

NCFlex Plan

For Employees Of The

State Of North Carolina

Effective As Amended And Restated

January 2025

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NCFLEX PLAN

Explanation and History

The State of North Carolina, herein referred to as the "State," established a Statewide Flexible Benefits Program, known as the NCFlex Plan (or the Plan), effective January 1, 1996 for the benefit of eligible Employees and Dependents on the terms and conditions described hereinafter.

WHEREAS, Employees are an important resource to state government; and

WHEREAS, the State desires to provide a uniform competitive compensation package that includes an up-to-date benefits program in order to maintain its competitive edge with businesses and other states in its region; and

WHEREAS, the State established the NCFlex Plan to provide tax-advantaged benefits to all Employees, regardless of the agency, department, university, or select community college where they work; and

WHEREAS, the State has expanded and revised the benefits of the NCFlex Plan as follows:

- Effective January 1, 2005, by allowing salary reduction of Compensation to pay for Cancer Insurance benefits.
- Effective January 1, 2005, by allowing salary reduction of Compensation to pay for Voluntary Group Term Life Insurance benefits.
- Effective January 1, 2005, to rename the Dependent Day Care Spending Account as the Dependent Day Care Flexible Spending Account.
- Effective January 1, 2005, to rename the Health Care Spending Account as the Health Care Flexible Spending Account.
- Effective January 1, 2005, to rename the Supplemental Medical Plan as the Supplemental Medical.
- Effective January 1, 2005, to rename the Vision Plan as the Vision Care Plan.
- Effective January 1, 2005, to rename the Voluntary Accidental Death and Dismemberment Insurance Plan as the Voluntary Accidental Death and Dismemberment Insurance.
- Effective January 1, 2006, to increase the Health Care Flexible Spending Account maximum from \$3,600 to \$4,200 per Plan Year.
- Effective January 1, 2008, to terminate the Supplemental Medical Plan.
- Effective January 1, 2009, by allowing salary reduction of Compensation to pay for Critical Illness Insurance benefits and by increasing the Health Care Flexible Spending Account maximum from \$4,200 to \$5,000 per year.
- Effective January 1, 2010, by adding Core Accidental Death and Dismemberment

Insurance to be paid for by the Employer.

- Effective January 1, 2011, to change the definition of Dependent.
- Effective January 1, 2011, to require that over-the-counter medicines only be reimbursable under the Health Care Flexible Spending Account if prescribed by a physician to comply with the Patient Protection and Affordable Care Act.
- Effective January 1, 2011, Participants in the Flexible Spending Accounts may use amounts placed in the accounts during a Plan Year to reimburse themselves for eligible expenses for services rendered between January 1 and March 15 of the next year following the end of the Plan Year, provided the claim for reimbursement is filed no later than April 30 of the year following the end of the Plan Year.
- Effective January 1, 2013, by decreasing the Health Care Flexible Spending Account maximum from \$5,000 to \$2,500 to comply with the Patient Protection and Affordable Care Act, and making certain plan design changes.
- Effective June 1, 2015, offer Tricare Supplement Insurance Plan.
- Effective as of January 1, 2018, to implement under the Health Care Flexible Spending Account a carry-over amount of up to \$500 in accordance with IRS Notice 2013-71 before any remaining balance is forfeited and accordingly, as of December 31, 2017, to eliminate the Health Care Flexible Spending Account grace period, which was operated in accordance with Prop. Treas. Reg. Sect. 1.125-1(e) prior to its elimination.
- Effective January 1, 2018, offer Voluntary Accident Plan benefits.

Effective January 1, 2020, to increase the Health Care Flexible Spending Account maximum up to \$2,700 for the 2020 Plan Year and effective January 1, 2021, to increase such amount up to \$2,750 for the 2021 Plan Year and for future Plan Years, will communicate such limit as part of annual enrollment not to exceed an amount permitted by the IRS.

- Effective January 1, 2020, to allow over-the-counter medicines and menstrual care physician prescription as provided under the Coronavirus Aid, Relief, and Economic Security Act.
- Effective January 1, 2020, to extend the Dependent Day Care Flexible Spending Account Grace Period applicable to the 2019 plan year that would have ended as of March 15, 2020 to September 30, 2020.
- Effective January 1, 2020, to increase the Health Care Flexible Spending Account carry-over amount at the end of the Plan Year from \$500 to \$550 for the immediately following Plan Year beginning in 2021 and for future Plan Years, will communicate such limit as part of annual enrollment not to exceed an amount permitted by the IRS.
- Effective January 1, 2020, Participants may elect to make a one-time, mid-year election change on a prospective basis under the Flexible Spending Accounts for the 2020 Plan Year as long as the election occurs no later than September 30, 2020, as a result of the COVID-19 public health crisis.

- Effective January 1, 2020, by allowing salary reduction of Compensation to pay for Short Term Disability Plan and Long-Term Disability Plan benefits.
- Effective January 1, 2021, to allow any unused contributions to the Health Care Flexible Spending Account at the end of the Plan Year beginning in 2020 to carry over to the Plan Year beginning in 2021.
- Effective January 1, 2021, to allow any unused contributions to the Health Care Flexible Spending Account at the end of the Plan Year beginning in 2021 to carry over to the Plan Year beginning in 2022.
- Effective January 1, 2021, to extend the Dependent Day Care Flexible Spending Account Grace Period applicable to the 2020 Plan Year that would have ended as of March 15, 2021 to December 31, 2021.
- Effective January 1, 2021, to extend the Dependent Day Care Flexible Spending Account Grace Period applicable to the 2021 Plan Year that would have ended as of March 15, 2022 to December 31, 2022.
- Effective January 1, 2021, to extend to age 14 for the 2021 Plan Year only, the definition of Dependent for purpose of reimbursements from the Dependent Day Care Flexible Spending Account, to the extent of the balance available at the end of the prior Plan Year.
- Effective January 1, 2023, to allow a new Health Care Flexible Spending Account yearly limit of \$2,850 and a new carry-over amount of \$570 to go into the next plan year of 2024.
- Effective January 1, 2023, to add a \$40,000 option to the Critical Illness plan.
- Effective January 1, 2023, to add a High Option Accident Plan.
- Effective January 1, 2021, to extend the claims submission deadline to April 30, 2022 for claims in the 2020 Plan year.
- Effective January 1, 2021, to extend the claims submission deadline to March 31, 2023 for claims in the 2021 Plan Year.
- Effective January 1, 2024, the High Option Accident Plan will be referred to as the Enhanced Option Accident Plan, and the Low Option Accident Plan will be referred to as the Classic Option Accident Plan.
- Effective January 1, 2024, to increase the Health Care Flexible Spending Account maximum up to \$30,050 for the 2024 Plan Year and effective January 1, 2025, to increase such amount up to \$3,200 for the 2025 Plan Year and for future Plan Years, will communicate such limit as part of annual enrollment not to exceed an amount permitted by the IRS.
- Effective January 1, 2024, to increase the Health Care Flexible Spending Account carry-over amount at the end of the Plan Year from \$570 to \$610 for the immediately following Plan Year beginning in 2024.
- Effective January 1, 2025, to increase the Health Care Flexible Spending Account carry-over amount at the end of the Plan Year from \$610 to \$640 for the immediately following

Plan Year beginning in 2025 and for future Plan Years, will communicate such limit as part of annual enrollment not to exceed an amount permitted by the IRS.

- Effective January 1, 2025, Sections 4.06(d), 6.04, 6.06, and 7.06 have been revised to remove any references to the COVID-19 Pandemic as these provisions no longer are applicable.

WHEREAS, the State desires to amend and restate the NCFlex Plan in its entirety effective February 1, 2025, in order to reflect certain plan design and new legal and regulatory requirements; and

NOW, THEREFORE, effective January 1, 2025, unless an earlier or later effective date is indicated herein for a specific change, the NCFlex Plan is hereby amended and restated as follows:

ARTICLE I

INTRODUCTION

1.01 Purpose of Plan

The purpose of the NCFlex Plan is to provide eligible Employees of the Employer a choice between certain taxable and nontaxable benefits under the Plan. The Plan is to be maintained for the exclusive benefit of the Employees.

1.02 Cafeteria Plan Status

The Plan is intended to constitute a cafeteria plan, within the meaning of Section 125 of the Code. In addition, it is intended that the Plan provide certain Health Care Flexible Spending Account Benefits in accordance with the terms of Section 105(h) of the Code, Dependent Day Care Flexible Spending Account Benefits in accordance with the provisions of Section 129 of the Code, employee group term life coverage in accordance with Section 79 of the Code, cancer coverage, core accidental death and dismemberment coverage, critical illness coverage, short term disability coverage, long term disability coverage, dental coverage, vision coverage, voluntary accident, and voluntary accidental death and dismemberment coverage in accordance with the terms of Sections 105 and 106 of the Code.

1.03 Nonqualified Benefits

This Plan document includes a provision to allow eligible Employees to elect dependent life insurance coverage on an after-tax basis, this was effective January 1, 2014. This benefit is included in this Plan document for convenience sake only and it is not considered to be a benefit offered under this Plan as a cafeteria plan.

ARTICLE II

DEFINITIONS

Capitalized terms when used in this Plan shall be defined as set forth in this Article.

2.01 Adjustment Date

shall mean the date on which the Participant's Health Care Flexible Spending Account and/or Dependent Day Care Flexible Spending Account is increased by the Participant's reduction of Compensation and reduced by payments made from such accounts.

