APPLICATION OF CONTRIBUTIONS.....	6
3.3	PERIODIC CONTRIBUTIONS.....	6

ARTICLE IV
BENEFITS

4.1	BENEFIT OPTIONS	7
4.2	HEALTH CARE REIMBURSEMENT PLAN BENEFIT	7
4.3	DEPENDENT CARE REIMBURSEMENT PLAN BENEFIT	7
4.4	MEDICAL INSURANCE BENEFIT	8
4.5	DENTAL INSURANCE BENEFIT	8
4.6	VISION INSURANCE BENEFIT.....	8
4.7	LIFE INSURANCE BENEFIT	8
4.8	HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION BENEFIT	9
4.9	NON DISCRIMINATION REQUIREMENTS	9

ARTICLE V
PARTICIPANT ELECTIONS

5.1	INITIAL ELECTIONS	10
5.2	SUBSEQUENT ANNUAL ELECTIONS.....	10
5.3	FAILURE TO ELECT.....	10
5.4	CHANGE OF ELECTIONS	11

ARTICLE VI
HEALTH CARE REIMBURSEMENT PLAN (HEALTH CARE FSA)

6.1	ESTABLISHMENT OF PLAN	15
6.2	DEFINITIONS	15
6.3	FORFEITURES	16
6.4	LIMITATION ON ALLOCATIONS	16
6.5	NONDISCRIMINATION REQUIREMENTS	16
6.6	COORDINATION WITH CAFETERIA PLAN	16
6.7	HEALTH CARE REIMBURSEMENT PLAN CLAIMS	17
6.8	DEBIT AND CREDIT CARDS	17
6.9	QUALIFIED RESERVIST DISTRIBUTIONS.....	19
6.10	GRACE PERIOD	20

ARTICLE VII
DEPENDENT CARE REIMBURSEMENT PLAN (DEPENDENT CARE FSA)

7.1	ESTABLISHMENT OF PROGRAM	21
7.2	DEFINITIONS	21
7.3	DEPENDENT CARE REIMBURSEMENT ACCOUNTS	22
7.4	INCREASES IN DEPENDENT CARE REIMBURSEMENT ACCOUNTS	22
7.5	DECREASES IN DEPENDENT CARE REIMBURSEMENT ACCOUNTS.....	23
7.6	ALLOWABLE DEPENDENT CARE REIMBURSEMENT	23
7.7	ANNUAL STATEMENT OF BENEFITS	23
7.8	FORFEITURES	23
7.9	LIMITATION ON PAYMENTS	23
7.10	NONDISCRIMINATION REQUIREMENTS	23
7.11	COORDINATION WITH CAFETERIA PLAN	24
7.12	DEPENDENT CARE REIMBURSEMENT PLAN CLAIMS	24

ARTICLE VIII
HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION BENEFIT

8.1	PURPOSE	25
8.2	DEFINITIONS	25
8.3	HSA CONTRIBUTION BENEFIT.....	26
8.4	ELIGIBILITY.....	27
8.5	CERTIFICATION OF ELIGIBILITY.....	27
8.6	CONTRIBUTIONS	27
8.7	LIMITS ON CONTRIBUTIONS	28
8.8	INVESTMENT OF HSA FUNDS	28
8.9	TAX CONSEQUENCES	28
8.10	DISTRIBUTION OF HSA FUNDS	29
8.11	REPORTING	29
8.12	CONTINUATION OF COVERAGE	29

8.13	HSA MAINTAINED BY TRUSTEE/CUSTODIAN	29
8.14	TERMS & CONDITIONS OF COVERAGE AND BENEFITS	29

ARTICLE IX
BENEFITS AND RIGHTS

9.1	CLAIM FOR BENEFITS	30
9.2	APPLICATION OF BENEFIT PLAN SURPLUS	31

ARTICLE X
ADMINISTRATION

10.1	PLAN ADMINISTRATION	31
10.2	EXAMINATION OF RECORDS	32
10.3	PAYMENT OF EXPENSES	32
10.4	INSURANCE CONTROL CLAUSE	32
10.5	INDEMNIFICATION OF ADMINISTRATOR	32

