**Bozeman School District #7**

**CAFETERIA PLAN**

**SUMMARY PLAN DESCRIPTION**

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# GENERAL INFORMATION ABOUT THE PLAN

## What is the purpose of the Cafeteria Plan?

The purpose of the Cafeteria Plan is to allow certainEmployees to use funds provided through Employee salary reduction and Employer Contributions, if any, to choose (and pay for) certain benefits made available by the Employer through the Cafeteria Plan.

## When does the Cafeteria Plan take effect?

The Cafeteria Plan was originally effective 09/01/2019. This restatement is effective 09/01/2020.

The Cafeteria Plan operates on a Plan Year running from 09/01/2020 through 08/31/2021.

## What Benefits are offered through the Cafeteria Plan?

The Optional Benefits available through this Plan are identified in Exhibit B.

**NOTE:** The Optional Benefits listed in Exhibit B are the only Optional Benefits available through this Cafeteria Plan. Any references to benefits not identified as Optional Benefits on Exhibit B should be disregarded.

## Who can participate in the Cafeteria Plan?

Employees who meet the requirements in Exhibit B are called “Eligible Employees.” Those Eligible Employees who actually participate in the Cafeteria Plan are called “Participants.” There are certain exceptions. They are described in the underlying Cafeteria Plan document. You will be notified if you fall within one of the exceptions.

If you are a Participant, the Cafeteria Plan allows you to pay your share of the cost of the Optional Benefits available through this Cafeteria Plan on a pre-tax basis. Participation in the Cafeteria Plan is tied to you being actually covered under one or moreOptional Benefits. An Employee covered under one or more of the Optional Benefits available through this Cafeteria Plan can also participate in this Cafeteria Plan.As a condition of participation in the Cafeteria Plan, you must observe all Cafeteria Plan rules and regulations.

**“Employee”** means a common-law employee of the Employer who is on the Employer’s W-2 payroll, except that the term “Employee” does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Internal Revenue Code §414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer’s W-2 payroll. The term “Employee” also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency, or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term “Employee” also does not include any individual deemed by the Internal Revenue Code to be self-employed, such as partners, shareholders of S-corporations who own more than 2% of the corporation’s stock and members of their families, and (in most cases) members of limited liability corporations. The term “Employee” includes “former employees” for the limited purpose of allowing continued eligibility for benefits as provided hereunder after an employee ceases to be employed by the Employer.

## When does my participation in the Cafeteria Plan begin?

For newly Eligible Employees, participation may begin on, or closely following, the date on which you satisfy the definition of Eligible Employee. If they are required, you must submit the enrollment forms within the time period established and communicated to you by the Plan Administrator.

**NOTE:** With respect to Optional Benefits involving premiums for group coverage, if you have enrolled in those benefits, you may automatically become a Participant in this Cafeteria Plan as described in Section 1.6.

If you do not become a Participant when first eligible, you may become a Participant at the start of any subsequent Plan Year.

As a condition to participation in the Cafeteria Plan, you must also:

### observe all Plan rules and regulations;

### agree to inquiries by the Plan Administrator with respect to any physician, hospital, or other provider of medical care or other services covered by Optional Benefits available through this Cafeteria Plan;

### submit to the Plan Administrator all notifications, reports, bills, and other information that the Plan Administrator may reasonably require; and

### agree to repay any overpayments or incorrect payments you receive from the Cafeteria Plan.

Participation continues until you elect not to participate, you are no longer an Eligible Employee, the Cafeteria Plan terminates, you are no longer covered under any Optional Benefits, your contributions cease, or your participation is terminated for cause.

## How do I enroll and make benefit elections?

### **Generally.** The Plan Administrator will provide you with the forms necessary to enroll and make elections, including information about the costs of the various Optional Benefits.

### **Initial Enrollment**. If you become an Eligible Employee other than at the start of a Plan Year, the initial enrollment period takes place at the time you become eligible to participate as described in Section 1.5. To the extent you have enrolled in the Group Medical Coverage, Group Dental Coverage, Group Vision Coverage, or Group Term Life and AD&D Benefits, you will be deemed to have elected to participate in the Cafeteria Plan for purposes of paying your share of the premium responsibility on a pre-tax basis through salary reduction. This will occur unless you specifically elect not to participate with respect to such coverage. The reimbursement-type Optional Benefits (see Exhibit B) requires an affirmative election. If you do not make an affirmative election with respect to these Optional Benefits during the initial enrollment period, you must generally wait until the next open enrollment period to begin participation. Such an election must be in writing and must be received by the Plan Administrator prior to the date your participation in the Cafeteria Plan would otherwise begin. Furthermore, if you fail to make an election, the Employer Contribution, if any, will be handled in accordance with Exhibit A.

### **Annual Enrollment**. The annual enrollment period for the coming Plan Year begins and ends on or before the last day of each plan year. If you do not make an election during the annual enrollment period, you will be deemed to have elected to not participate in the Cafeteria Plan. To the extent you continue your enrollment in the Group Medical Coverage, Group Dental Coverage, Group Vision Coverage, or Group Term Life and AD&D Benefits, you will be deemed to have elected to continue participation in the Cafeteria Plan for purposes of paying your share of the premium responsibility on a pre-tax basis through salary reduction. This will occur unless you specifically elect not to participate with respect to such coverage.The reimbursement-type Optional Benefits (see Exhibit B) requires an affirmative election. If you do not make an affirmative election with respect to these Optional Benefits during the initial enrollment period, you must generally wait until the next open enrollment period to begin participation.Such an election must be in writing and must be received by the Plan Administrator prior to the first day of the Plan Year. Furthermore, if you fail to make an election, the Employer Contribution, if any, will be handled in accordance with Exhibit A.

**NOTE: *THE LAW REQUIRES*** that enrollment forms received after the close of the enrollment period shall be void.

**CAUTION:** With limited exceptions, once made, elections remain in effect for the entire Plan Year. The exceptions are described below at Question 1.8.

## What is the maximum election I can make under the Cafeteria Plan?

The maximum salary reduction election available under this Cafeteria Plan is the sum of your cost of coverage under the available Optional Benefits minus any Employer Contribution, if any.

## Can I change my election during the Plan Year?

Generally, you cannot change your election regarding participation in the Cafeteria Plan or the Optional Benefits you have selected under the Cafeteria Plan during the Plan Year. You may change your elections only during the annual enrollment period, and then, only for the coming Plan Year. However, your elections will terminate automatically if you cease to be eligible to participate in the Cafeteria Plan. In addition, there are several other exceptions to this general rule.

**Caution:** The circumstances in which you are allowed to change your election, as further described below, are based upon the facts and circumstances of each particular situation. The descriptions of the rules below are general in nature. If you have questions regarding the application of the rules to your specific fact situation, please contact the Plan Administrator immediately. Any request to change your election must be withing the deadline described below.

**NOTE:** The exceptions to the general rule that elections are irrevocable for the Plan Year are determined under regulations issued by the IRS.

**NOTE:** The IRS recognizes only marriages that are valid under applicable state law. Accordingly, a reference to marital status or spouse in this Section 1.8 is applicable only if you are married to an individual and the marriage is valid under applicable state law.

**NOTE:** For purposes of this Section 1.8, if the election relates to an Optional Benefit involving health benefits (e.g., Group Medical Plan, Group Dental Plan, Health Flexible Spending Account, Individual Premium Feature, ICHRA Remainder) the term “dependent” means a “tax dependent” as defined below in Section 1.16. If the election relates to the Dependent Care Flexible Spending Account, the term “dependent” means a “qualifying individual” as defined below in Section 9.5.

### **Change in Status.** You may change or revoke your previous election during the Plan Year if one or more of the following changes in status occur:

#### a change in your legal marital status, including marriage, divorce, death of your spouse, legal separation or annulment;

**NOTE:** A change in the status of a domestic partnership is not a change in status.

#### a change in the number of your dependents, including the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent;

#### any of the following events that change your employment status or the employment status of your spouse or dependent: termination or commencement of employment, a reduction or increase in hours worked, a switch between part-time and full-time, a strike of lockout, a change in worksite, commencement or return from an unpaid leave of absence, a switch between hourly and salaried, a switch between union and non-union, or any similar event;

#### an event causing a dependent to satisfy or cease to satisfy the eligibility requirements applicable under a plan provided or paid for through this Cafeteria Plan; or

#### a change in place of residence for you, your spouse or your dependent.

A change or revocation shall be allowed in these circumstances only if such change or revocation is made on account of, and corresponds with, the change in status and the change in status affects eligibility for coverage under a plan sponsored by the Employer or another employer (referred to as the general consistency requirement). The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change or revocation satisfies the general consistency requirement.

**Example 1:** An Employee enrolls in single coverage under the Employer’s Group Medical Coverage and elects to pay the cost of that coverage through the Cafeteria Plan. The Employee also elects to participate in the Health Flexible Spending Account. During the Plan Year, the Employee gets married. If the Employee enrolls his or her new spouse in the Group Medical Coverage, the Employee may change his or her election to pay the increased cost of that coverage through the Cafeteria Plan. In addition, the Employee may increase his or her election under the Health Flexible Spending Account.

**Example 2:** Employer has three medical plan options: an indemnity option, an HMO option with a service area covering the location of one of the Employer’s operations, and an HMO option with a service are covering the location of the other operation. An Employee enrolls in the HMO option with a service area covering the area in which Employee works and makes an election to pay the cost of the coverage through a Cafeteria Plan. Employee also elects to participate in the Health Flexible Spending Account. If Employee is transferred to the other location, the Employee may switch to the other HMO option or the indemnity option and change his or her election to pay the cost of the new option. The Employee may also drop medical coverage and terminate his or her election under the Cafeteria Plan to pay the cost of medical coverage. The Employee cannot change his or her election under the Health Flexible Spending Account because the change in work location does not affect his or her eligibility under the Health Flexible Spending Account.

A requested change or revocation must also satisfy the following specific consistency requirements for you to be able to alter your election based on the change in status:

#### **Loss of Dependent Eligibility.** For a change in status involving your divorce, annulment or legal separation from your spouse, the death of your spouse or dependent, or your dependent ceasing to satisfy the eligibility requirements for coverage, you may elect to change your election only to reflect the cancellation of group health plan coverage for the affected spouse or dependent. Cancelling coverage for any other individual under these circumstances fails to correspond with that change in status. For example, if you have elected group medical coverage for you, your spouse, and your child, and you divorce during the Plan Year, you may drop your ex-spouse from the coverage and make an election change under this Cafeteria Plan to reflect the reduced cost of coverage. However, you would not be allowed to change your election to reflect the reduced cost attributable to dropping coverage for yourself or your child.

#### **Gain of Coverage Eligibility Under Another Employer’s Plan.** If you, your spouse, or your 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, you may elect to terminate or decrease your election under this Cafeteria Plan on account of that change in status only if coverage becomes effective or is increased under the other employer’s plan.

#### **Dependent Care Flexible Spending Account**. With respect to the Dependent Care Flexible Spending Account, you may change or terminate your election only if (i) the change or termination is made on account of and corresponds with a change is status that affects eligibility for coverage under the Dependent Care Flexible Spending Account; or (ii) the election change is on account of and corresponds with a change in status that affects eligibility of dependent care expenses for the tax exclusion available under the Internal Revenue Code. For example, if your child attains age 13 during the Plan Year, you may terminate your election under the Dependent Care Flexible Spending Account because your child is no longer eligible to participate in the Dependent Care Flexible Spending Account (i.e., she is no longer a qualifying individual).