2.02 Benefit Representative

shall mean individual employees or benefit departments of the Employer who have the duty and authority to enroll, respond to questions, process terminations and Status Change requests, and such other duties authorized by the Flexible Benefits Program Manager as permitted under the Plan and the Code.

The Flexible Benefits Program Manager shall have the duty to train Benefit Representatives and provide interpretative support in the operation of the Plan and shall have the authority to reverse any decision that violates the Plan rules or the Code.

2.03 Cancer Insurance

shall mean the group cancer insurance program, as described herein.

2.04 Critical Illness

shall mean the group critical illness insurance program, as described herein.

2.05 Code

shall mean the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation and rulings, which amend, supplement or replace such section or subsection, and shall be deemed a reference to comparable provisions of future laws.

2.06 Compensation

shall mean an Employee's base pay prior to any payroll reductions made under this Plan or any other plan allowing for reduction in Compensation.

2.07 Date of Employment

shall mean the first date on which an Employee completes an hour of service with the Employer.

2.08 Date of Reemployment

shall mean the first date on which an Employee completes an hour of service with the Employer following a termination of employment.

2.09 Dental Plan

shall mean the group dental insurance program, as described herein.

2.10 Dependent

shall mean as follows:

- (a) With respect to the Cancer Insurance, Critical Illness Insurance, Dental Plan, Vision Care Plan, Voluntary Accident Insurance, and Voluntary Accidental Death and Dismemberment Insurance, mean:
 - (1) The legally married spouse of the Participant,
 - (2) Any unmarried child, including a stepchild or a foster child, of the Participant who is dependent upon the Participant for support and maintenance until the end of the month in which the child reaches age 26, and
 - (3) Any unmarried child, including a stepchild or a foster child, of the Participant of any age who remains dependent upon the Participant for support and

maintenance and who is incapable of self-sustaining employment because of mental or physical handicap or disability.

If there is a conflict between this section and provisions of the insurance policy for a specific benefit, the provisions of the insurance policy shall control.

- (b) With respect to the Health Care Flexible Spending Account Benefits, Dependent shall mean an individual who is a dependent of the Participant as defined in Code Section 152, as modified by Code Sections 105 and 106 and their accompanying regulations and any child of the Participant (within the meaning of Code Section 152(f) (1)) who has not attained age 26, without regard to student, tax dependency, or marital status.
- (c) With respect to the Dependent Day Care Flexible Spending Account Benefits, Dependent shall mean:
 - (1) a dependent of the Participant (as defined in Code Section 152(a)(1)) who has not attained the age of 13 (age 14 for the 2021 Plan Year only, pursuant to the 2021 Consolidated Appropriations Act of 2021 (“CAA 2021”) and IRS Notice 2021-15);
 - (2) a dependent of the Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the year; or
 - (3) the Spouse of the Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the year.
 - (4) For purposes of (1) and (2), the child of divorced or legally separated parents shall be treated as a Dependent of the custodial parent (as defined in Code Section 152(e)(3)(A)).

2.11 Dependent Day Care Flexible Spending Account

shall mean the balance posted to the account of each Participant or Former Participant pursuant to Article VII.

2.12 Dependent Day Care Flexible Spending Account Benefits

shall mean those expenses eligible for reimbursement as provided by Article VII and that meet the criteria of a dependent day care assistance program in accordance with Section 129 of the Code.

2.13 Effective Date

shall mean January 1, 2025, the effective date of this amended and restated Plan. However, certain provisions of this Plan may have earlier or later effective dates as noted herein. Heretofore, the Employer established the Plan effective January 1, 1996, and has amended and restated the Plan on January 1, 2003, on January 1, 2005, on January 1, 2006, on January 1, 2008, on January 1, 2009, on January 1, 2010, on January 1, 2011, and on January 1, 2013.

2.14 Eligibility Date

shall mean the date on which an Employee becomes eligible to participate in the Plan as set forth in Article III.

2.15 Employee

shall mean any individual who holds a permanent, probationary or time-limited position and who is regularly in the active employment of the Employer. An individual shall be considered regularly in the active employment of the Employer with respect to any Plan Year if the relationship during such year between him and the Employer is the legal relationship of employer and employee, and if his customary employment for such year is for at least 20 hours per week, except that his customary employment for such year must be at least 30 hours per week for participation in the Combined Short and Long-Term Voluntary Disability Plan. The term "Employee" shall not include any individual who is not classified by the Employer as an employee, nor shall it include any individual classified by the Employer as a retired employee, a temporary employee, a leased employee, a contract employee, an independent contractor, or a self-employed individual.

2.16 Employer

shall mean the State of North Carolina and includes those entities authorized pursuant to the North Carolina General Statutes (N.C. G.S.) to establish the Plan for the benefit of their eligible Employees. These entities shall include the University of North Carolina System authorized pursuant to N.C. G.S. §§116-17.1 and -17.2, State departments, agencies and institutions authorized pursuant to N.C. G.S. §143-34.1, State community colleges authorized pursuant to N.C. G.S. §115-D, and Public Charter Schools authorized pursuant to N.C. G.S. §115C-238.29A.and §126-95(c).

2.17 Entry Date

for a new Employee, shall mean the first day of the month, after his Date of Employment, provided he enrolls within 30 days of his Date of Employment. The Entry Date for an Employee who has terminated employment and is reemployed with the same Plan Year shall be the Employee's Date of Reemployment, provided he enrolls within 30 days of his Date of Reemployment. An Employee who does not enter the Plan when first eligible may do so by making the election required by Section 4.02 prior to the beginning of such future Plan Year, and in such case the Entry Date for the Employee shall be the first day of the future Plan Year.

2.18 Flexible Benefits Administrator

shall mean the person providing services to the Employer in connection with operation of the Plan and performing such other functions, including the processing and payment of claims, as may be delegated from time to time. Provided, however, the Plan Administrator shall have ultimate authority concerning the operation and administration of the Plan.

2.19 Flexible Benefits Program Manager

shall mean the Employee who has the authority to coordinate the administration of the Plan, train and advise Benefit Representatives, review the actions of the Flexible Benefits Administrator, coordinate enrollment and communication efforts concerning the Plan Benefits under the Plan and other benefit programs, and perform any other duties relating to the operation of the Plan as designated by the Plan Administrator.

2.20 Forfeitures

shall mean the forfeited portion of a Participant's Health Care Flexible Spending Account or Dependent Day Care Flexible Spending Account in accordance with the provisions of Sections 8.02 and 8.03.

2.21 Former Participant

shall mean any person who ceases to be a Participant, but whose interest in the Plan has not been wholly distributed or forfeited.

2.22 Grace Period

Shall mean the period from January 1 to March 15 immediately following the end of a Plan Year in which Dependent Day Care Flexible Spending Account Benefits can continue to be incurred and unused amounts in the Dependent Day Care Flexible Spending Account from the prior Plan Year can be used as if the expenses had been incurred in the immediately preceding Plan Year. The Grace Period shall apply uniformly to Dependent Day Care Flexible Spending Account Participants as of the last day of the Plan Year and will not apply to or impact the Health Care Flexible Spending Account in any way in accordance with Prop. Treas. Reg. Sec. 1.125-1(e)(3)(i) and (ii).

2.23 Health Care Flexible Spending Account

shall mean the balance posted to the account of each Participant or Former Participant pursuant to Article VI.

2.24 Health Care Flexible Spending Account Benefits

shall mean health related expenditures that are reimbursed to Participants in accordance with Article VI.

2.25 Highly Compensated Employee

shall mean an individual as described in Code Section 414(q).

2.26 Highly Compensated Individual

shall mean an individual as described in Code Section 125(e), except that with respect to the Health Care Flexible Spending Account, Highly Compensated Individual shall mean an individual as described in Code Section 105(h).

2.27 Insurance Program

shall mean those qualified benefits under Code Section 125(f) that are offered under the Plan, other than the Health Care Flexible Spending Account Benefits and Dependent Day Care Flexible Spending Account Benefits. The Insurance Program includes the Cancer Insurance, Critical Illness Insurance, Short Term Disability Plan, Long Term Disability Plan, Dental Plan, Vision Care

Plan, TRICARE Supplement Plan, Voluntary Accident Insurance, Accidental Death and Dismemberment Insurance, and Voluntary Group Term Life Insurance.

2.28 Leave

shall mean any leave granted by the Employer during any calendar month that results in the Employee being in unpaid status for more than one-half of all the work days in the month.

2.29 Long Term Disability Plan

shall mean the long term disability insurance, as described herein.

2.30 Participant

shall mean every Employee who meets the requirements for participation set forth in Article III.

2.31 Plan

shall mean the NCFlex Plan as herein set forth or as it may be duly amended.

2.32 Plan Administrator

shall mean the person responsible for the functions and management of the Plan. Effective June 1, 2014 the Plan Administrator shall be the State Human Resource Director.

2.33 Plan Benefits

shall mean the Health Care Flexible Spending Account Benefits and Dependent Day Care Flexible Spending Account Benefits, and payments for coverage under the Cancer Insurance, Critical Illness Insurance, Short Term Disability Plan, Long Term Disability Plan, Dental Plan, Vision Care Plan, TRICARE Supplement Plan, Voluntary Accident Insurance, Voluntary Accidental Death and Dismemberment Insurance, and Voluntary Group Term Life Insurance, as may be elected by a Participant pursuant to Article IV as well as coverage under the Core Accidental Death and Dismemberment Insurance and Core Vision Wellness Exam paid for by the Employer in accordance with Article IV.