ARTICLE XI
AMENDMENT OR TERMINATION OF PLAN

11.1	AMENDMENT	33
11.2	TERMINATION	33

ARTICLE XI
MISCELLANEOUS

12.1	PLAN INTERPRETATION	33
12.2	GENDER AND NUMBER	33
12.3	WRITTEN DOCUMENT	34
12.4	EXCLUSIVE BENEFIT	34
12.5	PARTICIPANTS RIGHTS	34
12.6	ACTION BY THE EMPLOYER	34
12.7	EMPLOYER'S PROTECTIVE CLAUSES	34
12.8	NO GUARANTEE OF TAX CONSEQUENCES	35
12.9	INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS	35
12.10	FUNDING	35
12.11	GOVERNING LAW	35
12.12	SEVERABILITY	36
12.13	CAPTIONS	36
12.14	CONTINUATION OF COVERAGE	36
12.15	FAMILY AND MEDICAL LEAVE ACT	36
12.16	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT	36
12.17	UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT..	36

CITY OF CHANDLER SECTION 125 FLEXIBLE BENEFIT PLAN

Effective as of January 1, 1996
Amended and Restated as of January 1, 2015

INTRODUCTION

Effective as of January 1, 2015, the City of Chandler adopts this Amended and Restated City of Chandler Section 125 Flexible Benefit Plan as a welfare benefit plan in recognition of the contributions made to the City by its Employees. The purpose of the Plan is to provide taxable and nontaxable benefits for those Employees who qualify hereunder and their dependents and beneficiaries, and to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan was originally effective on January 1, 1996, and was restated effective January 1, 2004. The restatement and amendment effective in Benefit Year 2015 incorporates two amendments to the Plan that were previously approved by the Mayor and City Council and became effective on January 1, 2010; adds a Health Savings Account benefit; provides for annual and evergreen benefit elections, and makes other changes necessary to clarify and improve the implementation of the Plan. The Plan, which was formerly known as the City of Chandler Flexible Spending Account Program, shall be renamed the City of Chandler Section 125 Flexible Benefit Plan ("the Plan").

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

ARTICLE I DEFINITIONS

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

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

1.4 "Available Benefit" or "Benefit" means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.5 "Cafeteria Plan Benefit Dollars" means the amount available to Participants, pursuant to Article III, to purchase Benefits. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.6 "Code" means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.7 "Compensation" means the amounts received by the Participant from the Employer during a Plan Year.

1.8 "Dependent" means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)).

1.9 "Effective Date" means January 1, 1996.

1.10 "Election Period" means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.11 "Eligible Employee" means any Employee who has satisfied the provisions of Section 2.1.

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

1.12 "Employee" means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(0(2)).

1.13 "Employer" means City of Chandler and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan.

1.14 "Insurance Contract" means any contract issued by an Insurer underwriting an Available Benefit. It also includes any contract or agreement governing the administration of benefits for which the Employer is self-insured, including, but not limited to, Administrative Services Agreements.

1.15 "Insurance Premium Payment Plan" means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

1.16 "Insurer" means any insurance company that underwrites an Available Benefit under this Plan. The Employer is the "insurer" for those benefits for which the Employer is self-insured.

1.17 "Key Employee" means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.18 "Participant" means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 "Plan" means this instrument, including all amendments thereto.

1.20 "Plan Year" means the 12-month period beginning January 01 and ending December 31. The Plan Year shall be the coverage period for the Available Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 "Premium Expenses" or "Premiums" mean the Participant's cost for the Available Benefits described in Section 4.1.

1.22 "Premium Reimbursement Account" means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of Available Benefit is elected, sub-accounts shall be established for each type of Available Benefit.

1.23 "Salary Redirection" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

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

1.25 "Spouse" means the legally married husband or wife of a Participant, unless legally separated by court decree.

ARTICLE II PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate and election of benefits from which the Administrator shall furnish to the Employee. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to execute a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

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

2.4 TERMINATION OF PARTICIPATION

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

- (a) His termination of employment, subject to the provisions of Section 2.5;
- (b) His death, subject to the provisions of Section 2.6; or
- (c) The termination of this Plan, subject to the provisions of Section 11.2.