#### **Group Term Life Coverage and Group Disability Coverage.** For a change of status involving your legal marital status or the employment status of your spouse or dependent, you may increase or decrease the amount of your Group Term Life Coverage and/orGroup Disability Coverage and change your election under the Cafeteria Plan to pay the increased or decreased cost of such coverage without regard to the requirement that the event cause a loss or gain of eligibility.

#### **COBRA Coverage.** If you, your spouse, and/or your dependent elects COBRA continuation coverage (or similar health plan continuation coverage under state law) with respect to a group health plan sponsored by the Employer, you may increase your election for the purpose of paying the cost of the increased premium for such continuation coverage, provided you are still eligible under the Cafeteria Plan and are receiving compensation from the Employer.

### **Other Change in Election Events.** You may also change or revoke your previous election during the Plan Year in the following circumstances.

#### **HIPAA Special Enrollment Rights.**In certain cases, individuals are allowed to enroll in the Employer’s Group Medical Coverage pursuant to HIPAA special enrollment at times other than open enrollment. Generally, special enrollment is available upon: (i) acquiring a new spouse or dependent, (ii) losing other group coverage, (iii) losing coverage under Medicaid or a state children’s health insurance program (“SCHIP”), and (iv) becoming eligible for a subsidy under Medicaid or SCHIP for coverage under the Employer’s group health plan. (Please refer to the plan documentation for the Group Medical Coverage for additional information regarding HIPAA special enrollment, including information regarding the situations in which special enrollment is available and the deadline for requesting special enrollment under that plan.)

If you, your spouse, and/or your dependent actually enroll in the Group Medical Coverage pursuant to HIPAA special enrollment, then you may make a new election under the Cafeteria Plan to pay the cost of that new or increased coverage. For purposes of this provision an election to add previously eligible dependents as a result of the acquisition of a new spouse or dependent child (a/k/a the Tag-along Rule), shall be considered consistent with the special enrollment right.

Note: There are two separate steps involved in making an election change under this exception. You and/or your spouse and dependents must enroll in the Group Medical Coverage within the HIPAA special enrollment time period required under that plan. If such enrollment in the Group Medical Coverage changes your share of the cost of coverage, you must also request a change to your election under the Cafeteria Plan in accordance with paragraph (h) below. The time period described in paragraph (h) begins to run on the effective date of the special enrollment in the Group Medical Coverage. It is the coverage attributable to the HIPAA special enrollment that triggers the need to change election under the Cafeteria Plan.

#### **Certain Judgments, Decrees and Orders.**If a judgment, decree, or order (an “Order”) resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires you to cover your child (including a foster child who is your dependent) under the Group Medical Coverage, Group Dental Coverage, the Health Flexible Spending Account, or the Limited Scope Health Flexible Spending Account, you may change your election to pay the increased cost of coverage incurred to add the dependent child to your coverage. If an Order requires another individual to provide health coverage for your child (including a foster child who is your dependent) and the child is currently enrolled in the Group Medical Coverage, Group Dental Coverage, the Health Flexible Spending Account, or the Limited Scope Health Flexible Spending Account, you may terminate coverage for the child and change your election to reflect the reduced cost of coverage (if any), provided the other individual actually provides coverage to the child as required by the Order. For example, if you have enrolled in single coverage under the Group Medical Coverage, become divorced during the Plan Year, and are ordered to provide coverage to your child following the divorce, you may increase your election to pay the additional cost of the child’s coverage under the Group Medical Coverage.

#### **Medicare and Medicaid.**If you, your spouse, or your dependent is enrolled in the Group Medical Coverage or Group Dental Coverage, such individual subsequently enrolls in Medicare or Medicaid, and such individual’s coverage under the Employer’s plan is cancelled, you may change your election to reflect the reduced cost of coverage (if any) under the applicable Employer-sponsored group health plan. You may also reduce or cancel your election with respect to the Health Flexible Spending Account or the Limited Scope Health Flexible Spending Account.

**NOTE:** Certain changes to an individual’s Medicaid coverage also create a HIPAA special enrollment right. Election changes based on HIPAA special enrollment rights are described above.

### **Change in Cost**.

**NOTE:** Although the Plan Administrator will be aware of an increase or decrease in the cost of many Optional Benefits, you will need to notify the Plan Administrator of any changes to the cost of benefits under the Dependent Care Flexible Spending Account, the Individual Premium Featureand the ICHRA Remainder.

**NOTE:** This exception does not allow changes to your election under the Health Flexible Spending Account and the Limited Scope Health Flexible Spending Account. Furthermore, this exception does not apply to the Dependent Care Flexible Spending Account.if the dependent care provider is your relative.

#### **Automatic Increase or Decrease for Insignificant Cost Changes.** If the cost of coverage increases or decreases during a Plan Year by an insignificant amount, then your election to pay the cost of such coverage through the Cafeteria Plan shall be automatically increased or decreased to reflect such change in the cost. The Plan Administrator (in its sole discretion will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are “insignificant” based upon all the surrounding facts and circumstances (including but not limited to, the dollar amount or the percentage of the cost change).

#### **Significant Cost Increases.** If the Plan Administrator determines that the cost of coverage significantly increases during a Plan Year, you may either: (i) increase your election to pay the additional cost, (ii) enroll in another benefit package option providing similar coverage and change your election (if necessary) to pay the cost of that option through the Cafeteria Plan, or (iii) cancel the underlying coverage and revoke your election to pay the cost of that coverage through a Cafeteria Plan if no other benefit package option providing similar coverage is available. For example, if the cost of one option under the Group Medical Coverage significantly increases during the Plan Year, you may increase your election to pay the increased cost or enroll in another option available under the Group Medical Coverage and change your election to correspond to the new cost of Group Medical Coverage. If there is only one Group Medical Coverage option, you may increase your election to pay the increased cost of the options or cancel the Group Medical Coverage and revoke your election to pay for that coverage through the Cafeteria Plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes “similar coverage” based upon all the surrounding facts and circumstances.

#### **Significant Cost Decrease.** If the Plan Administrator determines that the cost of coverage significantly decreases during a Plan Year: (i) you may enroll in the coverage and make or change your election to pay the cost of the coverage through the Cafeteria Plan; or (ii) if you are already enrolled in the underlying coverage and are paying the cost of such coverage through the Cafeteria Plan, the Plan Administrator will automatically decrease your election to pay the cost of such coverage in accordance with the cost decrease.

For purposes of this rule, a change in cost allowing an election change can result from action taken by you (e.g., switching between full-time and part-time employment) or your Employer (e.g., changing the amount of Employer Contribution toward the cost of coverage).

### **Change in Coverage**.

**NOTE:** This exception does not allow changes to your election under the Health Flexible Spending Account and the Limited Scope Flexible Spending Account (as applicable).

#### **Significant Curtailment.** If the Plan Administrator determines your coverage, or the coverage of your spouse or dependent, is significantly curtailed during a Plan Year, you may enroll in another benefit package option providing similar coverage and make a corresponding election change to pay for that new coverage through the Cafeteria Plan. Coverage is “significantly curtailed” only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to all participants in general (e.g., a significant increase in the deductible, copays, or out-of-pocket maximum applicable under this plan). The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is “significant,” and whether a benefit package option constitutes “similar coverage” based upon all the surrounding facts and circumstances.

#### **Loss of Coverage.** If the Plan Administrator determines that your coverage, or the coverage of your spouse or dependent, is lost during a Plan Year, you may (i) enroll in another option providing similar coverage and make a corresponding election change to pay for that new coverage through the Cafeteria Plan, or (ii) if no other option providing similar coverage is available, cancel the underlying coverage and revoke your election to pay the cost of such coverage through this Cafeteria Plan. Coverage is deemed “lost” only if there is a complete loss of coverage (e.g., the benefit plan option is eliminated or an annual or lifetime maximum is reached) or other fundamental loss of coverage (e.g., a substantial decrease in the health care providers available under the option or a reduction in benefits for a specific type of medical condition with respect to which you or your spouse or dependent is currently receiving treatment. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a “loss” has occurred, and whether a benefit package option constitutes “similar coverage” based upon all the surrounding facts and circumstances.

**Application to Dependent Care Flexible Spending Account.** This rule allows you to change your election under the Dependent Care Flexible Spending Account to reflect changes regarding your dependent care provider, including: (1) the termination of one provider and the hiring of another provider, and (2) the termination of a provider because a relative becomes available to care for your child at no cost. You will need to notify the Plan Administrator of any such change in coverage under the Dependent Care Flexible Spending Account.

#### **Addition or Improvement of an Optional Benefit.**If during a Plan Year, a new plan or plan option is offered, or if coverage under an existing plan or option is significantly improved, you may enroll in the new or improved coverage and make or change your election to pay the cost of such coverage through the Cafeteria Plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether an Optional Benefit has been “significantly improved” based upon all the surrounding facts and circumstances.

#### **Change Under Another Employer-Sponsored Plan.** You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan of the Employer of a plan of another employer) if: (i) the other plan permits its participants to make an election change that would be permitted under the prevailing IRS guidance, or (ii) the Plan Year of this Cafeteria Plan is different from the plan year under the other plan. For example, if your spouse drops your coverage during open enrollment under his or her employer’s Group Medical Coverage and you enroll in the Employer’s Group Medical Coverage, you may make or change your election to pay for such coverage through the Cafeteria Plan.

#### **Loss of Governmental or Educational Coverage.** If you add coverage under an Employer-sponsored group health plan (e.g., the Group Medical Coverage or Group Dental Coverage) for yourself or your spouse or dependent because such individual has lost coverage under any health coverage sponsored by a governmental or educational institution (including, but not limited to, the following: a state children’s health insurance program (“SCHIP”), a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government health plan), you may make or change your election to pay the cost of such coverage under the Cafeteria Plan.

**NOTE:** Certain changes to an individual’s coverage under a state children’s health insurance program (“SCHIP”) also create a HIPAA special enrollment right. Election changes based upon HIPAA special enrollment rights are described above.

#### **Enrollment in Marketplace Coverage**.

* + - * 1. If you have made an election to pay for Group Medical Coverage, you may revoke that election if the following conditions are satisfied:

You either (1) are eligible to enroll in a qualified health plan through a public insurance exchange (the "Marketplace") via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (2) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

You cancel coverage under the Group Medical Coverage in accordance with the requirements of that plan; and

You, and any related individuals who were also enrolled in the Group Medical Coverage, have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which coverage under the Group Medical Coverage was effective (i.e., there is no break in coverage). The Plan Administrator may rely on your reasonable representation that the requirements of this paragraph (C) are met.

* + - * 1. If you have made an election to pay for Group Medical Coverage, you may reduce that election if the following conditions are satisfied:

Your spouse and/or dependents either (1) are eligible to enroll in a qualified health plan through the Marketplace via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (2) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

You cancel coverage under the Group Medical Coverage for such spouse and/or dependents in accordance with the requirements of that plan; and

Such spouse and/or dependents have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which the coverage under the Group Medical Coverage was effective (i.e., there is no break in coverage). The Plan Administrator may rely on your reasonable representation that the requirements of this paragraph (C) are met.