2.34 Plan Year

shall mean the twelve-month period ending on December 31 of each year. The Plan Year shall be the period of coverage for each benefit hereunder.

2.35 Short Term Disability Plan

shall mean the short term disability insurance, as described herein.

2.36 Spouse

shall mean the Employee's lawful spouse, as determined under applicable state law.

2.37 Status Change

shall mean any of the following with respect to Plan Benefits:

- (a) **Legal marital status:** Events that change an Employee's legal marital status, including but not limited to the following: marriage; death of Spouse; divorce; legal separation; and annulment.
- (b) **Number of dependents:** Events that change an Employee's number of Dependents, including but not limited to the following: birth, death, adoption, and placement for adoption.
- (c) **Employment status:** Any of the following events that change the employment status of the Employee, the Spouse, or a Dependent: a termination or commencement of employment; a commencement of or return from an unpaid Leave; and a change in the employee's worksite lasting longer than 30 days. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer or the employer of the 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 the employment status under this paragraph.
- (d) **Dependent satisfies or ceases to satisfy eligibility requirements:** Events that cause a Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- (e) **Residence:** A change in the place of residence of the Employee, Spouse, or Dependent that affects eligibility to receive Plan Benefits.
- (f) **Other Events:** Such other events that the Flexible Benefits Program Manager determines, consistent with applicable regulations and rulings under the Code, shall permit a change or revocation of an election during the Plan Year.

2.38 TRICARE Supplement Plan

shall mean the TRICARE supplement program, as described herein.

2.39 Vision Care Plan

shall mean the group vision insurance program, as described herein.

- (a) **Core Vision Wellness Exam** shall mean the core vision wellness exam program, as described herein.

2.40 Voluntary Accidental Death and Dismemberment Insurance

shall mean the group accidental death and dismemberment insurance program, as described herein.

- (a) **Core Accidental Death and Dismemberment Insurance** shall mean the core accidental death and dismemberment insurance program, as described herein.

2.41 Voluntary Group Term Life Insurance

shall mean the group term life insurance program, as described herein:

2.42 Voluntary Accident Plan

shall mean the group accident insurance program, as described herein.

ARTICLE III

PARTICIPATION

3.01 Commencement of Participants

An Employee shall participate in the Plan on the Effective Date, or if later, his Entry Date. An Employee who fails to take the necessary steps to participate in the Plan as of his initial Eligibility Date shall be able to participate in a future Plan Year provided he enrolls and makes the election required by Section 4.01 prior to the beginning of such future Plan Year.

3.02 Termination of Participation

- (a) Participation in the Plan shall terminate as to all Participants on the date the Plan is terminated, as herein after provided, and, as to each Participant, on the earliest of the following dates:
 - (1) The date the Plan is amended to terminate the coverage of a class of Employees of which the Participant is a member.
 - (2) The last day of the month during which the Participant ceases to be a member of a class or classes of Employees eligible for coverage (or, if sooner, the date on which a Participant's Compensation is insufficient to finance his elections under Section 4.01).
 - (3) Except as required by the Public Health Service Act, the date a Participant's active employment with the Employer is terminated.
- (b) If participation in the Health Care Flexible Spending Account ceases due to a termination of active employment or by reason of a reduction in the Employee's regularly scheduled hours, such participation may be continued as set forth herein.
 - (1) Following appropriate notice, an Employee may elect to continue coverage under the Plan for himself and/or his Dependents or a Dependent may elect to continue coverage, conditioned upon a timely election and timely payment of the required contributions to the Health Care Flexible Spending Account. An election to continue coverage shall be considered timely if such election is made within the 60-day period prescribed by Code Section 4980B. Required contributions shall be equal to 102% of the applicable premium, or cost to the Plan, for coverage of similarly situated Employees and/or Dependents who have not qualified for continuation coverage. Such continued coverage shall terminate upon the first to occur of the following:
 - (A) the date the Employer ceases to provide any group health plan to any Employee.
 - (B) the end of the period for which a contribution is made, if the next required contribution is not timely made. A contribution will not be timely made unless it is made within 30 days after the due date, which is the first day of the period (such as a calendar month) for which it is made. However, an Employee's or Dependent's first contribution under this Section shall be considered timely if made by the day which is 45 days after the day on which the Employee or Dependent made the initial election for continuation coverage under this Section.

- (C) the date after the election on which he becomes covered under any other group health care plan (as an employee or otherwise), provided the other group health plan does not exclude or limit the available coverage because of any pre-existing condition of such Employee or Dependent.
 - (D) the date after the election on which he becomes entitled to Medicare benefits under Title XVIII of the Social Security Act.
 - (E) the last day of the Plan Year in which Employee terminates employment or reduces his regularly scheduled hours.
- (c) This section shall be administered in accordance with the requirements of Code Section 4980B and any amendments thereto and any regulations thereunder. The Plan Administrator may adopt additional rules to ensure that the Plan meets the applicable requirements.

3.03 Special Rules for Unpaid Leave

If an Employee's Leave is unpaid, the Employer shall provide the Participant with notice of the terms of the payment of contributions during the Leave. A Participant taking an unpaid Leave may revoke an existing election and upon return from Leave may choose to reenroll in any plans he was enrolled in prior to the leave. Enrollment changes are permitted in accordance with the Family Status Change rules, as described in Section 4.06.

If a Participant drops coverage under the Health Care Flexible Spending Account during a period of unpaid Leave, claims incurred during this period shall be ineligible for reimbursement. When such Participant returns from an unpaid Leave, the Participant must (a) resume coverage at the prior contribution amount for each payroll period, or (b) resume coverage at the original level and make-up unpaid contributions.

3.04 Special Rules for Veterans

Prior to commencement of an absence from active work for service in the uniformed services, a Participant may choose to maintain or drop benefits under the Plan for the lesser of (a) the 24-month period beginning on the first date of absence, or (b) the period ending on the day after the date on which the Participant fails to apply for reinstatement or return to employment with the Employer, as determined under 38 U.S.C. Section 4312(e).

A Participant who elects to continue benefits under the Plan may not be charged more than 102% of the full premium for the applicable coverage, provided that a Participant whose service in the uniformed services is for less than 31 days may not be charged more than the Employee share, if any, for such coverage. The Participant shall be responsible for making the required contributions under the Plan during the period, which he is in uniformed service, pursuant to the requirements of the Plan. The Employer shall determine the manner in which such payments are made.

This Section 3.04 shall be applicable to all Plan Benefits, except the Dependent Day Care Flexible Spending Account, Health Care Flexible Spending Account, Voluntary Accident Insurance, Voluntary Accidental Death and Dismemberment Insurance, and Voluntary Group Term Life Insurance.

ARTICLE IV

ELECTION PROCEDURES AND PROGRAM OPERATIONS

4.01 Benefit Options

A Participant may receive his full Compensation for any Plan Year in cash or to have a portion of it applied by the Employer towards the following benefits:

- (a) In accordance with Article IV and Article V, a Participant may elect to reduce his Compensation by an amount equal to the premiums for qualified benefits under the Insurance Program.
- (b) In accordance with Article IV and Article VI, a Participant may elect to reduce his Compensation by a dollar amount that shall be credited to his Health Care Flexible Spending Account for the Plan Year. The election shall be subject to a per pay period and Plan Year minimum and maximum specified on the attached Schedule A. Such amounts shall be in addition to the amounts reduced, if any, pursuant to Sections 4.01(a) and 4.01(c).
- (c) In accordance with Article IV and Article VII, a Participant may elect to reduce his Compensation by a dollar amount that shall be credited to his Dependent Day Care Flexible Spending Account for the Plan Year. The election shall be subject to a per pay period minimum and maximum specified on the attached Schedule A. Such amounts shall be in addition to the amounts reduced, if any, pursuant to Sections 4.01(a) and 4.01(b).

4.02 Election Process

During annual enrollment, but prior to the beginning of the next Plan Year, the Flexible Benefits Program Manager shall provide an election form, which includes a salary reduction agreement, to each Employee who is eligible to participate in the Plan. This benefit election form shall also include an option to participate in the Core Accidental Death and Dismemberment Insurance and the Core Vision Wellness Exam which will be paid for by the Employer. The election form must be returned to the Employee's Benefit Representative on or before the last day of the annual enrollment period established by the Flexible Benefits Program Manager, and shall be effective on the first day of the next Plan Year. Eligible Employees failing to return an election form by the annual enrollment deadline shall be deemed to have continued the same coverage election under the Insurance Program, subject to any cost changes, as was in effect just prior to the beginning of the next Plan Year, and shall be deemed to have elected no benefit under the Health Care Flexible Spending Account and the Dependent Day Care Flexible Spending Account.

4.03 Electronic Plan Enrollment

The Flexible Benefits Program Manager, in his sole discretion, may require Employees to use an interactive telephone system or an internet-based enrollment system in order to enroll for benefits under the Plan in lieu of an election form. By using the system, an Employee shall consent to (a) deductions from his Compensation in accordance with his elections made through the system, or (b) the recording of his telephone call on the system, if applicable.

4.04 New Employees

As soon as practicable before a new Employee becomes a Participant under Section 3.01, the Flexible Benefits Program Manager shall provide access to the electronic plan enrollment system described in Section 4.03. If the Employee desires to become a Participant for the balance of the Plan Year, he shall so enroll on the electronic plan enrollment system and shall agree to a reduction in his Compensation as provided in Section 4.02. The electronic plan enrollment must be completed within 30 days from the Employee's Date of Employment with the Employer and the election shall be effective the first day of the month following the Employee's Date of Employment.