2.5 TERMINATION OF EMPLOYMENT

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

(a) With regard to Available Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) With regard to the Dependent Care Reimbursement Plan, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for the remainder of the Plan Year in which such termination occurs for after the Plan Year ends 90 days after termination, based on the level of his Dependent Care Reimbursement Account as of his date of termination,

(c) With regard to the Health Care Reimbursement Plan, the Participant may elect to continue his participation in the Plan.

(1) If the Participant elects to continue participation in the Health Care Reimbursement Plan for the remainder of the Plan Year in which such termination occurs, the Participant may continue to seek reimbursement from the Health Care Reimbursement Fund. The Participant shall be required to make contributions to the fund based on the elections made prior to the beginning of the Plan Year.

(2) If the Participant does not elect to continue participation in the Health Care Reimbursement Plan for the remainder of the Plan Year in which such termination occurs, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses incurred during the portion of the Plan Year preceding his date of termination, up to after the Plan Year ends 90 days after his termination.

(d) In the event a Participant terminates his participation in the Health Care Reimbursement Plan during the Plan Year, if Salary Redirections are made other than on a pro rata basis; upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

(e) This Section shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 12.14 of the Plan.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his estate, may submit claims for expenses or benefits for

the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Administrator may designate the Participant's Spouse, one of his Dependents or a representative of his estate.

ARTICLE III CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Available Benefit. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and Consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

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

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a

level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Care Reimbursement Plan, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year, In the event Salary Redirections are not made on a pro rata basis, upon termination of participation, a Participant may be entitled-to a refund of such Salary Redirections pursuant to Section 2.5.

ARTICLE IV BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect to have the amount of his Cafeteria Plan Benefit Dollars applied to any one or more of the following optional Benefits:

- (1) Health Care Reimbursement Plan (Health Care FSA)
- (2) Dependent Care Reimbursement Plan (Dependent Care FSA)
- (3) Medical Insurance Benefit
- (4) Dental Insurance Benefit
- (5) Vision Insurance Benefit
- (6) Life Insurance Benefit
- (7) Health Savings Account (HSA)

4.2 HEALTH CARE REIMBURSEMENT PLAN BENEFIT

Each Participant may elect coverage under the Health Care Reimbursement Plan (Health Care FSA) option, in which case Article VI shall apply.

4.3 DEPENDENT CARE REIMBURSEMENT PLAN BENEFIT

Each Participant may elect coverage under the Dependent Care Reimbursement Plan (Dependent Care FSA) option, in which case Article VII shall apply.

4.4 MEDICAL INSURANCE BENEFIT

(a) Each Participant may elect to be covered under a health and hospitalization Insurance Contract for the Participant, his or her spouse, and his or her Dependents.

(b) The Employer may select suitable health and hospitalization Insurance Contracts for use in providing this medical insurance benefit, which policies will provide uniform benefits for all Participants electing a particular option under this Benefit.

(c) The rights and conditions with respect to the benefits payable from such health and hospitalization Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) Each Participant may elect to be covered under the Employer's Dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

(b) The Employer may select suitable Dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

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

4.6 VISION INSURANCE BENEFIT

(a) Each Participant may elect to be covered under the Employer's Vision Insurance Contract. In addition, the Participant may elect either individual or family coverage,

(b) The Employer may select suitable Vision Insurance Contracts for use in providing this Vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

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

4.7 LIFE INSURANCE BENEFIT

(a) Each Participant may elect to be covered under the Employer's Life Insurance Contract.

(b) The Employer may select suitable life insurance policies for use in providing this life insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

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

4.8 HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION BENEFIT

Subject to the eligibility requirements for Health Savings Accounts, each Participant may elect to make contributions to a Health Savings Account, in which case Article VIII shall apply.