* + 1. **Reduction in Hours Without Loss of Eligibility.** If you have made an election to pay for Group Medical Coverage, you may revoke that election if the following conditions are satisfied:
       1. You have been in an employment status under which you were reasonably expected to average at least thirty (30) hours of service per week;
       2. You have experienced a change in employment status such that you will reasonably be expected to average less than thirty (30) hours of service per week after the change but nevertheless will remain eligible for Group Medical Coverage;
       3. You cancel coverage under the Group Medical Coverage in accordance with the requirements of that plan; and
       4. You, and any related individuals who were also enrolled in the Group Medical Coverage, have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage and that will be effective no later than the first day of the second month following the month in which coverage under the Group Medical Coverage ends. The Plan Administrator may rely on your reasonable representation that the requirements of this paragraph (4) are met.
    2. **Family and Medical Leave Act.** If you take a leave governed by the Family and Medical Leave Act of 1993 ("FMLA"), you may revoke or change an election as may be provided for under the FMLA and the Employer's FMLA policy required thereunder, provided the Employer is subject to FMLA.
    3. **Special Rule for HSA Contribution Feature.** You may change your election with respect to the HSA Contribution Feature prospectively on at least a monthly basis. You may also revoke your election with respect to the HSA Contribution Feature prospectively if you become ineligible to make or have made HSA contributions under the HSA Contribution Feature.
    4. **Other.** The Plan Administrator shall have the discretion to allow a change to or termination of an election to the extent such change or termination is the result of any other situation informally recognized by the Internal Revenue Service as providing an exception to the general rule that elections are irrevocable (e.g., corrections of mistakes, failure to satisfy underwriting). If the Plan Administrator determines before or during any Plan Year the Cafeteria Plan or an Optional Benefit may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code or other applicable law, the Plan Administrator may take such action as the Plan Administrator deems appropriate under the rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a modification of your election downward with or without your consent.
    5. **Procedure for Requesting a Change.** If a change in election is allowed under the rules described above, you must typically inform the Plan Administrator of your new election within thirty (30) days of the occurrence of the event allowing the change unless applicable state law allows a longer election period. Your election change must be on account of and consistent with the status change that has occurred. In general, that means the event must result in a change in coverage that changes the cost. Subject to the provisions of the underlying group health plan, an election made to pay the cost of medical coverage for a newborn or newly adopted dependent child pursuant to HIPAA special enrollment right may be retroactive for up to thirty (30) days, provided it applies to compensation not yet currently available. All other new elections shall be effective prospectively immediately following the date the Participant files the new election with the Plan Administrator. Elections made pursuant to this Section shall be effective foe the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

## Who holds the funds I have set aside under the Cafeteria Plan?

Your salary reduction contributions are held as part of the Employer’s general assets until they are used to pay for your benefits. There is no separate trust.

## Who holds the funds I have set aside under the Cafeteria Plan?

If your employment with the Employer terminates during the Plan Year, your active participation with this Cafeteria Plan ceases and your elections are terminated. You will not be able to make any more contributions under this Cafeteria Plan. You may, however, be entitled to continuation coverage with respect to the underlying Optional Benefit. See the discussions of continuation coverage later in this summary for additional information.

If you are rehired after thirty (30) days following a termination of employment and again become a Participant, you will have two “periods of coverage” – that period prior to the termination of employment and that period following the re-employment. Expenses incurred prior to the termination of employment shall be subject to the election in effect upon termination. Upon re-employment, you shall have an opportunity to make a new election and expenses incurred after re-employment shall be subject to the election made upon re-employment.

If you are rehired within thirty (30) days following a termination of employment, your election in effect prior to the termination of employment will be reinstated upon re-employment.

## Will I have any administrative costs under the Cafeteria Plan?

No. The entire cost of administering the Cafeteria Plan is paid by the Employer, from Plan forfeitures, or a combination of both.

## How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan (including each of the Optional Benefits) indefinitely, it has the right to amend or terminate the Cafeteria Plan in whole or in part at any time. The Employer does this through an official written action of its governing body. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended or terminated accordingly. You will be informed if any changes are made to the Cafeteria Plan.

## Are my benefits taxable?

Because the Cafeteria Plan is intended to meet certain requirements of the federal tax laws, many of the benefits you receive under the Cafeteria Plan will not be currently taxable to you. However, neither the Employer nor the Plan Administrator can guarantee the tax treatment of benefits with respect to any Participant, as individual circumstances may produce differing results. If you are uncertain, you should consult your own tax adviser.

You should realize that any benefits you receive through the Cafeteria Plan (e.g., premium payments, medical expense reimbursements) cannot be claimed as a medical expense deduction on your income tax return. However, unless your medical expenses exceed seven and one-half percent (7.5%) of your adjusted gross income, you are not permitted to use the deduction anyway.

Any reimbursements made with pre-tax dollars for dependent care expenses affect your ability to claim the dependent care credit. This is explained further in the description of the Dependent Care Flexible Spending Account later in this summary.

If you pay the cost of Group Term Life Coverage through this Cafeteria Plan, the cost of some of that coverage may be taxable to you. See the description of Group Term Life and AD&D Coverage later in this Summary for additional information.

**Note:** If the Plan Administrator determines before or during any Plan Year the Cafeteria Plan may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a re-characterization within the Plan Year of benefits provided under the Cafeteria Plan as taxable income, with or without consent of the affected Participants.

## What is the impact on my Social Security benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, your Social Security benefits, which are based upon your taxable compensation, may be affected at your retirement. However, the tax savings you obtain through participation in the Cafeteria Plan often will offset any reduction in your future Social Security benefits.

## What contributions are made to the Cafeteria Plan?

* + 1. **Employer Contribution.** The Employer may make a fixed dollar contribution per Plan Year, or portion of a Plan Year (e.g., month, pay period), per Participant. The amount of the Employer Contribution may change from year to year as announced by the Employer prior to the Plan Year start. The Employer Contribution must be used in accordance with Exhibit A. The portion of the Employer Contribution not used to pay for benefits shall be forfeited. No Employer Contribution shall be credited to any Employee during a period of leave of absence, whether authorized or unauthorized, unless required by the Family Medical Leave Act (“FMLA”) or other applicable law. Unless indicated otherwise in Exhibit A, Employees who are not eligible for participation on the first day of the Plan Year shall have their annual Employer Contribution pro-rated by multiplying the annual available Employer Contribution by a fraction, the numerator of which is the number of months the Employee is eligible for participation for the Plan Year, the denominator which is twelve.
    2. **Salary Reduction Contributions.**To the extent the cost of an Optional Benefit exceeds the Employer Contribution (if any), you may elect in accordance with the election procedures described in Section 1.6 to receive your full compensation in cash, or to have a portion of such compensation applied by the Employer toward your share of the cost of Optional Benefits. If so elected, your compensation will be reduced, and an amount equal to the reduction will be allocated by the Employer to the Optional Benefits you have designated. Your compensation shall be reduced by pro-rata amounts of your total salary reduction election. Salary reduction is done on a pre-tax basis before any withholdings have been made. The frequency of salary reduction contributions shall be every payroll period. Notwithstanding the forgoing, if participation in an Optional Benefit extends to the last day of the month in which your employment terminates, if necessary, additional salary reduction contributions shall be taken from your final pay check to pay for the coverage provided during the period of time following the date on which your employment terminates.
    3. **Salary Deduction Contributions.** Sometimes the Internal Revenue Code or the Cafeteria Plan does not allow payment with pre-tax dollars. Payments which may be made with after-tax dollars may be paid through a salary deduction agreement. A salary deductionprovides for a payroll deduction to be made throughout a Plan Year out of your compensation after taxes and withholdings have been made.

## What if coverage is provided to someone other than your spouse and tax dependents?

If you participate in an Optional Benefit that covers a dependent who is not your “spouse” or “tax dependent,” the entire cost of coverage for Optional Benefits for which you are responsible shall be paid pre-tax through this Cafeteria Plan and the fair market value of the coverage for that Dependent shall be imputed as income to you as the coverage is provided. This provision applies regardless of whether the cost of coverage is paid by salary reduction or allocation of available Employer Contributions, if any.

For purposes of this Cafeteria Plan, “spouse” means a person to whom you are legally married in accordance with applicable state law.

For purposes of this Cafeteria Plan, “tax dependent” generally includes an individual who satisfies the requirements of paragraph (a), (b), or (c) below:

### an individual who:

* + - 1. is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and
      2. will not attain age 27 during the relevant calendar year.

### an individual who:

* + - 1. is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;
      2. has the same principal place of abode as you for at least one-half of the relevant year;
      3. will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;
      4. did not provide over half of his/her own support during the relevant year;
      5. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;
      6. is younger than you (unless he/she is permanently and totally disabled); and
      7. does not file a joint tax return with his or her spouse.

### an individual who:

* + - 1. is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent’s ancestor), stepparent, brother or sister’s son or daughter, parent’s brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such relative, an individual who has the same principal place of abode as you and is a member of your household;
      2. has received more than one-half of his/her support from you during the relevant year;
      3. is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (a) above with respect to any person);
      4. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.
      5. is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

**NOTE:** The definition "tax dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return and is different than the definition of "qualifying individual" that applies under the Dependent care Flexible Spending Account. Additional special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

## How are claims determined?

**NOTE:** This claims determination procedure applies only with respect to issues related to the Cafeteria Plan (e.g., the ability to pay for benefits on a pre-tax basis and the election of Optional Benefits) and claims for reimbursement under the Dependent Care Flexible Spending Account and Health Flexible Spending Account, Limited Scope Health Flexible Spending Account, and claims for payment/reimbursement of premiums under Individual Premium Feature and ICHRA Remainder. Claims for other Optional Benefits (e.g., claims under the major medical and dental coverages or individual insurance policies) are handled through the claims determination procedures in those separate plans or policies.

### **Administrator.** For purposes of this Section, the Plan Administrator may contract with a third party to perform some or all of the claims determination functions. Where the language refers to the Plan Administrator, the function may be handled by a Claims Administrator. Exhibit A identifies whether there is a Claims Administrator and how to contact that Claims Administrator.

### **Claim Submission.** Unless a separate procedure is provided with respect to an Optional Benefit, a claim for benefits must be made in writing and submitted to the Plan Administrator. Please refer to the sections of this summary describing each Optional Benefit for additional information.

### **Benefits Denials.** The Plan Administratordecides your claim within a reasonable time not longer than thirty (30) days after it is received. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Plan Administrator, including when a claim is incomplete. You will receive written notice of any extension, indicating the reasons for the extension and the date by which a decision is expected to be made. If your claim is incomplete, and the Plan Administrator notifies you of that fact, the time period for deciding your claim will be suspended from the date the notice is provided through the date on which you respond or by which you are supposed to respond. You will be given at least forty-five (45) days in which to respond. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

If the Plan Administrator denies your claim, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth:

* + - 1. the specific reason or reasons for the denial;
      2. reference to the specific Plan provision on which the denial is based;
      3. a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and
      4. appropriate information as to the steps to be taken if you wish to appeal the Claims Administrator's determination, including your right to submit written comments and have them considered, and your right to review (on request and at no charge) relevant documents and other information.