4.05 Changes by Flexible Benefits Program Manager

If the Flexible Benefits Program Manager determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Highly Compensated Employees or Individuals, the Flexible Benefits Program Manager shall take such action as the Flexible Benefits Program Manager, in his discretion, deems appropriate. Such action, if any, may include, without limitation, a modification of elections by Highly Compensated Employees or Individuals, and the application of any tax withholdings on previous reimbursements exceeding the testing limits, with or without the consent of such Employees.

4.06 Irrevocability of Election by the Participant During the Plan Year

- (a) Elections made under the Plan shall be irrevocable by the Participant during the Plan Year unless an election change is permitted by a status change as defined in Section 2.35 or in the following subsection (b).
- (b) A Participant may be entitled to make an election change if any of the following occur:
 - (1) *Status Change*: As provided in Section 2.34, a Participant may revoke a benefit election for the balance of the Plan Year and file a new election only if both the revocation and the new election are on account of and consistent with a Status Change that affects the coverage eligibility of a Participant, a Participant's Spouse, or a Participant's Dependent.
 - (A) *Loss of Dependent Eligibility*. For a Status Change involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent's ceasing to satisfy the eligibility requirements under the Plan, a Participant may elect to enroll, increase, decrease, or terminate participation in the Plan provided the change is consistent with that Status Change.
 - (B) *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Status Change in which a Participant, Spouse or Dependent gains eligibility for coverage under another employer's plan as a result of a change in marital status or a change in employment status, the Participant may elect to terminate or decrease coverage provided that corresponding coverage is elected under the other employer's plan.
 - (2) *Judgment, Decree, or Order*: This paragraph applies to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in

legal custody (including a qualified medical child support order) that requires accident or health coverage for the Employee's child or for a foster child who is a Dependent of the Employee, as defined in Code Section 152 (except that any child to whom Code Section 152(e) applies is treated as a Dependent of both parents). The Plan shall change the Employee's election to provide coverage for the child if the order requires health coverage for the child under the Insurance Program or Health Care Flexible Spending Account; or permit the Employee to make an election change to cancel coverage for the child if the order requires the Spouse, former Spouse, or other individual to provide coverage for the child and that coverage is, in fact, provided. This section does not apply to the Dependent Day Care Flexible Spending Account, Voluntary Accident Insurance, Voluntary Accidental Death and Dismemberment Insurance, and Voluntary Group Term Life Insurance.

- (3) *Entitlement to Medicare or Medicaid:* If an Employee, Spouse, or Dependent who is enrolled for health coverage under the Insurance Program or Health Care Flexible Spending Account becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare or Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Plan shall permit the Employee to make a prospective election change to cancel or reduce health coverage of that Employee, Spouse, or Dependent. In addition, if an Employee, Spouse, or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan shall permit the Employee to make a prospective election to commence or increase health coverage of that Employee, Spouse, or Dependent. This section does not apply to the Dependent Day Care Flexible Spending Account, Voluntary Accident Insurance, Voluntary Accidental Death and Dismemberment Insurance, and Voluntary Group Term Life Insurance.
- (4) *Change in Cost:*
- (A) *Automatic Changes for Insignificant Cost Changes.* In the event that the cost of coverage under the Insurance Program or Dependent Day Care Flexible Spending Account increases or decreases by an insignificant amount during the Plan Year, Participant elections under this Plan and corresponding salary reduction amounts shall be automatically adjusted to reflect any corresponding change in the Participant's election for the remainder of the Plan Year. However, this paragraph does not apply to an election change with respect to the Health Care Flexible Spending Account. With respect to the Dependent Day Care Flexible Spending Account, this paragraph applies if the cost change is imposed by a dependent day care provider who is not a relative of the Participant. For this purpose, a relative is an individual who is related to the Participant as described in Code Section 152(a)(1) through (8), incorporating the rules of Code Section 152(b)(1) and (2).
- (B) *Significant Cost Increases.* If the Flexible Benefits Program Manager determines that the cost of coverage under the Insurance Program or Dependent Day Care Flexible Spending Account has significantly increased, the Flexible Benefits Program Manager in his discretion

may allow each Participant a choice between authorizing a corresponding increase in his salary reductions or revoking his elections prospectively and make new elections for coverage under the Insurance Program or Dependent Day Care Flexible Spending Account offering similar coverage, provided the new election is consistent with the reason that such change was permitted. With respect to the Dependent Day Care Flexible Spending Account, this paragraph applies if the cost change is imposed by a dependent day care provider who is not a relative of the Participant. For this purpose, a relative is an individual who is related to the Participant as described in Code Section 152(a)(1) through (8), incorporating the rules of Code Section 152(b)(1) and (2). However, this paragraph does not apply to an election change with respect to the Health Care Flexible Spending Account.

(5) *Change in Coverage:*

- (A) *Significant Curtailment or Cessation of Coverage.* If coverage under the Insurance Program or Dependent Day Care Flexible Spending Account is significantly curtailed or ceases during a Plan Year, each affected Participant may prospectively revoke coverage, and receive on a prospective basis coverage under another benefit plan with similar coverage (if offered by the Employer). However, this paragraph does not apply to an election change with respect to the Health Care Flexible Spending Account.
- (B) *Addition of Benefit Options.* If during a Plan Year the Employer adds a new benefit option under the Plan, the Employer may permit Participants eligible for benefits under such new benefit option to change their elections under this Plan to obtain benefits under the new benefit option. However, this paragraph does not apply to an election change with respect to the Health Care Flexible Spending Account.
- (C) *Open Enrollment under Spouse or Dependent's Employer's Plan.* The Plan may permit a Participant to make a prospective election change that corresponds with an open enrollment period change made by a Spouse or Dependent when the plan of that individual's employer has a different period of coverage. However, this paragraph does not apply to an election change with respect to the Health Care Flexible Spending Account.
- (D) *Change in Coverage of Spouse or Dependent under Plan of Spouse or Dependent's Employer.* A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the Spouse's, former Spouse's, or Dependent's employer, so long as the cafeteria plan of the Spouse's, former Spouse's, or Dependent's employer permits its participants to make an election change that would be permitted under Code Section 125. However, this paragraph does not apply to an election change with respect to the Health Care Flexible Spending Account.
- (E) *Loss of Coverage under Other Group Health Coverage.* The Plan shall

permit a Participant to make an election on a prospective basis to add health coverage under the Plan for the Participant, Spouse, or Dependent if the Participant, Spouse, or Dependent loses coverage under any group health coverage sponsored by a government or educational institution, including a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a Foreign government group health plan. However, this paragraph does not apply to an election change with respect to the Dependent Day Care Flexible Spending Account, Health Care Flexible Spending Account, Voluntary Accident Insurance, Voluntary Accidental Death and Dismemberment Insurance, and Voluntary Group Term Life Insurance.

- (6) *Special Dependent Day Care Flexible Spending Account Changes:*
- (A) *Participant Changes Dependent Care Service Provider.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in his dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider and does not replace the provider, the Participant may terminate his Dependent Day Care Flexible Spending Account election.
 - (B) *Child Become Ineligible or Begins School.* If a child reaches age 13 (age 14 for the 2021 Plan Year only, pursuant to the CAA 2021 and IRS Notice 2021-15) during the Plan Year and becomes ineligible under the Dependent Day Care Flexible Spending Account, the Participant may decrease or terminate his election. If a child begins kindergarten or first grade, the Participant may decrease or terminate his Dependent Day Care Flexible Spending Account election.
- (7) *Special Enrollment Rights:* The Plan shall permit a Participant to revoke an election and make a new election that corresponds with the special enrollment rights provided in Section 9801(f) of the Code.
- (c) A Participant entitled to make an election change under this Section 4.06 must do so by completing the Family/Employment Status Change Process (incorporated by reference into this Plan) within 30 days of the event. All election changes shall be effective the first day of the month following the date of the Status Change and is subject to the Benefit Representative's approval. However, if the Status Change event is birth, adoption or placement for adoption, the Participant is allowed to change his Health Care Flexible Spending Account retroactive to the date of the event provided the request is made within 30 days of the event.

If the change is requested at the end of the Plan Year, the Benefits and payroll processing deadlines will determine in which month and Plan Year the change will take effect. The Benefit Representative, based on prevailing IRS guidance, has sole

discretion to approve or reject an election change request and such decision shall be final.

4.07 Employer Contributions

- (a) The Employer shall contribute to the Plan for each Plan Year an amount equal to:
 - (1) the total of each Participant's reduction of Compensation as elected pursuant to Section 4.01(a);
 - (2) an amount equal to the premium for the core accidental death and dismemberment benefit elected by the participants pursuant to Section 4.02;
 - (3) a portion of the premium for the Dental Plan(s),
 - (4) an amount equal to the costs of the Core Vision Wellness Exam benefit elected by the participants pursuant to Section 4.02, and
 - (5) a portion of the premium for the Vision Plan(s)
 - (6) each Participant's reduction of Compensation as elected pursuant to Sections 4.01(b) and 4.01(c).
- (b) The total contribution for the Plan Year, pursuant to this Section 4.07, shall not exceed the amount equal to those premiums eligible to be paid pursuant to the Plan, including the premium for the core accidental death and dismemberment benefit and cost of the Core Vision Wellness Exam, during the Plan Year for which Participant elections are made plus Participant's reduction of Compensation pursuant to Sections 4.01(b) and 4.01(c).
- (c) Except as provided in Sections 8.02 and 8.03, all contributions made by the Employer shall be used for the exclusive benefit of Participants under the Plan.