4.9 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Care Reimbursement Plan Benefits and Dependent Care Reimbursement Plan Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so before his effective date of participation pursuant to Section 2.2. However, if such Employee does not complete an application to participate and benefit election form and deliver it to the Administrator before such date, his Election Period shall extend 30 calendar days after such date, or for such further period as the Administrator shall determine and apply on a uniform and nondiscriminatory basis. However, any election during the extended 30-day election period pursuant to this Section 5.1 shall not be effective until the first pay period following the later of such Participant's effective date of participation pursuant to Section 2.2 or the date of the receipt of the election form by the Administrator, and shall be limited to the Benefit expenses incurred for the balance of the Plan Year for which the election is made.

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

5.2 SUBSEQUENT ANNUAL ELECTIONS

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

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

The following shall apply to any Participant who does not complete an election of

benefits form pursuant to Section 5.2. during the Election Period prior to the Plan Year:

- (a) *Affirmative Elections.* For reimbursement-type benefits, the Participant shall be deemed to have elected not to participate in such Available Benefits for the upcoming Plan Year. The Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Health Savings Account require affirmative elections annually.
- (b) *Continuing (Evergreen) Elections.*
 - (i) For premium-type benefits, an Eligible Employee shall be deemed to have elected to maintain the same Available Benefit(s) for the upcoming Plan Year at the same coverage levels as elected by the Employee for the current Plan Year and to have agreed to pay any portion of the cost for which the Eligible Employee is responsible for such Available Benefit(s) through salary redirection unless (1) the Eligible Employee specifically elects not to participate with respect to such Available Benefit(s) and notifies the Plan Administrator in writing on or before the close of the Election Period, or (2) such deemed Election is otherwise prohibited by law. The Medical Insurance Benefit, Dental Insurance Benefit, Vision Insurance Benefit, and Life Insurance Benefit are premium-type benefits subject to automatic and continuing (evergreen) elections.
 - (ii) *Exception:* If substantial changes are made to an Available Benefit, the Employer may determine that an affirmative election is required. The Employer shall provide notice to Participants in advance of the Election Period that an affirmative election of the Benefit is required for the upcoming Plan Year. If a Participant does not make an election of such Available Benefit(s) during the Election Period, the Participant shall be deemed to have elected not to participate in the Available Benefit for the upcoming Plan Year.

5.4 CHANGE OF ELECTIONS

(a) Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, and the

Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, spouse or dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's spouse, or dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980(B) or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator, For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: Events that change a Participant's legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, spouse, or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, spouse or dependent provided such change in the place of residence affects the eligibility of the employee or the employee's spouse or dependent(s) for coverage under the group policy/plan.

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

(b) Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f). Such change shall take place on a prospective basis.

(c) Notwithstanding subsection (a), in the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a dependent of the Participant):

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

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

(d) Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's spouse or dependent if the Participant or the Participant's spouse or dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), If the Participant or the Participant's spouse or dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

If the coverage under an Available Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's spouse or dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a spouse's, former spouse's or dependent's employer if (1) the cafeteria plan or other benefits plan of the spouse's, former spouse's or dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a spouse's, former spouse's or dependent's employer.

A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available, A cost change is allowable in the Dependent Care Reimbursement Plan only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a cost or coverage change under this subsection.

ARTICLE VI
HEALTH CARE REIMBURSEMENT PLAN
(HEALTH CARE FLEXIBLE SPENDING ACCOUNT)

6.1 ESTABLISHMENT OF PLAN

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

6.2 DEFINITIONS

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

(a) "Claims Run-out Period" means the period beginning on the first day following the close of the Plan Year or applicable Grace Period and ending 90 days after the close of the Plan Year (i.e., March 31).

(b) "Health Care Reimbursement Account" means the recordkeeping account established by the Plan Administrator for each Plan Year for each Participant from whom an Election to create such an account is received and Cafeteria Plan Benefit Dollars are allocated. Allowable Medical Expenses are reimbursed from this Account.

(c) "Health Care Reimbursement Plan" means the plan of benefits contained in this Article, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant or his Dependents.

(d) "Highly Compensated Participant" means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

- (1) one of the 5 highest paid officers;
- (2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
- (3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(e) "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. However, a Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's spouse or individual policies

maintained by the Participant or his spouse or Dependent. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(f) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Plan.

6.3 FORFEITURES

The amount in the Participant's Health Care Reimbursement Account as of the end of any Plan Year including any applicable Grace Period (after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 9.2.