### **Appealing a Denial.** If your claim is denied in whole or in part, you may appeal to the Plan Administrator for a review of the denied claim. Your appeal must be made in writing within one hundred eighty (180) days of the Plan Administrator's initial notice of adverse benefit determination or you will lose your right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit In court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

### **Decision upon Appeal.**The Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same Individual who decided your initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted In connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

* + - 1. the specific reason or reasons for the denial;
      2. the specific Plan provision(s) on which the decision is based;
      3. a statement of your right to review (on request and at no charge) relevant documents and other information;
      4. if the Plan Administrator relied on "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and

## How are insurance refunds handled?

Any refund provided to the Employer by an insurance company that has issued an insurance contract for a component of the Cafeteria Plan will be allocated as provided herein. The refund will constitute Plan assets only to the extent required by applicable law.The refund will be allocated between the Employer and the Participants as required or permitted under applicable law. The portion of the refund allocated to Participants will be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the insurance company.

## Who has the authority to interpret the Plan?

To the fullest extent permitted under applicable law, the Plan Administrator and any other Plan fiduciary acting in its fiduciary capacity shall have the authority and discretion to interpret and apply Plan terms.

# GROUP MEDICAL COVERAGE

## How do I enroll and make benefit elections?

An important feature of the Cafeteria Plan is the opportunity it provides you to pay your share of the cost of medical coverage on a pre-tax basis. The medical coverage is provided through your Employer and is referred to herein as the "Group Medical Coverage." Your share of the cost for that coverage is paid with the allocation of Employer Contributions (if any) and pre-tax dollars through salary reduction under this portion of the Cafeteria Plan.

The Group Medical Coverage is described in separate materials which have been provided to you either directly by the carrier (the insurance company or HMO) or by your Employer. Those descriptive materials are incorporated into this summary description by reference and identified in Exhibit B. If you have not been provided this Information, you should contact the Plan Administrator. The benefits under the Group Medical Coverage are provided in accordance with the applicable Group Medical Coverage documents.

The Group Medical Coverage is subject to privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA'').

## How do I become a Participant in this portion of the Cafeteria Plan?

To participate in this portion of the Cafeteria Plan, you must first enroll In the Group Medical Coverage. You may select coverage under the Group Medical Coverage for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Medical Coverage. Please refer to the contract or policy governing the Group Medical Coverage for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Medical Coverage, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in section 1.4. If you satisfy those requirements, you must elect to pay your share of the cost of Group Medical Coveragein accordance with Section 1.6.

## How is my cost of Group Medical Coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Medical Coverage is generally paid by allocation of any available Employer Contribution, as indicated in Exhibit B, and to the extent Employer Contributionis insufficient, withpre-tax dollars through salary reduction.

**NOTE:**You must be a Participant in the Cafeteria Plan for your portion of the premiums to be paid pre-tax.

If you pay the cost of Group Medical Coverage through this portion of the Cafeteria Plan and you have enrolled an individual who is not your spouse or "tax dependent'' (as those terms are defined in Section 1.16), then the taxation of that individual's coverage will be handled as described In Section 1.16.

## How is my cost of group medical coverage paid?

If you cease to be eligible for coverage under the Group Medical Coverage, your coverage under that Plan will terminate in accordance with the terms and conditions of that Plan. In most cases, if you lose coverage under the Group Medical Coverage, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Medical Coverage on a pre-tax basis through this portion of the Cafeteria Plan stops.

## Can coverage be continued?

If you cease to be eligible for coverage under the Group Medical Coverage, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), and applicable continuation requirements under state law. These continuation rights are described later in this summary.

## What if I am subject to a medical child support order?

The Group Medical Coverage recognizes child support orders regarding the provision of medical coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998 to the extent required by law. If a child is enrolled in the Group Medical Coverage pursuant to a child support order, you will be able to pay the cost of that coverage through this portion of the Cafeteria Plan, provided you are eligible to participate as described above.

# GROUP TERM LIFE AND AD&D BENEFITS

## What benefits are provided?

An important feature of the Cafeteria Plan is the opportunity it provides you to pay your share of the cost of group term life Insurance and/or accidental death and dismemberment insurance coverage on apre-tax basis. The coverage is provided through your Employer and is referred to as the "Group Term Life and AD&D Coverage". Your share of the cost for that coverage is paid with the allocation of Employer Contributions and pre-tax dollars through salary reduction under this portion the Cafeteria Plan.

**NOTE:** The Plan does not allow the pre-tax payment of the cost of your spouse or dependent’s life insurance coverage.

The Group Term Life and AD&D Coverage is fully insured, which means that all benefits are provided through one or more contracts or policies obtained by your Employer with one or more third party insurance carriers. The Group Term Life and AD&D Coverageis described in separate materials which have been provided to you either directly by the insurance carrier or by the Employer. Those descriptive materials are incorporated into this summary description by referenceand identified in Exhibit B. If you have not been provided this information, you should contact the Plan Administrator. The group term life and accidental death and dismemberment benefits are provided in accordance with the applicable contract or policy issued by the carrier.

## How do I become a Participant in this portion of the Cafeteria Plan?

To participate in this portion of the Cafeteria Plan, you must first enroll in the Group Term Life and AD&D Coverage. Please refer Exhibit B and to the contract or policy governing the Group Term Life and AD&D Coverage for information regarding how to enroll in that plan.

If you have enrolled in the Group Term Life and AD&D Coverage, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in Section 1.4. If you satisfy those requirements, you must elect to pay your share of the cost of Group Term Life and AD&D Coverage in accordance with Section 1.6.

## How is my cost of coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Term Life and AD&D Coverage is paid by allocation of any available Employer Contribution, if indicated in Exhibit B, and, to the extent the Employer Contribution is insufficient, with pre-tax dollars through salary reduction. Your Employer will forward the salary reduction dollars (if any) to the insurance carrier along with any Employer Contribution you have designated to be used to pay for this coverage.

**NOTE:** You must be a Participant in the Cafeteria Plan for your portion of the premiums to be paid pre-tax.

## How much group term life insurance coverage can I purchase?

Up to $50,000 worth of Employer paid coverage may be excluded from your taxable income. For this purpose, “Employer paid” includes coverage automatically provided by the Employer, coverage paid with Employer Contributions, and coverage paid by you on a pre-tax basis through salary reduction under this Cafeteria Plan. If the face amount of the Employer paid coverage exceeds $50,000, the cost of the coverage in excess of $50,000 will be imputed to you as income to the extent required by law.

## What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Term Life and AD&D Coverage, your coverage under that plan will terminate in accordance with the terms and conditions of that plan. In most cases, if you lose coverage under the Group Term Life and AD&D Coverage, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described In Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Term Life and AD&D Coverage on a pre-tax basis through this portion of the Cafeteria Plan stops.

## Can coverage be continued?

If you cease to be eligible for coverage under the Group Term Life and AD&D Coverage, you ***may***be able to continue that coverage. There shall be compliance with applicable state law regarding continuation of coverage and conversion of coverage to the extent such state law is not preempted by federal law. In addition, any continuation and conversion rights provided under the terms of the insurance contract(s) through which benefit are provided shall be available to the extent they are not prohibited or preempted by federal law.

# DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

## What benefits are provided?

The Plan permits you to elect to receive reimbursement for some or all of your work related dependent care expenses under the Dependent care Flexible Spending Account ("Dependent Care FSA"). Under the Dependent Care FSA, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer. You may also use any available Employer Contributions, if indicated in Exhibit B.Those pre-tax dollars will be used to reimburse you for your eligible expenses. You save Social Security and income taxes on the amount of your salary reduction for dependent care expenses.

**NOTE:** Participation in the Dependent care FSA will impact your ability to receive the dependent care tax credit with respect to your federal income taxes. Additional information is provided below regarding this tax credit.

## How do I become a Participant in the Dependent Care FSA?

To become a Participant in the Dependent Care FSA, you must first become a Participant in the Cafeteria Plan. You must also satisfy the eligibility requirements for the Dependent Care FSA. The Dependent Care FSA's eligibility requirements are the same as the eligibility requirements for the Cafeteria Plan as described in Section 1.4. If you satisfy those requirements, you become a Participant in the Dependent care FSA by electing benefits under the Dependent Care FSA during your initial or subsequent annual enrollment periods.

## What is my account?

If you elect benefits under the Dependent care FSA, an account will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to receive. These benefits may be funded by allocation of any available Employer Contribution, as indicated in Exhibit B, and, to the extent the Employer Contribution is insufficient, with pre-tax dollars through salary reduction contributions. A pro-rated of your election will be credited to you account according to the schedule described in Section 1.14.

The account is a bookkeeping account only. The Employer pays benefits under the Dependent Care FSA from its general assets. There is no trust. The amount that is available in your account at any particular time will be whatever has been credited to such account less any reimbursements

## What are the maximum benefits I may receive?

The maximum amount of benefits you may receive under the Dependent Care FSA is $5,000 per calendar year if you:

### are married and file a joint return;

### are married, but you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA, your spouse maintains a separate residence for the last six (6) months of the calendar year, and you file a separate tax return; or

### are single, or a head of household for tax purposes.

A reduced maximum is available if any of the following situations exist:

### if you are married and reside together with your spouse, but file separate tax returns, the maximum is reduced to $2,500 (and only one parent may submit claims for reimbursement under the Dependent Care FSA); or

### if you or your spouse have earned income less than $5,000 per tax year, the maximum is reduced to the lesser of your earned income or your spouse's earned income.

**Note:** The Dependent Care FSA’s maximum described above is also the maximum amount of employer-provided dependent care benefits that are excludable from income. If you are married, the maximum tax exclusion applies on a combined or aggregate basis. Accordingly, if your spouse has a dependent care program available through his or her employer, the maximum annual tax exclusion will apply to the combined benefits received by your spouse under his/her employer’s program plus the benefits you receive under this Dependent Care FSA. ***It is your responsibility to monitor your combined maximum benefits and to report any benefits in excess of the maximum on your income tax return.***

**NOTE:** If your spouse is a student or is incapable of caring for himself or herself, in general, you spouse will be deemed to have earned income of not less than $250 per month if you have one Qualifying Individual or $500 per month you have two or more Qualifying Individuals.

**NOTE:** The maximums apply on a tax or calendar year basis. The Plan Year is not the calendar year. As a result, you must watch your elections and reimbursements carefully to ensure you do not exceed the maximum.

## Who is a “Qualifying Individual” for whom I can submit claims for reimbursement?

**NOTE:** The rules are not the same as the tax deduction or exemption rules. It is your responsibility to determine whether you can request reimbursement for expenses incurred with respect to a particular individual. As discussed below, special rules apply in some cases. For additional information, please refer to the resources listed below and consult your tax advisor.

**General Rule.** Subject to the two special rules described below, you may be reimbursed for Eligible Expenses incurred with respect to any “Qualifying Individual.” A Qualifying Individual is a person described in paragraph (a), (b), (c), (d) or (e) below.

### Your “child” who:

* + - 1. is under age thirteen (13);
      2. has the same principal place of abode as you for at least one-half of the year;
      3. does not provide over half of his/her own support during the year; and
      4. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico

### Your “child” who:

* + - 1. is mentally or physically unable to care for himself or herself;
      2. has the same principal place of abode as you for at least one-half of the year;
      3. does not provide over half of his/her own support during the year;
      4. has not attained age nineteen (19) during the year (age twenty-four (24) if a full-time student) or is permanently and totally disabled;
      5. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;
      6. is younger than you (unless he/she is permanently and totally disabled); and
      7. does not file a joint tax return with his or her spouse.