4.08 Allocation to Accounts and for Premium Payments

Any amounts of Compensation reduced by a Participant and contributed to the Plan by the Employer shall be credited to the Health Care Flexible Spending Account and/or Dependent Day Care Flexible Spending Account as elected by the Participant pursuant to Article IV. Amounts shall be available for payment of premiums as further elected pursuant to Article IV and Article V for one or more of the following Plans:

- (a) Cancer Insurance,
- (b) Critical Illness Insurance,
- (c) Short Term Disability Plan,
- (d) Long Term Disability Plan,
- (e) Dental Plan,
- (f) Vision Care Plan,

- (g) TRICARE Supplement Plan,
- (h) Voluntary Accidental Death and Dismemberment Insurance,
- (i) Voluntary Group Term Life Insurance,
- (j) Core Accidental Death and Dismemberment Insurance,
- (k) Core Vision Wellness Exam, and
- (l) Voluntary Accident Insurance.

Amounts in the Health Care Flexible Spending Account shall be available for Health Care Flexible Spending Account Benefits pursuant to Article VI. Amounts in the Dependent Day Care Flexible Spending Account shall be available for Dependent Day Care Flexible Spending Account Benefits pursuant to Article VII.

4.09 After-Tax Election with Respect to Dependent Life Coverage

The Voluntary Group Term Life Insurance benefit under this Plan includes an option to choose dependent life insurance coverage on an after-tax basis. A Participant choosing that option will not be treated as having made an election under the cafeteria plan features of this Plan because that option cannot be offered under a cafeteria plan. Nonetheless, the Participant will have the premium deducted from his or her Compensation on an after-tax basis and contributed to the Plan by the Employer.

ARTICLE V

INSURANCE PROGRAM BENEFITS

5.01 Type of Plan

The benefits under the Insurance Program shall be paid under the terms of such plans as in effect from time to time. The Plan shall not be responsible for the payment of benefits from the Insurance Program, but the insurance company shall pay such benefits for each of the respective plans. This Article shall provide for payment of the premiums for these benefits through reduction of Compensation by Participants. The premiums shall be paid under the terms of each such plan as are in effect from time to time in each plan and those payment provisions for each benefit are incorporated herein by reference into this Plan.

5.02 Election of Plan Benefits

During the period designated by the Plan Administrator but by no later than December 31, each Participant may elect to reduce his Compensation in accordance with Article IV to purchase coverage under the Insurance Program for the next Plan Year. Such election shall be irrevocable except as described in Sections 2.35 and 4.06.

5.03 Adjustments

The premium amounts shall be transferred to the requisite entity for the benefits under this Article V as elected by the Participants. All such adjustments shall be made through the payroll system maintained by the Employer.

ARTICLE VI

HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

6.01 Type of Plan

A Participant under the Health Care Flexible Spending Account receives benefits in the form of health care reimbursements referred in Section 6.04 and tax savings through reduction of Compensation.

6.02 Health Care Flexible Spending Account

A Participant's Health Care Flexible Spending Account shall be credited with the amount elected under Section 4.01(b) and debited with the Health Care Flexible Spending Account Benefits paid in accordance with this Article.

6.03 Maximum and Minimum Contributions

The maximum and minimum dollar amounts available to each Participant for reimbursement under his Health Care Flexible Spending Account are specified on the attached Schedule A. The maximum and minimum amounts are stated on a per pay period and Plan Year basis. The maximum amounts for the Health Care Flexible Spending Account are subject to annual cost-of-living adjustments in accordance with guidance issued by the Internal Revenue Service, at the discretion of the Plan Administrator.

6.04 Health Care Flexible Spending Account Benefits

A Participant who incurs medical care expenses for himself, his Spouse, or his Dependents may request reimbursement of the health care expenses. Payment of the requested Health Care Flexible Spending Account Benefits shall be made to the extent the request satisfies the following requirements:

- (a) the medical care expenses must qualify either (1) under Code Section 213(d) as permitted under Code Section 125 and applicable IRS regulations or (2) be over-the-counter medicines and drugs sold lawfully without a prescription or menstrual care products as permitted by Code Section 106; but shall not include a premium payment or expenses for any qualified long-term care insurance contracts or any health insurance coverage such as (but not limited to) health coverage under an individual policy or a plan maintained by the employer of the Participant's Spouse or Dependent; and

- (b) the expenses must have been incurred and services rendered after the participant's entry date, while the participant is covered under the Health Care Flexible Spending Account, and within the Plan Year, January 1 to December 31 of the Plan Year, provided the claim for reimbursement is filed no later than March 31 of the year following the end of the Plan Year; and
- (c) the request must meet the documentation requirements of Section 6.05 and must be submitted within the timeframe set by Section 6.06; and
- (d) the Participant must provide a written statement that these expenses have not been reimbursed and will not be reimbursed in the future, such as by insurance or another Code Section 125 arrangement; and
- (e) the total reimbursement for the Plan Year does not exceed the amount elected by the Participant under the Health Care Flexible Spending Account for the Plan Year.
- (f) If, as of the end of the Plan Year, the Participant has a balance in his/her Health Care Flexible Spending Account (net of claims incurred but not reimbursed), such remaining balance in excess of six hundred, forty dollars (\$640) shall be forfeited to the extent not paid to the Participant pursuant to a claim properly submitted by the applicable claim submission deadline. All claims must be submitted on or before March 31 (or such other date as determined by the Plan Administrator) following the end of the Plan Year.

6.05 Documentation of Expenses

A Participant who applies for reimbursement of Health Care Flexible Spending Account Benefits shall submit the request for reimbursement online or in writing on a claim form which shall require the following information to the Flexible Benefits Administrator:

- (a) a statement from the health care provider listing:
 - (1) the person's name for whom the health care expenses were incurred; and
 - (2) amount of expenses; and
 - (3) date incurred; and
 - (4) nature of the expenses; OR

a health plan's or administrator's explanation of benefit reports or other statements from an independent third party showing that the health care expenses were properly incurred, the amount of such expenses and any payments received from a health plan;

AND

- (b) a statement from the Participant that the health care expenses have not been reimbursed and that the Participant shall not seek reimbursement through any other source

AND

- (c) such other information as the Flexible Benefits Administrator shall from time to time require.

If the Health Care Flexible Spending Account is accessible by an electronic debit/credit card, the Participant shall be required to comply with substantiation procedures established by the Flexible Benefits Administrator in accordance with Prop. Treas. Reg. Sec. 1.125-6 or other applicable IRS guidance.

6.06 Submission of Claims

All claims for expenses pursuant to this Article must be submitted during the Plan Year in which the expenses are incurred, or on or before March 31 following the close of such Plan Year. Except for the final reimbursement claim filed for the Plan Year, no other claim filed in accordance with Section 6.05 shall be reimbursable under the Health Care Flexible Spending Account unless and until the aggregate claim for reimbursement is at least \$25. There is no minimum claim amount if the Health Care Flexible Spending Account is accessed by an electronic debit/credit card.

6.07 Assignability

Amounts payable by the Plan may not be assigned to physicians, hospitals or other providers of services covered by the Plan.

6.08 Coordination of Benefits

Benefits provided by this Plan may not be coordinated with any other health care benefits provided by any other plan. For purposes of coordination of benefits, this Plan is not a group health plan.

6.09 Lost Participant

Any benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the Participant to whom payment is due, provided, however, that such benefit shall be reinstated if a claim is made by the Participant for the forfeited benefit, but only if such claim is made within the time prescribed in Section 6.06.

6.10 Separate Written Plan

For purposes of Sections 105(b) and 106 of the Code, this Article shall constitute a separate medical reimbursement plan. To the extent necessary, other provisions of the Plan shall be incorporated herein by reference into this Article.

ARTICLE VII

DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

7.01 Type of Plan

A Participant under the Dependent Day Care Flexible Spending Account receives benefits in the form of dependent day care reimbursements referenced in Section 7.04 and tax savings through a reduction of Compensation.

7.02 Dependent Day Care Flexible Spending Account

A Participant's Dependent Day Care Flexible Spending Account shall be credited with the amount elected under Section 4.01(c) and debited with the Dependent Day Care Flexible Spending Account Benefits paid in accordance with this Article.

7.03 Maximum and Minimum Contributions

The maximum dollar amount available to each Participant for reimbursement for a Plan Year pursuant to this Article shall be \$5,000, or \$2,500 if married filing separately. If a Participant's Spouse also participates in a dependent day care assistance plan under Code Section 129, the Participant shall be responsible for reducing his election dollar-for-dollar by the amount contributed to the Spouse's dependent day care assistance plan to satisfy the \$5,000 family maximum. The minimum amount a Participant may contribute per pay period is specified on the attached Schedule A. The maximum and minimum amounts are stated on a per pay period and Plan Year basis. In addition, the amount available to each Participant for reimbursement is subject to the limits set forth in Section 7.08.