6.4 LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Care Reimbursement Plan to the contrary, a Participant may allocate no more than the maximum allowable amount established by the IRS for the applicable tax year to the Health Care Reimbursement Account in or on account of any Plan Year.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) It is the intent of this Health Care Reimbursement Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.

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

6.6 HEALTH CARE REIMBURSEMENT ACCOUNT

The Health Care Reimbursement Account will be credited with the amount elected by the Participant and the Employer Contribution, if any, at the beginning of the Plan Year. A

Participant's Health Care Reimbursement Account will be decreased from time to time in the amount of payments made to the Participant for eligible Medical Expenses incurred during the Plan Year and the Grace Period, if applicable.

6.7 HEALTH CARE REIMBURSEMENT PLAN CLAIMS

(a) All Medical Expenses incurred by a Participant shall be reimbursed during the Plan Year (including Grace Period) subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Reimbursement Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time, Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant submits claims after the close of the Claims Run-Out Period for such Plan Year (and Grace Period), those Medical Expense claims shall not be considered for reimbursement by the Administrator.

(d) Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Reimbursement Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

6.8 DEBIT AND CREDIT CARDS

(a) Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards

(c) If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Reimbursement Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of, the affected Participant who has elected the second highest contribution to the Dependent Care Reimbursement Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Available Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

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

7.12 DEPENDENT CARE REIMBURSEMENT PLAN CLAIMS

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

- (a) The Dependent or Dependents for whom the services were performed;
- (b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;
- (c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 3 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following: the Spouse's salary or wages if he or she is employed, or if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution,

(i) If a Participant fails to submit a claim within the 90 day period immediately following the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

ARTICLE VIII HEALTH SAVINGS ACCOUNT CONTRIBUTION BENEFIT

8.1 PURPOSE

The purpose of this Article is to provide for the pre-tax funding of a Health Savings Account (HSA) under this Plan as an Available Benefit.

8.2 DEFINITIONS

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

(a) "Certification of HSA Eligibility" means the form (if any) provided by the Plan Administrator in which the Participant certifies he or she is eligible for HSA contributions.

(b) "Health Savings Account" or "HSA" means a health savings account under Section 223 of the Code established and owned by a Participant to which contributions are made under this portion of the Plan. The HSA is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Section 223(d)(2) of the Code. The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax salary reduction contributions to an HSA, the HSA is not intended to be a benefit plan sponsored or maintained by the Employer. To participate in this HSA Contribution Feature, the HSA must be established at a trustee/custodian selected by the Employer.

(c) "HSA Contribution Benefit" means the portion of the Plan described in this Article, which consists of contributions to a Participant's HSA through salary redirection and Employer Contributions, if any.

(d) "High Deductible Health Plan" or "HDHP" means a "qualifying high deductible health plan" under Section 223(c)(2) of the Code sponsored by the Employer.

(e) "Permitted Insurance or Permitted Coverage" means:

(1) insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities related to ownership or use of property, or similar liabilities as specified by the IRS;

(2) insurance for specified disease or illness (e.g., cancer insurance);

(3) insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance);

(4) coverage for accidents, disability, dental care, vision care, preventive care, or long-term care;

(5) some medical reimbursement accounts and health reimbursement arrangements ("HRAs") (e.g., limited scope medical reimbursement accounts and HRAs, suspended HRAs, post-deductible medical reimbursement accounts and HRAs, and retirement HRAs); and

(6) some wellness programs and employee assistance programs (e.g., those that do not provide significant benefits in the nature of non-preventive medical care or treatment).

8.3 HSA CONTRIBUTION BENEFIT

A Participant who has elected to participate in the Employer's High Deductible Health Plan ("HDHP") can elect to participate in a Health Savings Account by electing to pay the contributions on a pre-tax salary reduction (redirection) basis to the Participant's HSA

established and maintained outside of the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited. This funding feature constitutes the HSA benefits offered under this Plan. An election to make a contribution to an HSA shall be made by the Participant executing a Salary Redirection Agreement. Notwithstanding anything to the contrary contained in this Plan, the Salary Redirection Agreement can be made, increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective on the first day of the next payroll period following the date that the election change was filed with and received by the Employer or as soon as practicable thereafter. No other elections under this Plan for other benefits can occur as a result of a change in an HSA election except as otherwise provided in this Plan.