### Your “child” who:

* + - 1. is mentally or physically unable to care for himself or herself,
      2. has the same principal place of abode as you for at least one-half of the year,
      3. has received more than one-half of his/her support from you during the relevant year,
      4. is not any person’s “qualifying child” (as that term is defined under Section 152 of the Code), and
      5. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

### Your “relative” who:

* + - 1. is mentally or physically unable to care for himself or herself,
      2. has the same principal place of abode as you for at least one-half of the year,
      3. has received more than one-half of his/her support from you during the relevant year,
      4. is not any person’s “qualifying child” (as that term is defined under Section 152 of the Code), and
      5. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

### Your “spouse,” if your spouse is physically or mentally incapacitated and has the same principal place of abode as you for at least one-half of the year.

**“Child”** generally includes your son, daughter, stepson, stepdaughter, eligible foster child, brother, sister, stepbrother, stepsister, or a descendant of any such person.

**“Relative”** generally includes parent (or a parent’s ancestor), stepparent, parent’s brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or an individual who (although not related to you) has the same principal place of abode as you and is a member of your household.

**“Spouse**” means an individual to whom you are legally married under applicable state law.

## What if two people claim a child as a Qualifying Individual?

With the exception of two parents that file income taxes jointly, only one person is entitled to treat the child as a Qualifying Individual. Where multiple people are involved, there are two special rules to determine which person is entitled to treat the child as a Qualifying Individual.

### **Divorced or Separated Parents, or Parents Living Apart**.

**Important Note:** In this situation, only one person is entitled to treat the child as a Qualified Individual for purposes of the Dependent Care FSA.

If a child’s parents are divorced, legally separated, separated pursuant to a written agreement, or live apart at all times during the last six (6) months of the calendar year, a special rule applies if: (i) the child is under age 13 or is mentally or physically unable to care for himself or herself; (ii) the child receives more than 50% of his or her support from the parents (in aggregate); and (iii) the child resides with the parents (in aggregate) for more than 50% of the year. In such situations, the child is the Qualifying Individual of the custodial parent even if the custodial parent has released the right to claim the child as a dependent. The custodial parent is generally the parent with whom the child resides for the greater number of nights during the calendar year or, if the child resides with both parents for an equal number of nights, the parent with the higher adjusted gross income for the year.

### Other Situations. If the special rule described above regarding divorce, etc. does not apply, other special tie-breaker rules of may apply. If an individual is a Qualifying Individual (under paragraphs (a) or (b) of the definition provided above) with respect to more than one person, then:

* + - 1. if both persons are the individual’s parents and they file separate federal income tax returns, then the child is the Qualifying Individual of the parent with whom the child resides for the longest period of time during the calendar year (or, if child resides with both parents for the same amount of time during the year, the parent with the highest adjusted gross income for the year). However, if that parent (i.e., the custodial parent or the parent with the highest adjusted gross income) does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other parent (i.e., the non-custodial parent or the parent with the lowest adjusted gross income). ***This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the Dependent Care FSA***.
      2. if one person is the individual’s parent and the other is not, the child is the Qualifying Individual of the parent. However, if the parent does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the non-parent). ***This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the Dependent Care FSA.***
      3. if neither person is the individual’s parent, the child is the Qualifying Individual of the person with the highest adjusted gross income for the year in question. However, if that person does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the Earned Income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the person with the lowest adjusted gross income). ***This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the Dependent Care FSA.***

**Important:** If you enroll for dependent care benefits, it will be assumed that you are the one person entitled to treat the child as a Qualifying Individual for purposes of reimbursement under the Dependent Care FSA.

## What is an "Eligible Expense"?

### **General Rule—Covered.** An "Eligible Expense" generally means expenses for the care of a Qualifying Individual incurred by you (or your spouse) to enable you (and your spouse) to be gainfully employed. Eligible Expenses generally include:

* + - 1. day care expenses;
      2. the cost of nursery school, preschool, or similar programs below the level of kindergarten;
      3. the cost of after-school care (including care for Qualifying Individuals in kindergarten and beyond);
      4. the cost of day camp, including specialty day camp (but not overnight camp);
      5. the cost of transportation provided by a care provider;
      6. the cost of meals incidental to and inseparable from care (i.e., not separately itemized on bill);
      7. employment taxes paid on behalf of a care provider;
      8. the cost of room and board provided to a care provider (e.g., a live in nanny);
      9. certain indirect expenses, such as application and agency fees, if they must be paid to obtain the care and care is actually provided; and
      10. placement or “hold the spot” fees provided that they must be paid to obtain the care (not Eligible Expenses unless and until care is actually provided by the provider to whom such fees are paid).

### **General Rule—Not Covered.** Expenses incurred that do not enable you to be gainfully employed are generally not “eligible” including, but not limited to, expenses incurred while on vacation, sick leave, or any other type of situation where you (and your spouse) are not at work or actively looking for work (i.e., gainfully employed). Your spouse, if any, is deemed to be gainfully employed if he/she is: (1) a full time student, or (2) mentally or physically incapable of self-care and resides with you for more than one-half of the calendar year.

### **Daily Allocation.** Usually, expenses must be allocated on a daily basis so that expenses incurred on a day you (or your spouse) were not at work may not be reimbursed.

**Special Rule.** If you pay for care on at least a weekly basis, without deduction for days on which care is not provided, you are not required to allocate expenses for short, temporary absences from work, such as vacations and sick days. You are also not required to allocate expenses on a daily basis if you (or your spouse) work on a part-time basis and you pay for care on at least a weekly basis without deduction for days on which care is not provided.

### **Who and Where Rules.** Expenses that would otherwise be “Eligible Expenses” cannot be reimbursed if they are paid to: (1) an individual who is your child under the age of nineteen (19) at the end of the calendar year; (2) an individual you (or your spouse) claim as a dependent on your tax return; (3) an individual who was your spouse at any time during the calendar year; or (4) a parent of a Qualifying Individual who is your child under age thirteen (13).

Expenses that would otherwise be “Eligible Expenses” for services provided outside of your home may be reimbursed only if the care is for a Qualifying Individual who is: (1) your (or your spouse’s) “child” under the age of thirteen (13); or (2) is another Qualifying Individual who regularly spends at least eight (8) hours per day in your home.

## How do I receive reimbursements under the Dependent Care FSA?

### **Periodic Reimbursements.** When you incur an expense that is eligible for reimbursement, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form may be submitted via email, facsimile, mail, or the Claims Administrator’s website. The claim form will typically set forth:

* + - 1. the amount, date and nature of the expense;
      2. the name of the person or entity to which the expense was paid;
      3. your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source; and
      4. such other information as the Plan Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim.

If there are enough dollars credited to your account, you will be reimbursed for your Eligible Expenses according to the schedule established by the Plan Administrator.

**Claim Deadline.** You may submit claims for reimbursement of Eligible Expenses incurred during the Plan Year for the period of time specified in Exhibit A that begins on the first day following the close of the Plan Year or, if applicable, the Grace Period. This period following the end of the Plan Year or, if applicable, the Grace Period during which claims for reimbursement may be filed is referred to as the “Claims Run-Out Period.”

## What limits apply to reimbursements under the Dependent Care FSA?

You cannot be reimbursed for any expenses above your ***available*** account balance. If your claim was for an amount that was more than your current account balance, the excess part of the claim will be carried over into following months, to be paid as your balance becomes adequate. You also cannot be reimbursed for any expenses that arise before the effective date of the Dependent Care FSA, for any expenses that arise before you become a Participant in the Dependent Care FSA, or for any expenses incurred after the close of the Plan Year.

Note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

## What is the Grace Period?

There is no Grace Period associate with the Dependent Care FSA.

## Will I be taxed on the Dependent Care FSA benefits I receive?

Normally, you will not be taxed on benefits under the Dependent Care FSA. However to qualify for tax-free treatment, you will be required to file IRS Form 2441 or a similar form with a list of names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you claimed a tax-free reimbursement.

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

You may choose to participate in the Dependent Care FSA and receive credit on your federal income tax return too. However, the tax credit and the account cannot be used for the same expenses. In addition, the amount of the household and dependent care tax credit is reduced dollar for dollar by the reimbursement you receive from your account.

In certain cases, it may be more beneficial for you to claim a tax credit for your dependent care expenses rather than pay for those expenses through the account. You may want to consult your tax advisor regarding the best options under the applicable rules.

## What is the dependent care tax credit?

The dependent care tax credit is an allowance for a percentage of your annual eligible dependent care expenses as a credit against your federal income tax. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one dependent, or $6,000 for two or more dependents.

Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one dependent or $2,100 for two or more dependents) to a minimum of 20% of such expenses (producing a maximum credit of $600 for one dependent or $1,200 for two or more dependents.) The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

## When would it be better for me to use the tax credit?

In general, if your income tax bracket is 15% or less, it will be more advantageous for you to forego participation in the Dependent Care FSA, pay the expenses with after-tax dollars, and claim the dependent care tax credits. However, you should analyze your own situation carefully to determine which method is right for you. The actual determination of the preferable method for treating benefit payments depends on a number of factors such as one’s tax filing status (e.g., married, single, head of household), number of dependents, etc. Each Participant will have to determine his or her tax position individually in order to make the decisions between taxable and tax-free benefits. If you are uncertain about whether to participate in this Dependent Care FSA or take the dependent care credit, please refer to the resources listed below and consult your tax advisor.

## What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for coverage under the Dependent Care FSA, you may not make any further contributions to your account. However, you may continue to submit claims for reimbursement of Eligible Expenses incurred both while you were a Participant and during the remainder of the Plan Year <<and applicable Grace Period>> in which your participation ceased until the expiration of the claims run out period.

If your employment terminates or you otherwise cease to be eligible for coverage under the Dependent Care FSA, you may not make any further contributions to your account. However, you may continue to submit claims for reimbursement of Eligible Expenses incurred while you were a Participant until the expiration of the claims run out period.

If your employment terminates or you otherwise cease to be eligible for coverage under the Dependent Care FSA, you may not make any further contributions to your account. However, you may continue to submit claims for reimbursement of Eligible Expenses incurred while you were a Participant for a period of X (X) days after the date you ceased to be eligible to participate.

## What if I receive benefits in error?

If a reimbursement is made by the Dependent Care FSA in excess of the amount to which you are entitled under the Dependent Care FSA, the Dependent Care FSA has the right to recover such overpayment. Repayment of an overpayment is a condition of participation in the Cafeteria Plan.

## What if the dependent care expenses I incur during the Plan Year are less than the annual benefit I have elected?

Any amounts remaining in your account attributable to a particular Plan Year shall be forfeited following the Claims Run-Out Period described in Section 9.6. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual dependent care expenses you have incurred, on the one hand, and the annual benefit you have elected and paid for, on the other. ***If you do not use it, you lose it.***

## What reporting will I receive?

The amounts reimbursed under this Dependent Care FSA for each calendar year will be reported on your W-2. If the actual amount paid is not known by the deadline for providing the W-2 (e.g., because of the Claims Run-Out Period), the Employer may report a reasonable estimate of the reimbursements that will be paid under the Dependent Care FSA for the year. A reasonable estimate may be the amount of benefits you elected under the Dependent Care FSA for the year.