7.04 Dependent Day Care Flexible Spending Account Benefits

A Participant who incurs expenses for household services and dependent day care services may request payment of Dependent Day Care Flexible Spending Account Benefits to cover those expenses. Payment of the requested Dependent Day Care Flexible Spending Account Benefits shall be made to the extent the request satisfies the following requirements:

- (a) the expenses must have been paid for household services or dependent day care services incurred, that is the date service is rendered, after the Participant's Entry Date, while the Participant is covered under the Dependent Day Care Flexible Spending Account, and within the Plan Year to enable the Participant (or if married, the Participant and his Spouse) to be employed for any period for which there are one or more Dependents, with respect to the Participant. Effective January 1, 2011, such services may also be incurred between January 1 and March 15 of the next year following the end of the Plan Year, which is referred to as the Grace Period. However, the Grace Period applicable to the 2019 Plan Year which would have ended as of March 15, 2020 will be extended through September 30, 2020 in accordance with IRS Notice 2020-29. Additionally, the Grace Period applicable to the 2020 and 2021 Plan Years which would have ended as of March 15, 2021 and March 15, 2022, respectively will be extended through December 31, 2021 and December 31, 2022, respectively, in accordance with the CAA 2021 and IRS Notice 2021-15.

- (1) an individual with respect to whom a personal exemption is allowed under Code Section 151(c) to a Participant or his Spouse,
 - (2) the Participant's Spouse, or
 - (3) a Participant's child who has not attained age 19 at the close of the Participant's tax year.
- (b) if such services are provided outside the Participant's household, they must be incurred for care of a Participant's Dependent who has not attained the age of 13 (age of 14 for the 2021 Plan Year only, pursuant to the CAA 2021 and IRS Notice 2021-15 and only to the extent of the remaining balance in the Dependent Day Care Flexible Spending Account as of the end of the 2020 Plan Year), or another Dependent who regularly spends at least eight hours per day in the Participant's household;
 - (c) if the expenses are incurred for services provided by a dependent care center, the center must comply with all applicable state and local laws and regulations;
 - (d) the request must meet the documentation requirements of Section 7.05 and must be submitted within the timeframe set by Section 7.06; and
 - (e) the claim reimbursements may not exceed the amount credited to the Participant's Dependent Day Care Flexible Spending Account on the Adjustment Date.

7.05 Documentation of Expenses

- (a) A Participant who applies for reimbursement of Dependent Day Care Flexible Spending Account Benefits shall submit the following information to the Flexible Benefits Administrator:
 - (1) a statement from the dependent day care provider listing the amount of expenses, date incurred and nature of expenses;
 - (2) the name of each Dependent for whom the expenses are incurred;
 - (3) the name, address and taxpayer identification number of the dependent day care provider; and
 - (4) a written statement by the Participant that these expenses have not been reimbursed and will not be reimbursed in the future, including under another Code Section 129 plan.
- (b) Except for the final reimbursement claim filed for the Plan Year, no other claim shall be reimbursable under the Dependent Day Care Flexible Spending Account unless and until the aggregate claim for reimbursement is at least \$25. There is no minimum claim amount if the Dependent Day Care Flexible Spending Account is accessed by an electronic debit/credit card.
- (c) If the Dependent Day Care Flexible Spending Account is accessible by an electronic debit/credit card, the Participant shall be required to comply with substantiation

procedures established by the Flexible Benefits Administrator in accordance with Prop. Treas. Reg. Sec. 1.125-6 or other applicable IRS guidance.

- (d) An electronic debit/credit card may be used to reimburse Dependent Day Care Flexible Spending Account expenses.

7.06 Submission of Claims

All claims for expenses pursuant to this Article must be submitted during the Plan Year in which the expenses are incurred, or on or before March 31 following the close of such Plan Year.

7.07 Statement to Participants

On or before January 31, a written statement shall be provided to a Participant who has elected coverage under the Dependent Day Care Flexible Spending Account during the preceding calendar year.

7.08 Maximum Benefit

The maximum benefit allowable for Dependent Day Care Flexible Spending Account Benefits for a Plan Year shall be the lesser of the Participant's earned income, the Participant's Spouse's earned income as determined by Code Section 129, or the maximum dollar amount established by Section 7.03. For purposes of this Section, the Spouse of any Participant who is a student or physically or mentally disabled as described in Code Section 21(d)(2) shall be deemed for each month during which such Spouse is a student or physically or mentally disabled to be gainfully employed and have earned income for such month of:

- (a) \$250, if there is only one Dependent with respect to the Participant for such month; or
- (b) \$500, if there is more than one Dependent with respect to the Participant for such month.

7.09 Assignability

Amounts payable by the Plan may not be used to make direct payments to providers of dependent day care services.

7.10 Lost Participant

Any benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the Participant to whom payment is due, provided, however, that such benefit shall be reinstated if a claim is made by the Participant for the forfeited benefit, but only if such claim is made within the time prescribed in Section 7.06.

7.11 Separate Written Plan

For purposes of Section 129 of the Code, this Article shall constitute a separate dependent day care assistance plan. To the extent necessary, other provisions of the Plan shall be incorporated by reference into this Article.

ARTICLE VIII

FLEXIBLE SPENDING ACCOUNTS ADMINISTRATION

8.01 Plan Administrator Responsibility

The Plan Administrator shall determine the Participants and Former Participants who are entitled to one or more of the allocations hereinafter described. The Plan Administrator shall maintain for each Participant a separate Health Care Flexible Spending Account and Dependent Day Care Flexible Spending Account to record the amount attributable to reductions of Compensation pursuant to Section 4.02 and payments. Each such account shall consist of a record of the contributions and adjustments.

8.02 Health Care Flexible Spending Account Adjustments and Forfeitures

As of each Adjustment Date, the Health Care Flexible Spending Account of each Participant and Former Participant shall be adjusted by the following additions and subtractions:

- (a) *Compensation Reductions:* There shall be added to the Health Care Flexible Spending Account of each Participant those amounts of Compensation reduced pursuant to Section 4.01(b).
- (b) *Payments:* There shall be subtracted the total amount of any payments made from the Health Care Flexible Spending Account to the Participant or for his benefit. Provided however, the total amount that is to be contributed to the Health Care Flexible Spending Account during the Plan Year shall be available for reimbursement to the Participant at all times during the Plan Year, reduced as of any particular time for prior reimbursements for the same Plan Year. Provided further that if a Participant, due to termination of employment or reduction in hours, ceases to make contributions to the Health Care Flexible Spending Account during a Plan Year, the amount available for reimbursement of claims incurred prior to the date of such event shall be the Participant's annual election reduced by prior reimbursements for the same Plan Year.
- (c) *Forfeitures (carry-over):* If, as of the end of the Plan Year, the Participant has a balance in his/her Health Care Flexible Spending Account (net of claims incurred but not reimbursed), such remaining balance in excess of six hundred forty dollars (\$640) shall be forfeited to the extent not paid to the Participant pursuant to a claim properly submitted by the applicable claim submission deadline. Notwithstanding the preceding sentence, pursuant to the CAA 2021 and IRS Notice 2021-15, any balance remaining in a Participant's Health Care Flexible Spending Account at the end of the 2024 Plan Year shall carry over to the 2025 Plan Year, and any balance remaining in a Participant's Health Care Flexible Spending Account at the end of the 2025 Plan Year shall carry over to the 2026 Plan Year. All claims must be submitted on or before March 31 (or such other date as determined by the Plan Administrator) following the end of the Plan Year. The forfeited amounts may be used to reduce the plan administrative expenses. Any claims pursuant to Article VI that are incurred within the Plan Year and prior to the Participant's termination or ineligible date, unless COBRA is elected, but unpaid as of December 31, shall be processed before any amounts are forfeited. Such claims must be submitted on or before March 31 (or such other date as determined by the Plan Administrator) of such next Plan Year.

- (d) *Qualified Reservist Distribution:* Notwithstanding the foregoing, a Participant who is ordered or called to active duty military service for a period longer than 179 days by reason of being a member of a reserve component may request a “qualified reservist distribution” (as defined under Code Section 125(h)(2)) of all or a portion of the amount contributed to his Health Care Flexible Spending Account up to the date of such request less the amount of any claims for reimbursement received by the Plan Administrator as of such request. Such request must be submitted in writing to the Plan Administrator before the last day of the Plan Year) which includes the date of such order or call. If approved, claims incurred after the date of such request shall be denied and the Plan Administrator shall issue such distribution within a reasonable period but in no event later than sixty (60) days following its receipt of the required notice from the Participant.

8.03 Dependent Day Care Flexible Spending Account Adjustments and Forfeitures

As of each Adjustment Date, the Dependent Day Care Flexible Spending Account of each Participant and Former Participant shall be adjusted by the following additions and subtractions:

- (a) *Compensation Reductions:* There shall be added to the Dependent Day Care Flexible Spending Account of each Participant those amounts of Compensation reduced pursuant to Section 4.01(c).
- (b) *Payments:* There shall be subtracted the total amount of any payments up to the account balance made from the Dependent Day Care Flexible Spending Account to the Participant or for his benefit. Provided however, the amount that is contributed to the Dependent Day Care Flexible Spending Account during the Plan Year will be available for reimbursement to the Participant during the Plan Year, reduced as of any particular time for prior reimbursements for the same Plan Year. Provided further that if a Participant, due to termination of employment or a change to ineligible status, ceases to make contributions to the Dependent Day Care Flexible Spending Account during the Plan Year, the amount available for reimbursement of claims incurred prior to the date of such event shall be the Participant’s account balance.
- (c) *Forfeitures (use it or lose it rule):* As of March 15 following the end of each Plan Year (also known as the end of the Grace Period), any amounts remaining in the Dependent Day Care Flexible Spending Account attributable to such Plan Year shall be forfeited. The forfeited amounts may be used to reduce the plan administrative expenses. Any claims pursuant to Article VII that are incurred within the Plan Year or between January 1 and March 15 of the next Plan Year following the end of the Plan Year and prior to the Participant’s termination or ineligible date, but unpaid as of March 15, shall be processed before any amounts are forfeited. Such claims must be submitted on or before March 31 of such next Plan Year (or such other date designated by the Plan Administrator).