8.4 ELIGIBILITY

To be eligible for the HSA Contributions Benefit, the Employee must:

- (a) be eligible to participate in this Plan under Section 2.1;
- (b) be covered by the High Deductible Health Plan;
- (c) not be claimed as another person's dependent for purposes of such person's federal income tax return;
- (d) not be actually covered by Medicare; and
- (e) not have any health coverage other than Permitted Insurance, Permitted Coverage, or coverage under a high deductible health plan (as defined under Section 223(c)(2) of the Code), whether or not such coverage is sponsored by the Employer.

8.5 CERTIFICATION OF ELIGIBILITY

The Plan Administrator may require the Participant to provide a Certification of HSA Eligibility at the time of enrollment and periodically thereafter.

8.6 CONTRIBUTIONS

(a) *Employee Contributions.* Amounts withheld from a Participant's compensation pursuant to a Salary Redirection Agreement with respect to this Available Benefit shall be contributed to the Participant's HSA as soon as administratively feasible.

(b) *Employer Contributions.* Employer Contributions, if any, will be contributed to the Participant's HSA at the times established by the Employer.

To the extent the Employer makes any Employer Contributions to the HSAs maintained by its Employees, such Employer Contributions shall be considered made through this Plan for purposes of any comparability or nondiscrimination rules applicable

to this Plan.

(c) *Contributions Prohibited When Covered by Health FSA with Grace Period.* An Employee who is covered by a Health Care Flexible Spending Account (Health FSA) with a Grace Period is ineligible to contribute to the HSA until the first day of the first month following the end of the Grace Period.

8.7 LIMITS ON CONTRIBUTIONS

Contributions made by a Participant and/or on a Participant's behalf (i.e., Employer Contributions) into the HSA under this Plan are limited in accordance with the following rules.

(a) *General Limit.* During a taxable year, total contributions to all health savings account owned by a Participant cannot exceed the statutory indexed amount.

(b) *Catch Up Contributions.* An additional "catch-up" amount (determined on a monthly basis) can be contributed for eligible individuals who attain age 55 before the close of the taxable year.

(c) *Special Rule for Married Participants.* If the Participant is married and both the Participant and Participant's Spouse have coverage under a High Deductible Health Plan (as defined in Section 223 of the Code), the applicable limit is divided equally between them (unless they agree to a different allocation).

(d) *Rollover Contributions.* Rollover contributions may also be made to the HSA from another health savings account or from an Archer MSA. Rollover contributions are not subject to the contribution limit described above.

(e) *Treatment of Excess Contributions.* To the extent total contributions to a Participant's HSA made during the taxable year exceed the applicable limit on such contributions, then the contributions in excess of the limit shall be included in the Participant's gross income and shall be subject to an excise tax as provided in Section 4973(g) of the Code, unless returned in accordance with Section 223(f)(3) of the Code.

8.8 INVESTMENT OF HSA FUNDS

A Participant may invest his or her HSA funds as allowed by the HSA trustee/custodian. The Employer shall have no control or responsibility for how a Participant's HSA funds are invested

8.9 TAX CONSEQUENCES

It is intended that the HSA contributions made under this Plan shall be excluded from the Participant's gross income under Section 223 of the Code.

8.10 DISTRIBUTION OF HSA FUNDS

The Employer shall have no responsibility or control over distributions made from a Participant's HSA. The Employer shall have no responsibility to substantiate expenses for which such distributions are made. A Participant need not be a Participant in this Plan, be covered by a High Deductible Health Plan of this Employer, nor be covered by any other high deductible health plan in order to receive a distribution from the Participant's HSA.

8.11 REPORTING

The Employer shall be responsible for reporting contributions made to a Participant's HSA through this Plan on the Participant's Form W-2. Participants shall be responsible for reporting contributions to their HSAs and distributions from their HSAs on appropriate forms. Participants shall also be responsible for determining whether an HSA distribution is taxable.