## Is the Dependent Care FSA Plan governed by ERISA?

No. The Dependent Care FSA Plan is not subject to ERISA. The Statement of ERISA Rights section of this summary does not apply to the Dependent Care FSA Plan.

## Is the Dependent Care FSA Plan subject to COBRA?

No. The Dependent Care FSA Plan is not subject to COBRA.

## Is the Dependent Care FSA Plan subject to HIPAA?

No. The Dependent Care FSA Plan is not a group health plan, and, therefore, not subject to HIPAA Privacy, HIPAA Security, or HIPAA Special Enrollment.

# HEALTH FLEXIBLE SPENDING ACCOUNT

## What benefits are provided?

The Plan permits you to elect to receive reimbursement for some or all of your uninsured medical and dental expenses under the Health Flexible Spending Account ("Health FSA"). Under the Health FSA, you provide a source of pre‑tax dollars by entering into a salary reduction agreement with your Employer. You may also use any available Employer Contributions, if indicated in Exhibit B. Those pre‑tax dollars will be used to reimburse you for your Eligible Expenses. You save Social Security and income taxes on the amount of your salary reduction for medical expenses.

The coverage provided through the Health FSA is subject to the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The Health FSA is intended to be an excepted benefit under the HIPAA portability rules. Accordingly, neither the HIPAA portability rules nor the mandates of the Patient Protection and Affordable Care Act, as amended, including the preventive care mandate, apply to the Health FSA.

## How do I become a Participant?

To become a Participant in the Health FSA, you must first become a Participant in the Cafeteria Plan. You must also satisfy the eligibility requirements for the Health FSA. The Health FSA’s eligibility requirements are the same as the eligibility requirements for the Cafeteria Plan as described in Section 1.4. If you satisfy those requirements, you become a Participant in the Health FSA by electing benefits under the Health FSA during your initial or subsequent annual enrollment periods.

**NOTE:** Participation in this Health FSA will make you ineligible to participate in the HSA Contribution Feature, and will make you and any of your dependents covered by the Health FSA ineligible to make or receive contributions to a health savings account (“HSA”).

## What is my account?

If you elect benefits under the Health FSA, an account will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to receive. These benefits may be funded by allocation of any available Employer Contribution and, to the extent the Employer Contribution is insufficient, with pre‑tax dollars through salary reduction contributions.

The account is a bookkeeping account only. Benefits under the Health FSA are paid from the Employer’s general assets. There is no trust. The full amount of your election under the Health FSA will be available at any time during the Plan Year, reduced by the amount of prior reimbursements under the Health FSA received during the Plan Year.

## What are the maximum reimbursements I may receive?

The maximum amount of medical expense reimbursements per Plan Year is specified in Exhibit A.

## What is an "Eligible Expense"?

### **Generally.** An “Eligible Expense,” in most situations, means an expense (1) for which you could have claimed a medical expense deduction on an itemized federal income tax return; and (2) for which you have not otherwise been reimbursed from health coverage, or some other source. Eligible Expenses include expenses incurred by you and your “spouse” and “dependents.”

For purposes of this Health FSA, “**spouse**” means a person to whom you are legally married in accordance with applicable state law.

For purposes of this Health FSA, unless modified in Exhibit A, “**dependent**” generally includes an individual who satisfies the requirements of paragraph (1), (2), or (3) below:

* + - 1. An individual who:
         1. is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and
         2. will not attain age 27 during the relevant calendar year.
      2. An individual who:
         1. is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;
         2. has the same principal place of abode as you for at least one-half of the relevant year;
         3. will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;
         4. did not provide over half of his/her own support during the relevant year;
         5. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;
         6. is younger than you (unless he/she is permanently and totally disabled); and
         7. does not file a joint tax return with his or her spouse.
      3. An individual who:
         1. is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent’s ancestor), stepparent, brother or sister’s son or daughter, parent’s brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;
         2. has received more than one-half of his/her support from you during the relevant year;
         3. is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (1) above with respect to any person); and
         4. is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

**NOTE:**The definition “dependent” is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return. Furthermore, an individual eligible for dependent coverage under the Group Medical Coverage is not necessarily a “dependent” for purposes of the Health FSA. Additional special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

### **Exceptions.** Despite the general rule stated above, Eligible Expense ***does not include*** premiums for qualified long term care coverage or premiums for any group health plan or individual coverage, or long term care. Additional limitations, if any, are specified in Exhibit A.

**IMPORTANT:** Please review Exhibit C—Eligible Medical Care Expenses to help determine what is an Eligible Expense. You are also encouraged to consult your personal tax advisor or IRS Publication 502, "Medical and Dental Expenses" for further guidance as to what is or is not an Eligible Expense.Publication 502 addresses medical care expenses a person may deduct on his or her income taxes. Many, but not all¸ expenses that are tax deductible are also reimbursable under the Health FSA.

## How do I receive my reimbursements under the Health FSA?

### **Periodic Reimbursements.** When you incur an expense that is eligible for reimbursement, you submit a claim to the Claims Administrator on a claim form that will be supplied to you. The claim form may be submitted via email, facsimile, mail, or the Claims Administrator’s website. The claim form will typically set forth:

* + - 1. the amount, date and nature of the expense;
      2. the name of the person or entity to which the expense was paid;
      3. your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source; and
      4. such other information as the Plan Administrator may require, including copies of bills or receipts from the provider(s) to support your claim.

If there are enough dollars credited to your Health FSA, you will be reimbursed for your Eligible Expenses according to the schedule established by the Plan Administrator.

**Claim Deadline.**You may submit claims for reimbursement of Eligible Expenses incurred during the Plan Year for the period of time specified in Exhibit A that begins on the first day following the close of the Plan Year or, if applicable, the Grace Period. This period following the end of the Plan Year or, if applicable, the Grace Period during which claims for reimbursement may be filed is referred to as the “Claims Run-Out Period.”

### **Electronic Payment Card Claims.**The electronic payment card allows you to pay for Eligible Expenses at the time that you incur the expense. The electronic payment card works as follows:

* + - 1. **You must make an election to use the card.** In order to be eligible for the electronic payment card, you must agree to abide by the terms and conditions of the electronic payment card program as set forth herein and in the electronic payment cardholder agreement (the “Cardholder Agreement”), including agreeing to any fees applicable to participate in the program, limitations as to card usage, the Plan’s right to withhold and offset ineligible claims, etc. You must agree to abide by the terms of the program each Plan Year. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the program for the new Plan Year. The Cardholder Agreement is part of the terms and conditions of your Plan and this Summary Plan Description.
      2. **The balance of the card is limited.** The balance of the card is limited to the balance of your account.
      3. **The card will be turned off when coverage terminates.** The card will be turned off when your coverage under the Health FSA terminates.
      4. **You must certify proper use of the card.** As specified in the Cardholder Agreement, you certify during the applicable Plan Year that the amounts in your account will only be used for Eligible Expenses (i.e., medical care expenses incurred by you, your spouse, and your tax dependents), that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source, and that you will obtain and retain a third party statement from the health care provider (e.g., receipt, invoice, etc.) each time you swipe the card. Failure to abide by this certification will result in termination of card use privileges.
      5. **Reimbursement under the card is limited to certain places where you purchase health care related items.** Use of the card is limited to merchants who: (i) have health care related merchant category codes other than the drug store or pharmacies merchant category code; (ii) have the drug store or pharmacies merchant category code and with respect to whom 90% of the store’s gross receipts during the prior taxable year consisted of items that qualify as expenses for medical care under Section 213(d) of the Code (a “90% pharmacy”); or (iii) participate in an inventory information approval system developed by the card provider that verifies, at the time of purchase, that the goods being purchased constitute medical care.
      6. **You swipe the card at the health care provider like you do any other credit or debit card.** When you incur an Eligible Expense at a doctor’s office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider’s office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under your account (or as otherwise limited by the program) at the time you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment is being made is an Eligible Expense and that you have not been reimbursed by any other source nor will you seek reimbursement from another source.
      7. **You must obtain and retain a receipt/third party statement each time you swipe the card.** You must obtain a third party statement from the health care provider (e.g. receipt, invoice, etc.) each time you swipe the card that includes the following information:
         1. The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug;
         2. The date the expense was incurred; and
         3. The amount of the expense.

Although it is not required to be submitted for all purchases, you must retain this receipt for one year following the close of the Plan Year in which the expense was incurred. Even though payment may be made under the card arrangement, a written thirdparty statement may be required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from the Claims Administrator if a third party statement is needed. If requested, you must provide the third party statement to the Claims Administrator within 30 days (or such longer period provided in the letter from the Claims Administrator) of the request.

* + - 1. **There are situations where the third party statement will not be required to be provided to the Claims Administrator.** There may be situations in which you will not be required to provide the written statement to the Claims Administrator, including:
         1. **Co-Pay Match.** No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-providers that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the payment matches a specific co-payment you have under one of the Employer’s group health plans for the particular service that was provided or a multiple of that co-payment of not more than five (5) times the dollar amount of the co-payment. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, $20, $30, $40, or $50, you will not be required to provide the third party statement to the Claims Administrator.
         2. **Previously Approved Claim Match.** No written statement is required if the electronic payment card is used at medical care providers (i.e., merchants or service-provides that have health care related merchant category codes such as physicians, pharmacies, dentists, vision care offices, and hospitals) and the expense is in the same amount, for the same duration, and at the same provider as a previously approved expense (e.g. the Claims Administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy; each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Claims Administrator if the expense incurred is the same amount).
         3. **Provider Match Program.** No third party statement is required to be submitted to the Claims Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g. your prescription benefits manager) that verifies the amount and nature of the expense and that the expense is an eligible expense.
         4. **Inventory Information Approval System.** No third party statement is required to be submitted to the Claims Administrator if the electronic payment card is used at a merchant (of any kind) that participates in an inventory information approval system developed by the card provider. Such system verifies, at the time of purchase, that the goods being purchased constitute medical care.

**Note:** You must still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Claims Administrator does request it.

* + - 1. **Special rules apply to the use of the electronic payment card to purchase over-the-counter drugs and medicines other than insulin.** Notwithstanding the rules described above regarding the use of the card to purchase medical care, the card may be used to purchase such over-the-counter drugs and medicines only in the following circumstances:
         1. At any 90% pharmacy if the expense is substantiated after the purchase in accordance with paragraph (7) above.
         2. At drug stores, pharmacies, non-health care merchants that have pharmacies, and mail order or web-based merchants that sell prescription drugs if (A) the cardholder presents the prescription to the pharmacist; (B) the pharmacist assigns a prescription number and dispenses the over-the-counter drug or medicine in accordance with applicable law; (C) the pharmacy retains a record of the transaction, including the name on prescription, prescription number, date, and the amount of the purchase; (D) the pharmacy’s records are accessible by the employer or its agent; (E) the debit card system does not allow over-the-counter drugs or medicines without a prescription number; and (F) the expense is substantiated in accordance with the standard rules described above in paragraphs (vii) and (viii).
         3. At merchants having healthcare related merchant codes (other than merchants described in item ii above) if the expense is substantiated in accordance with the standard rules described above in paragraphs (vii) and (viii).

**Note:** If the over-the-counter medicine cannot be purchased with the electronic payment card, it may still be reimbursed using the manual reimbursement procedures described in paragraph (a) above.