ARTICLE IX

PLAN RESPONSIBILITIES AND ADMINISTRATION

9.01 Allocation of Responsibilities

The responsibilities allocated to the named individuals are as follows:

- (a) The Director of the Office of State Human Resources shall have the sole authority to:
 - (1) be responsible for central flexible benefits coordination for Employees,
 - (2) amend, modify or terminate the Plan,
 - (3) administer the Plan including managing insurance and third party administration contracts for Plan Benefits under the Plan, and
 - (4) speak on behalf of the Plan before the State Legislature.
- (b) The Flexible Benefits Program Manager shall have the authority to:
 - (1) coordinate the administration of the Plan,
 - (2) review the actions of the Flexible Benefits Administrator,
 - (3) coordinate the Committees and Sub-Committees,
 - (4) coordinate enrollment and communication efforts concerning the Plan Benefits under the Plan and other benefit programs, and
 - (5) perform any other duties relating to the operation of the Plan as designated by the Director of the Office of State Human Resources.
 - (6) make recommendations to the Director of the Office of State Human Resources regarding administration of the Plan,
 - (7) develop administrative guidelines,
 - (8) review existing flexible benefit programs in State governments,
 - (9) recommend pretax benefits to be included in the Plan,
 - (10) assist in reviewing contracts and administering the Health Care Flexible Spending Account and the Dependent Day Care Flexible Spending Account, and
 - (11) undertake other functions as necessary.

- (c) The Flexible Benefits Administrator shall have the authority to manage the operation and administration of the Health Care Flexible Spending Account and the Dependent Day Care Flexible Spending Account.
- (e) The insurance companies providing the Insurance Program shall be solely responsible for providing the benefits provided under the Insurance Program, for determining eligibility for benefits under the Insurance Program, and for administering the claims and claims review procedures under the Insurance Program.
- (g) Persons and entities responsible for administering the Health Care Flexible Spending Account and the Dependent Day Care Flexible Spending Account are empowered to exercise exclusive and absolute discretion with respect to matters for which they are responsible, including the interpretation of the terms of the Plan relating to the Health Care Flexible Spending Account and the Dependent Day Care Flexible Spending Account. Such discretionary determinations, including those regarding Plan terms and eligibility, shall be final and conclusive and shall bind all Employees and beneficiaries and the Employer.

9.02 Claims Procedures for Flexible Spending Accounts

- (a) *Application for Flexible Spending Account Claims:* Any claim by a Participant for benefits under the Health Care Flexible Spending Account and Dependent Day Care Flexible Spending Account shall be submitted to the Flexible Benefits Administrator who shall be responsible for determining the initial qualification of the claim.
- (b) *Limitations:* Notwithstanding anything in the Plan to the contrary, no benefits for expenses incurred in a Plan Year under the Health Care Flexible Spending Account and Dependent Day Care Flexible Spending Account shall be payable under the Plan to any Participant who submits a claim for benefits after March 31 following the close of such Plan Year.

Each Participant or other interested person shall file with the Flexible Benefits Administrator such pertinent information concerning himself as the Flexible Benefits Administrator may specify, and in such manner and form as the Flexible Benefits Administrator may specify or provide, and such person shall not have any rights or be entitled to any benefits hereunder, as the case may be, unless such information is filed by him or on his behalf. Each Participant claiming benefits under the Plan shall supply at such times and in such manner as the Flexible Benefits Administrator may require, written proof that expenses were incurred or that the benefit is covered under the Plan. If the Flexible Benefits Administrator shall determine that a Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits hereunder shall be payable to such Participant.

- (c) *Notification of Decision:* Notice of a decision by the Flexible Benefits Administrator with respect to a claim shall be furnished to the Participant within 30 days following the receipt of the claim by the Flexible Benefits Administrator unless special circumstances require an extension of time for processing the claim. If there is a need for such an extension, the Flexible Benefits Administrator shall furnish written notice of the extension to the Participant prior to the expiration of the initial 30-day period. In no event shall such extension exceed a period of 30 days from the end of the initial 30-day period. The notice of extension shall indicate the special circumstances

requiring the extension and the date by which the notice of decision with respect to the claim shall be furnished. Commencement of benefit payments shall constitute notice of approval of a claim to the extent of the amount of the approved benefit. If such claim shall be wholly or partially denied, such notice shall be in writing and worded in a manner calculated to be understood by the Participant and shall set forth: (a) the specific reason or reasons for the denial; (b) specific reference to pertinent provisions of the Plan on which the denial is based; (c) a description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary; and (d) an explanation of the Plan's claims review procedure. If the Flexible Benefits Administrator fails to notify the Participant of the decision regarding his claim in accordance with this Article, the claim shall be deemed denied and the Participant shall then be permitted to proceed with the claims review procedure provided in Section 9.02(d).

- (d) *Claims Review Procedure:* Within 180 days following receipt by the Participant of notice of the claim denial, or within 180 days following the close of the 30-day period referred to in Section 9.02(c) if the Flexible Benefits Administrator fails to notify the Participant of the decision during such time period the Participant may appeal denial of the claim. The Participant shall be given an opportunity to review pertinent documents and to submit issues and comments in writing. A request for review by the Participant shall be in writing and shall contain all additional information, which the Participant wishes the Plan Administrator or its representative to consider. Following such request for review, the Plan Administrator or its representative shall fully and fairly review the decision denying the claim. The Plan Administrator or its representative may hold a hearing or conduct an independent investigation regarding the merits of the denied claim. Within 60 days following receipt of the Participant's request for review, the Plan Administrator or its representative shall deliver the decision to the Participant in writing. If the decision on review is not furnished within the prescribed time, the claim shall be deemed denied on review.

For all purposes under the Plan, decisions on claims where no review is requested and decisions on claims where review is requested shall be final, binding, and conclusive on all interested parties

9.03 Claims Procedures for Insurance Program

Each insurance company for an Insurance Program shall establish a claims procedure and a claims review procedure for the Insurance Program and shall process claims for benefits and the review of denied claims made by Participants in accordance with such procedures. Such claims procedure and claims review procedures shall be sent by the insurance companies to the Flexible Benefits Program Manager and shall be kept in a file in the Office of State Human Resources to be designated the "Claims Procedures for Insurance Program File." The procedures kept in the Claims Procedures for Insurance Program File shall be available to Participants and Employees on request made to the Flexible Benefits Program Manager, and the Flexible Benefits Program Manager shall make such procedures available to Participants and Employees for review in such manner as the Flexible Benefits Program Manager deems reasonable.

9.04 Correction of Mistakes

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 Flexible Benefits Program Manager shall, to the extent that it deems administratively possible and otherwise permissible under Code Section 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 Flexible Benefits Program Manager may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

9.05 Plan Expenses

Except as otherwise provided in the Plan, all expenses and charges incurred in the administration and operation of the Plan, including fees and expenses which the Plan Administrator agrees to pay the Flexible Benefits Administrator or other agents or professionals employed or retained pursuant hereto, shall be paid out of the assets of the Employer. No compensation shall be paid by the Plan to the administrator if employed by the Employer but said persons may be reimbursed for their reasonable expenses incurred in carrying out their duties, responsibilities and authority hereunder, and the compensation, or the properly allocable portion thereof, paid to other Employees who are involved in the administration and operation of the Plan and all other properly allowable expenses shall, to the extent not paid by the Employer, be treated as administrative expenses.

9.06 Bonding

No bond shall be required of the Flexible Benefits Program Manager and his staff, the Benefit Representatives, or the Plan Administrator, except as otherwise required by law.

9.07 Notices

Any notice, application, instruction, designation or other form of communication required to be given or submitted by any Participant shall be in such form as is prescribed from time to time by the Flexible Benefits Program Manager, sent by inter-office mail, first class mail, facsimile, electronic mail or delivered in person to the Flexible Benefits Program Manager. Any notice, statement, report or other communication from the Employer, the Flexible Benefits Administrator or the Flexible Benefits Program Manager or their representative to any Participant, other Employee, or representative of a Participant or other Employee, shall be deemed to have been duly delivered when given to such person or delivered by inter-office mail, first class mail, facsimile, or electronic mail to such person at his address last appearing on the records of the Employer. Each person entitled to receive benefits under the Plan shall file in accordance herewith his complete mailing address and each change therein.

9.08 Agent for Service of Legal Process

The agent for the service of legal process under the Plan shall be the Plan Administrator or its designated representative.

9.09 Nondiscriminatory Exercise of Authority

This Plan is intended to be legally enforceable. Accordingly, whenever, in the administration of the Plan, any interpretive action by the Plan Administrator is required, the Plan Administrator shall exercise his authority in a nondiscriminatory manner, as determined by the Plan

Administrator in his discretion, so that all persons similarly situated shall receive substantially the same treatment.