8.12 CONTINUATION OF COVERAGE

This HSA Contribution Benefit and the underlying HSA are not group health plans for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, ("COBRA"), as amended, and reflected in the Public Health Services Act ("PHSA"), as amended, the Family and Medical Leave Act ("FMLA"), and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). COBRA, FMLA, and USERRA do not apply to this HSA Contribution Feature and the underlying HSA.

8.13 HSA MAINTAINED BY TRUSTEE/CUSTODIAN

The HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be selected by the Employer. The Employer will maintain records to monitor the amount of HSA contributions a Participant makes to his or her HSA pursuant to the Participant's Salary Redirection Agreement under this Plan, but the Employer will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

8.14 TERMS & CONDITIONS OF COVERAGE AND BENEFITS

The HSA Contribution Benefit under this Plan consist solely of the ability of the Participants to make contributions to their HSAs on a pre-tax salary redirection basis. The terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA documents, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

ARTICLE IX
BENEFITS AND RIGHTS

9.1 CLAIM FOR BENEFITS

(a) Any claim for Benefits underwritten by an Insurance Contract shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure. Any other claim for Benefits shall be made to the Administrator. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. If the Administrator does not notify the Participant of the denial of the claim within the 90 day period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

- (1) specific references to the pertinent Plan provisions on which the denial is based;
- (2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and
- (3) an explanation of the Plan's claim procedure.

(b) Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

- (1) request a review upon written notice to the Administrator;
- (2) review pertinent documents; and
- (3) submit issues and comments in writing.

(c) A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(d) Any balance remaining in the Participant's Health Care Reimbursement Account or Dependent Care Reimbursement Account as of the end of each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in

writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

9.2 APPLICATION OF BENEFIT PLAN SURPLUS

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

ARTICLE X ADMINISTRATION

10.1 PLAN ADMINISTRATION

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

- (a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- (b) To interpret the Plan, the Administrators interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- (d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
- (e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan;

(f) To approve reimbursement requests and to authorize the payment of benefits;
and

(g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

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

10.2 EXAMINATION OF RECORDS

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

10.3 PAYMENT OF EXPENSES

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

10.4 INSURANCE CONTROL CLAUSE

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

10.5 INDEMNIFICATION OF ADMINISTRATOR

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

ARTICLE XI
AMENDMENT OR TERMINATION OF PLAN

11.1 AMENDMENT

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

11.2 TERMINATION

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Contract.

No further addition shall be made to the Health Care Reimbursement Fund or Dependent Care Reimbursement Account, but all payments from such fund shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims). Any amounts remaining in any such fund or account as of the end of the Plan Year in which Plan termination occurs shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XII
MISCELLANEOUS

12.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 12.12.

12.2 GENDER AND NUMBER

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

12.3 WRITTEN DOCUMENT

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

12.4 EXCLUSIVE BENEFIT

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

12.5 PARTICIPANT'S RIGHTS

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

12.6 ACTION BY THE EMPLOYER

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

12.7 EMPLOYER'S PROTECTIVE CLAUSES

(a) Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) The Employer's liability to the Participant shall only extend to and shall be limited to any payment actually received by the Employer from the Insurer. In the event that the full insurance Benefit contemplated is not promptly received by the Employer within a reasonable time after submission of a claim, then the Employer shall notify the Participant of such facts and the Employer shall no longer have any legal obligation whatsoever (except to execute any document called for by a settlement reached by the Participant). The Participant shall be free to settle, compromise or refuse to pursue the claim as the Participant, in his sole discretion, shall see fit.

(c) The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not

be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

12.8 NO GUARANTEE OF TAX CONSEQUENCES

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

12.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

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

12.10 FUNDING

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

12.11 GOVERNING LAW

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

12.12 SEVERABILITY

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

12.13 CAPTIONS

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

12.14 CONTINUATION OF COVERAGE

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

12.15 FAMILY AND MEDICAL LEAVE ACT

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

12.16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

12.17 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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

IN WITNESS WHEREOF, this restated Plan document is hereby executed this ____ day of _____, 2014.

ATTEST:

CITY OF CHANDLER

CITY CLERK

MAYOR