* + - 1. **You must pay back any improperly paid claims**. If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator within the applicable time period, the card will be turned off and you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, then the amount of the improperly paid claim may be withheld from your pay (if allowed by applicable law) and/or offset against future eligible claims under the Health FSA. If the amount of the improperly paid claim is not collected in full as described herein, the remaining unpaid amount will be treated as an indebtedness to the Employer.
      2. **You must pay back any improperly paid claims.** If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator within the applicable time period, the card will be turned off and you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, then the amount of the improperly paid claim may be withheld from your pay (if allowed by applicable law) and/or offset against future eligible claims under the Health FSA. If the amount of the improperly paid claim is not collected in full as described herein, the remaining unpaid amount will be treated as an indebtedness to the Employer.
      3. **Your use of the payment card is not a claim.** The use of an electronic payment card does not constitute a “claim” under the claims procedures.

## What limits apply to reimbursements under the Health FSA?

You cannot be reimbursed for any expenses above the amount of your Plan Year election. You also cannot be reimbursed for any expenses that were incurred before the effective date of the Health FSA, for any expenses incurred before you become a Participant in the Health FSA, or for any expenses incurred after you terminate employment or otherwise cease to be eligible for coverage under the Health FSA, unless coverage is continued.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

**Special Rule:** A special rule applies to expenses for orthodontia care. Such expenses may be reimbursed before the orthodontia care has been provided if you have actually paid the healthcare provider in advance in order to receive the services (e.g., an upfront payment required to receive services).

## What is the Grace Period?

There is no Grace Period associated with the Health FSA.

## Which plan pays first if I participate in the Employer’s health reimbursement arrangement?

If you participate in a health reimbursement arrangement (the “HRA”) sponsored by the Employer and you or your spouse or dependent incurs an Eligible Expense that is also eligible for reimbursement under the HRA, then the Eligible Expense must be reimbursed from this Health FSA first. Once your account balance has been exhausted, then an Eligible Expense, or any portion of an Eligible Expense that has not been reimbursed by this Health FSA, may be reimbursed by the HRA.

## What if I am no longer eligible?

If your employment terminates, or you otherwise cease to be eligible for coverage under the Health FSA, your benefits under the Health FSA stop. You may not make any further contributions to your account, and you may not submit claims for reimbursement of expenses incurred after you terminated employment or otherwise ceased to be eligible for coverage. You may, however, continue to submit claims for expenses incurred before you terminated employment or otherwise ceased to be eligible for coverage until the expiration of the claims run out period following the end of the Plan Year described above.

If your employment terminates or you otherwise cease to be eligible for coverage under the Health FSA, you may not make any further contributions to your account, and you may not submit claims for reimbursement of expenses incurred after you terminated employment or otherwise ceased to be eligible for coverage. You may, however, continue to submit claims for reimbursement of expenses incurred before you terminated employment or otherwise ceased to be eligible for coverage for xx (xx) days after the date you ceased to eligible to participate.

**NOTE:** This rule may differ from the rule applicable to the Dependent Care FSA. Please refer to the prior part of this summary for the rules that apply to the Dependent Care FSA.

## Can coverage be continued?

If your employment terminates or you otherwise cease to be eligible for the Health FSA, you and any others who receive their coverage through you may be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA”) and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These continuation rights are described later in this summary.

## Is Carryover available?

No. Any amounts remaining in your account attributable to a particular Plan Year shall be forfeited following the Claims Run-Out Period. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred, on the one hand, and the annual benefit you have elected and paid for, on the other. ***If you do not use it, you lose it.***

## What if I receive benefits in error?

If a payment for benefits is made by the Health FSA in excess of the benefit to which you are entitled under the Health FSA, the Health FSA has the right to recover such overpayment from the payee. Repayment of an overpayment is a condition of participation in the Cafeteria Plan.

## What if I am subject to a child support order?

The Health FSA shall recognize child support orders regarding the provision of medical coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998, to the extent required by law. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

# CONTINUATION COVERAGE

## What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA”) requires most employers with twenty (20) or more Employees to offer Employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. The Group Medical Coverage, Group Dental Coverage, Group Vision Coverage, Health Flexible Spending Account, and Limited Scope Health Flexible Spending Account shall be operated consistent with COBRA. Please refer to the Employer’s COBRA policies and procedures contained in a separate document and is incorporated by reference into this summary. This document is available to you upon request, at no charge.

## What special COBRA rules apply to the Health FSA and Limited Scope Health FSA?

Modified COBRA continuation coverage rules apply to the Health FSA and Limited Scope Health FSA (as applicable). Continuation coverage is generally available on the same terms and conditions that apply to the group health plans. There are, however, several differences. For example, the beginning date of the continuation coverage is earlier. If elected, continuation coverage begins on the date of the qualifying event. Furthermore, the maximum duration of the continuation coverage is much shorter. If the account is “underspent” at the time of the loss, the maximum duration of COBRA is through the end of the Plan Year in which the loss takes place. If the account is “overspent” at the time of the loss, there is no requirement that COBRA be offered.

**Underspent.** An account is UNDERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is greater than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

**Overspent.** An account is OVERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is less than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

## What are my continuation rights under USERRA?

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA for a period of up to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. This continuation right is similar to, and runs concurrent with, your continuation right under COBRA (if any). The Group Medical Coverage, Group Dental Coverage, Group Vision Coverage, Health Flexible Spending Account, and Limited Scope Health Flexible Spending Account (as applicable) shall be operated consistent with USERRA and pursuant to USERRA policies and procedures contained in a separate document and is incorporated by reference into this Cafeteria Plan. This document is available to you upon request, at no charge.

## What are my continuation and/or conversion rights for group health plan coverage under state law?

Some, but not all, states require continuation and/or conversion of group health insurance (including medical, dental, and vision insurance) upon certain events. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact the Plan Administrator.

## What are my continuation and/or conversion rights for group term life insurance coverage under state law?

Some, but not all, states require continuation and/or conversion of group-term life insurance. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact the Plan Administrator.

# FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 (“FMLA”) imposes certain obligations on employers with fifty (50) or more Employees. This Cafeteria Plan shall be administered in a manner consistent with the FMLA and the Employer’s FMLA Policy required thereunder. You will be provided with a complete explanation of FMLA rights and responsibilities. In the event you are entitled and elect to continue coverage under the Plan during an FMLA leave, such coverage shall terminate if your FMLA leave expires and you do not return to work.

**NOTE:** You should contact your Employer regarding any FMLA questions.

**EXHIBIT A:**

**EMPLOYER AND PLAN INFORMATION**

|  |  |
| --- | --- |
| **Name of Plan:** | Bozeman School District #7 Cafeteria Plan |

|  |  |
| --- | --- |
| **Effective Date:** | 09/01/2020 |

|  |  |
| --- | --- |
| **Effective Date of Original Plan:** | 09/01/2019 |

|  |  |
| --- | --- |
| **Employer:** | Bozeman School District #7  404 West Main St  Bozeman, MT, 59715  Phone: 406-552-6045 |

|  |  |
| --- | --- |
| **Employer Identification Number:** | 81-6000413 |

|  |  |
| --- | --- |
| **Organization Type:** | Educational Organization |
|  |  |
| **Employer Subject to ERISA:** | No |

|  |  |
| --- | --- |
| **Affiliated Employer(s):** | N/A |

|  |  |
| --- | --- |
| **Plan Administrator:** | Bozeman School District #7  404 West Main St  Bozeman, MT 59715  Phone: 406-552-6045 |
|  |  |
| **Claims Administrator:** | Bozeman School District #7  404 West Main St  Bozeman, MT 59715  Phone: 406-552-6045 |

|  |  |
| --- | --- |
| **Agent for Service of Legal Process:** | Bozeman School District #7  404 West Main St  Bozeman, MT 59715  Phone: 406-552-6045  Legal process may also be served on the Plan Administrator. |

|  |  |
| --- | --- |
| **Plan Year:** | 09/01/2020 - 08/31/2021 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Frequency of Salary Reduction Contributions:** | | Monthly | |
| **State of Governing Law:** | | MT | |
| **Modifications to Irrevocable Election Rules:** | | None | |
| **Top-Paid Group Election:** | | No | |
|  | |  | |
| **Special Rule - Newly Hired:** | | No | |
|  | |  | |
| **Employer Contribution Upon Failure to Make Initial Election:** | | Forfeited | |
|  | |  | |
| **Employer Contribution Upon Failure to Make Annual Election:** | | Forfeited | |
|  | |  | |
| **Cash Out of Employer Contribution:** | | Not Available | |
|  | |  | |
| **Cash Out Amount Available:** | | N/A | |
|  | |  | |
| **Additional Restrictions to Cash Out of Employer Contribution:** | | None | |
|  | |  | |
| **Cash In Lieu of Coverage:** | | Not Available | |
|  | |  | |
| **Amount of Cash In Lieu of Coverage Payment:** | | N/A | |
|  | |  | |
| **Conditions of Receiving Cash In Lieu of Coverage:** | | None | |
|  | |  | |
| **Dependent Care Flexible Spending Account - Offered** | | | |
|  | |  | |
| **Electronic Payment Cards:** | | Not Available |
| **Claims Run-Out Period:** | | 60 days |
|  | |  |
| **Grace Period:** | | No |
|  | |  |
| **Grace Period Expires:** | | N/A |
|  | |  |
| **Reimbursement Upon Termination of Participation:** | | If submitted within claims run-out period |
|  | |  |
| **Qualifying Individuals Include:** | | Qualifying Child, Qualifying relative |
|  | |  |
| **Other Dependent Care Limitations:** | | None |
|  | |  | |
|  | |  | |
| **Health Flexible Spending Account - Offered** | | | |
| **Electronic Payment Cards:** | | Available | |
|  | |  | |
| **Claims Run-Out Period:** | | 60 days | |
|  | |  | |
| **Grace Period:** | | No | |
|  | |  | |
| **Grace Period Expires:** | | N/A | |
|  | |  | |
| **Reimbursement Upon Termination of Participation:** | | If submitted within claims run-out period | |
|  | |  | |
| **Account Carryover:** | | No | |
|  | |  | |
| **Maximum Carryover Amount:** | | N/A | |
|  | |  | |
| **Forfeiture of Carryover:** | | As Provided in Plan Document | |
|  | |  | |
| **Maximum Reimbursement for the Plan Year:** | | An amount equal to the maximum salary reduction contribution allowed under Code § 125(i) | |
| **For Participants joining the Plan mid-Plan Year, the maximum is:** | | Unchanged | |
|  | |  | |
| **Dependent Means:** | | As Provided in Plan Document | |
|  | |  | |
| **Medical Expense Means:** | | As Provided in Plan Document | |
|  | |  | |
| **Other Limitations:** | | None | |
|  | |  | |
|  | | | |
| **Limited Scope Health Flexible Spending Account - Not Offered** | | | |
| **Electronic Payment Cards:** | | N/A | |
|  | |  | |
| **Claims Run-Out Period:** | | N/A | |
|  | |  | |
| **Grace Period:** | | N/A | |
|  | |  | |
| **Grace Period Expires:** | | N/A | |
|  | |  | |
| **Reimbursement Upon Termination of Participation:** | | N/A | |
|  | |  | |
| **Account Carryover:** | | N/A | |
|  | |  | |
| **Maximum Carryover Amount:** | | N/A | |
|  | |  | |
| **Forfeiture of Carryover:** | | N/A | |
|  | |  | |
| **Maximum Reimbursement for the Plan Year:** | | N/A | |
|  | |  | |
| **For Participants joining the Plan mid-Plan Year, the maximum is:** | | N/A | |
|  | |  | |
| **Dependent Means:** | | N/A | |
|  | |  | |
| **Medical Expense Means:** | | N/A | |
|  | |  | |
| **Other Limitations:** | | None | |
|  | |  | |
|  | |  | |
| **Group Disability Coverage - Not Offered** | | | |
|  | |  | |
| **Type of Benefits:** | | N/A |
|  | |  |
| **Tax Consequence:** | | N/A |
|  | |  | |
| **Individual Premium Feature - Not Offered** | | | |
|  | |  | |
| **Claims Run-Out Period:** | | N/A |
|  | |  |
| **Dependent Means:** | | N/A |
|  | |  |
| **Insurance Contract Means:** | | N/A |
|  | |  |
| **Benefit Administered by:** | | N/A |
|  | |  |
| **Form of Benefit:** | | N/A |
|  | |  |
| **Reimbursement Upon Termination of Participation:** | | N/A |
|  | |  |
| **Automatic Reimbursement of Recurring Claims:** | | N/A |
|  | |  |
|  | |  | |
| **HSA Contribution Feature - Not Offered** | | | |
|  | |  | |
| **HSA Trustee/Custodian:** | | N/A | |
|  | |  | |
| **High Deductible Health Plan Means:** | | N/A | |
|  | |  | |
| **Certification of HSA Eligibility:** | | N/A | |
|  | |  | |
| **Limits on Contributions:** | | N/A | |
|  | |  | |
|  | |  | |
| **Cash Payment - Not Offered** | |  | |
|  | |  | |
| **Cash Out of the "Unspent" Portion of the Employer Contribution:** | | N/A | |
|  | |  | |
| **Cash in Lieu of Coverage:** | | N/A | |
|  | |  | |
| **Payment:** | | N/A | |
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**EXHIBIT B:**