9.10 Indemnification

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Plan Administrator, Flexible Benefits Program Manager and his staff, and Benefit Representative, including any Employee or former Employee who formerly served as one of these representatives against all liabilities, damages, costs and expenses (including attorneys' 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 X

AMENDMENT OR TERMINATION OF PLAN

10.01 Right to Amend or Terminate

The Plan Administrator shall have the right at any time to amend or modify the Plan, retroactively or otherwise, or to terminate or partially terminate the Plan, provided that no such amendment or termination shall in any manner impair the right of a Participant who is entitled to benefits under the Plan upon the adoption of such amendment to receive benefit payments provided for herein or under the Plan prior to such amendment. No Participant shall have vested rights to benefits payable under the Plan.

10.02 Effect of Termination

Upon complete or partial termination of the Plan, the Plan Administrator shall provide for the payment of benefits to each Participant with respect to which benefits are payable on the date of termination and for the payment of all expenses and charges properly payable hereunder, and of any payments due to the Flexible Benefits Administrator.

ARTICLE XI

LIMITATIONS ON DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER

11.01 Definitions

Whenever used in this Article, the following terms shall have the respective meanings set forth below.

- (a) *Plan Administration Functions*: means administrative functions performed by the Employer on behalf of the Health Care Flexible Spending Account, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.
- (b) *Health Information*: means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR 160.103), employer, life insurer, school or university or health care clearinghouse (as defined in 45 CFR 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.
- (c) *Individually Identifiable Health Information*: means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer or health care clearinghouse that identifies

the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

- (d) *Summary Health Information*: means information, including Individually Identifiable Health Information, which summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed:
- (1) names,
 - (2) geographic information more specific than state,
 - (3) all elements of dates relating to the individual(s) involved (e.g. birth date and date of death) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older),
 - (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN or serial numbers,
 - (5) facial photographs or biometric identifiers (e.g., finger prints), and
 - (6) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.
- (e) *Protected Health Information ("PHI")*: means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

11.02 Disclosure of SHI

The Health Care Flexible Spending Account may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

11.03 Disclosure of PHI and Limitations on Use of PHI

The Plan will disclose PHI to the Employer only in accordance with 45 CFR 164.504(f) and the provisions of this Section.

- (a) PHI disclosed to the Employer in accordance with this Section may only be used for the following permitted and required uses and disclosures: quality assurance, claims processing, auditing, monitoring.
- (b) The Plan hereby incorporates the following provisions (1) through (10) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that the Plan has been so amended.

Additionally, the Employer agrees:

- (1) not to use or further disclose PHI other than as permitted in Section 11.03(a) or as required by law,
 - (2) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions,
 - (3) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan,
 - (4) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section 11.03(a),
 - (5) to make PHI available to individuals in accordance with 45 CFR 164.524,
 - (6) to make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR 164.526,
 - (7) to make the information available required to provide individuals with an accounting of disclosures in accordance with 45 CFR 164.528,
 - (8) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request,
 - (9) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible, and
 - (10) to ensure that adequate separation between the Plan and the Employer, as required by 45 CFR 164.504(f), is established and maintained.
- (c) The Plan will disclose PHI only to the following employees or classes of employees:
- (1) **Claims Processing.** Benefit Representatives of the Employer shall have access to PHI for particular Participants in order to help the Participants make claims under the Health Care Flexible Spending Account. PHI will be made available to Benefit Representatives only if the Participant to which the PHI relates consents in accordance with the rules of 45 CFR 164.524 to the release of PHI to a Benefit Representative.
 - (2) **Quality Assurance, Auditing and Monitoring.** The Flexible Benefits Program Manager shall have access to PHI for the purpose of quality assurance, auditing and/or monitoring the performance of the Flexible Benefits Administrator in administering the Health Care Flexible Spending Account.

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

- (d) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section 11.03(c) shall be addressed in the following manner:

The individual who does not comply with the permitted uses or disclosures of PHI shall be warned by the Flexible Benefits Program Manager and required to undergo training in the Privacy rules set forth in this Article. If the same individual again does not comply with the permitted uses or disclosures of PHI, the individual's access to PHI will be denied.

11.04 HIPAA Data Security Standards

The Employer, as plan sponsor, shall (effective April 20, 2005):

- (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan,
- (b) Ensure that the adequate separation required by 45 CFR Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures,
- (c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information, and
- (d) Report to the Plan any security incident of which it becomes aware.

All terms used but not otherwise defined in the Plan shall have the same meaning as those terms in 45 CFR Parts 160 and 164.

ARTICLE XII

MISCELLANEOUS

12.01 In General

Any and all rights or benefits accruing to any person under the Plan shall be subject to all terms and conditions of the Plan. The adoption and maintenance of the Plan shall not constitute a contract between the Employer and any Employee or be a consideration for, or an inducement or condition of, employment of any Employee. Neither participation nor anything contained in the Plan shall give any Employee the right to be retained in the employ of the Employer, nor shall it interfere with the right of the Employer to discharge any Employee at any time. The Employer does not guarantee that any favorable tax consequences will result from an Employee's participation in the Plan. In the event any provision of this Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of this Plan, and it shall be construed and enforced as if such illegal or invalid provision had never been included in the Plan.

12.02 Filing of Information

Each Employee or other interested person shall file with the Plan such pertinent information concerning himself as the Plan may specify, including proof or continued proof of dependency or eligibility, and in such manner and form as the Plan may specify or provide, and such person shall not have rights or be entitled to any benefits or further benefits hereunder unless such information is filed by him or on his behalf.

12.03 Payment to Others than Participants

If the Plan shall find that any person to whom any benefits are payable under the Plan is unable to care for his affairs, then any payment due to him or his estate (unless a prior claim therefore has been made by a duly appointed legal representative) may be paid to the Spouse, a child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan to be a proper recipient on behalf of such person otherwise entitled to payment, or the Plan may in its discretion hold such payment until a legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of the Plan.

12.04 Recovery of Payments Made by Mistake

Notwithstanding anything to the contrary, a Participant or Former Participant is entitled to only those benefits provided by the Plan and promptly shall return any payment, or portion thereof, made by mistake of fact or law. The Plan may offset the future benefits of any recipient who refuses to return an erroneous payment, in addition to pursuing any other remedies provided by law.

12.05 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment nor will guarantee that any amounts paid to or for the benefit of a Participant under this Plan 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 Flexible Benefits Program Manager if the Participant has any reason to believe that such payment is not so excludable.

12.06 No Waiver or Estoppel

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

12.07 Limitation on Actions

No action at law or in equity shall be instituted to recover under the Plan before a Participant or former Participant has exhausted all rights of appeal under Article IX; nor shall any such action be instituted at any time unless instituted within three years after the date the expenses which are the subject of or are otherwise involved in such action are incurred or are alleged to have been incurred; provided that any limitation on actions regarding benefits shall be as provided in the Plan.

12.08 Compliance with Applicable Law

Notwithstanding any other provision of the Plan to the contrary, in all instances the Plan shall be construed, administered, and enforced according to the laws of the State of North Carolina, except to the extent preempted by federal law.

12.09 Reclassification

This section applies to any individual who is classified by the Employer as a retired employee, leased employee, and independent contractor or as coming within another non-Employee or ineligible designation. If any such individual is thereafter required by the Internal Revenue Service, Department of Labor or other government agency, or by any court or other tribunal, to be classified as an Employee, such individual shall not be eligible to participate in this Plan unless and until the time he is designated by the Flexible Benefits Program Manager as an eligible Employee. Such designation shall only provide for eligibility prospectively from the time it is made.

12.10 Construction

The Plan shall be construed according to the laws of the State of North Carolina, and all provisions hereof shall be administered according to the laws of said state.

12.11 Severability of Provisions

If any provision of this Plan is determined to be invalid or unenforceable, that provision shall be severable from the other provisions of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

12.12 Headings

All article and section headings herein have been inserted for convenience only and shall not affect the meaning of the language contained herein.

12.13 Gender and Number

The masculine gender shall be deemed to include the feminine and the singular shall include the plural unless otherwise clearly required by the context.

IN WITNESS WHEREOF, the NCFlex Plan is executed on behalf of the Employer, the _____ day of _____, 20____.

STATE OF NORTH CAROLINA

By: _____
Total Rewards Director

Attest:

By: _____
Secretary

SCHEDULE A

Minimum And Maximum Contributions

For The Flexible Spending Accounts

Minimum Contribution

The minimum contribution for both the Health Care Flexible Spending Account and the Dependent Day Care Flexible Spending Account is as follows:

- Monthly (12 pay periods) \$10.00
- Semimonthly (24 pay periods) \$ 5.00
- Biweekly (26 pay periods, 24 benefit deductions) \$ 5.00

Maximum Contribution (Effective January 1, 2009 and before January 1, 2013)

A Participant's maximum annual contribution to the Dependent Day Care Flexible Spending Account is \$5,000 (\$2,500 if married filing separately). A Participant's maximum annual contribution to the Health Care Flexible Spending Account is \$5,000.

Maximum Contribution (Effective January 1, 2013)

Except as provided above, a Participant's maximum annual contribution to the Dependent Day Care Flexible Spending Account is \$5,000 (\$2,500 if married filing separately) and a participant's maximum annual contribution to the Health Care Flexible Spending Account is \$2,500, as indexed for cost-of-living by the IRS; however, such amounts may be less than the maximum permitted by the IRS as communicated to Participants by the Plan Administrator. So, for example, the Health Care Flexible Spending Account contribution limit for the 2020 Plan Year is \$2,700. If annual enrollment materials communicate a lower amount due to a delay by the IRS in issuing the indexed Health Care Flexible Spending Account limit for the next Plan Year then, Participants will only be able to contribute such lower amount.