**OPTIONAL BENEFIT(S)**

Optional Benefit(s) consist of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| ☒ | Group Medical Coverage | Plan Name: | Major Medical/Dental/Vision |
| Provider Name: | Blue Cross Blue Shield of Montana |
| Provider Address: |  |
| Provider Phone: | 800-447-7828 |
| Group ID No.: | <TODO> |
| ERISA Plan Number: | 501 |
| Eligibility: | Full Time employees working 30 hours per week; |
| Waiting Period: | 60 days following date of hire; |
| Election Type: | Affirmative |
| Employer Contribution: | Available |

|  |  |  |  |
| --- | --- | --- | --- |
| ☒ | Group Term Life Coverage | Plan Name: | Group Life Insurance |
| Provider Name: | Mutual of Omaha |
| Provider Address: | Mutual of Omaha Plaza, Omaha, NE, 68175 |
| Provider Phone: | 800-775-8805 |
| Group ID No.: | <TODO> |
| ERISA Plan Number: | 501 |
| Eligibility: | Full Time employees working 30 hours per week; |
| Waiting Period: | 60 days following date of hire; |
| Election Type: | Affirmative |
| Employer Contribution: | Available |

|  |  |  |  |
| --- | --- | --- | --- |
| ☒ | Group Term Life Coverage | Plan Name: | Voluntary Life Insurance |
| Provider Name: | Mutual of Omaha |
| Provider Address: | Mutual of Omaha Plaza, Omaha, NE, 68175 |
| Provider Phone: | 800-775-8805 |
| Group ID No.: | VOLUNTARY LIFE |
| ERISA Plan Number: | 501 |
| Eligibility: | Full Time employees working 30 hours per week; |
| Waiting Period: | 60 days following date of hire; |
| Election Type: | Affirmative |
| Employer Contribution: | Available |

|  |  |  |  |
| --- | --- | --- | --- |
| ☒ | Dependent Care Flexible Spending Account | Plan Name: | Dependent Care Account |
| Provider Name: | ConnectYourCare |
| Provider Address: |  |
| Provider Phone: | 877-292-4040 |
| Group ID No.: | N/A |
| ERISA Plan Number: | N/A |
| Eligibility: | Full Time employees working 30 hours per week; |
| Waiting Period: | 60 days following date of hire; |
| Election Type: | Affirmative |
| Employer Contribution: | Not Available |

|  |  |  |  |
| --- | --- | --- | --- |
| ☒ | Health Flexible Spending Account | Plan Name: | Flexible Spending Account |
| Provider Name: | ConnectYourCare |
| Provider Address: |  |
| Provider Phone: | 877-292-4040 |
| Group ID No.: | N/A |
| ERISA Plan Number: | 501 |
| Eligibility: | Full Time employees working 30 hours per week; |
| Waiting Period: | 60 days following date of hire; |
| Election Type: | Affirmative |
| Employer Contribution: | Not Available |

**EXHIBIT C:**

**ELIGIBLE MEDICAL CARE EXPENSES**

**Health FSA.**  Medical and dental expenses that qualify as expenses for medical care under Internal Revenue Service rules generally qualify as Eligible Expenses for reimbursement under the Health FSA.  Those may take the form of co-pays, deductibles, and medical expenses not covered by other insurance.  Often expenses that qualify for deductions under IRS rules are Eligible Expenses, but in some instances expenses that are deductible will not be reimbursable and expenses that are not deductible will be reimbursable.  Some specific examples are identified below.  The following is not an exhaustive list and there are other expenses that are eligible if they satisfy the IRS rules.

**Limited Scope Health FSA**.  Only a limited number of the following expenses are Eligible Expenses for reimbursement under the Limited Scope Health FSA.  The expenses must be for dental and vision care.  Dental care expenses are primarily listed under the “Dental & Orthodontic Care” section.  Vision care expenses are primarily listed under the “Vision Care” section.

|  |  |
| --- | --- |
| **Dental & Orthodontic Care** |  |
| *Allowable expenses*:   * Dental treatment * Artificial teeth/dentures * Braces, orthodontic devices | *Expenses specifically disallowed by the IRS or courts*:   * Teeth whitening * Toothbrushes and toothpaste, even if special type is recommended by dentist |
| **Therapy Treatments** |  |
| *Allowable expenses*:   * X-ray treatments * Treatment for alcoholism or drug dependency * Legal sterilization * Acupuncture * Vaccinations * Hair transplant to treat specific medical conditions * Physical therapy (as a medical treatment) * Fee to use swimming pool for exercises prescribed by physician to alleviate specific medical condition such as rheumatoid arthritis * Speech therapy * Smoking cessation programs and drugs to alleviate nicotine withdrawal | *Expenses specifically disallowed by the IRS or courts*:   * Physical treatments unrelated to a specific health problem (e.g., massage for general well-being) * Any illegal treatment * Cosmetic surgery * Treatment for baldness (unless it is for a specific medical condition and not for cosmetic purposes) * Electrolysis (unless it is for a specific medical condition and not for cosmetic purposes) |
| **Fees/Services** |  |
| *Allowable expenses*:   * Physician’s fees and hospital services * Nursing services for care of a specific medical ailment * Cost of a nurse’s room and board if paid by the taxpayer where nurse’s services qualify * Social Security tax paid with respect to wages of a nurse where nurse’s services qualify * Services of chiropractors * Christian Science practitioner fees * Diagnostic tests | *Expenses specifically disallowed by the IRS or courts*:   * Payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a non-medical nature * Nursemaids or practical nurses who render general care for healthy infants * Fees for exercise, athletic, or health club membership when there is no specific health reason for needing membership * Marriage counseling provided by clergyman |

|  |  |
| --- | --- |
| **Hearing Expenses** |  |
| *Allowable expenses*:   * Hearing aids and hearing aid batteries * Hearing aid repair * Special telephone equipment |  |
| **Medicine and Drugs** |  |
| *Allowable expenses:*   * Medicine and drugs that require a prescription * Insulin * Over the counter medicine and drugs when used to alleviate or treat personal injuries or sickness (including antacids, antihistamines, aspirin/pain relievers, bandages, cold medicines, acne medicine, etc.) | *Expenses specifically disallowed by the IRS or courts:*   * Medicine and drugs for personal, general health, or cosmetic purposes * Dietary supplements if for general health |
| **Medical Equipment** |  |
| *Allowable expenses:*   * Blood sugar test kits * Wheelchair or autoette (cost of operating/maintaining) * Crutches (purchased or rented) * Special mattress & plywood boards prescribed to alleviate arthritis * Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition * Artificial limbs * Support hose (if medically necessary) * Wigs (where necessary to mental health of individual who loses hair because of disease) * Excess cost of orthopedic shoes over cost of ordinary shoes * Breast pumps for nursing mothers | *Expenses specifically disallowed by the IRS or courts:*   * Wigs, when not medically necessary for mental health * Vacuum cleaner purchased by an individual with dust allergy * Mechanical exercise device not specifically prescribed by physician |
| **Physicals** |  |
| *Allowable expenses:*   * Physicals and other well visits * Immunizations | *Expenses specifically disallowed by the IRS or courts:*   * Physicals for employment purposes |
| **Vision Care** |  |
| *Allowable expenses:*   * Optometrist’s or ophthalmologist’s fees * Eyeglasses and prescription sunglasses * Insurance for replacement of lost or damaged contact lenses * Contact lens and contact lens solutions * Laser eye surgery |  |

|  |  |
| --- | --- |
| **Assistance for the Handicapped** |  |
| *Allowable expenses:*   * Cost of guide for a blind person * Cost of note-taker for a deaf child in school * Cost of Braille books and magazines in excess of cost of regular editions * Seeing eye dog (cost of buying, training and maintaining) * Household visual alert system for deaf person * Excess costs of specifically equipping automobile for handicapped person over cost of ordinary automobile; device for lifting handicapped person into automobile * Special devices, such as tape recorder and typewriter, for a blind person |  |
| **Psychiatric Care** |  |
| *Allowable expenses*:   * Services of psychotherapists, psychiatrists, and psychologists | *Expenses specifically disallowed by the IRS or courts*:   * Psychoanalysis undertaken to satisfy curriculum requirements of a student |
| **Miscellaneous Charges** |  |
| *Allowable expenses:*   * X-rays * Expenses for services connected with donating an organ * Excess cost of medically prescribed diet * The cost of a medically prescribed weight loss program * Breast reconstructive surgery following mastectomy as part of treatment for cancer * Contraceptives * Fertility treatments * Medical records charges * Bandages * Lactation supplies for nursing mothers * Cost of transportation primarily for and essential to medical care (e.g., the expense of traveling to and from a medical service provider) * Menstrual care products, which include tampons, pads, liners, cups, sponges, or similar products used by individuals with respect to menstruation or other genital-tract secretions | *Expenses specifically disallowed by the IRS or courts:*   * Expenses of divorce when doctor or psychiatrist recommends divorce * Cost of toiletries, cosmetics, and sundry items (e.g., soap, toothbrushes) * Cost of special foods taken as a substitute for regular diet, when the special diet is not medically necessary or taxpayer cannot show cost in excess of cost of a normal diet * Maternity clothes * Diaper service * Distilled water purchased to avoid drinking fluoridated county water supply * Installation of power steering in automobile * Pajamas purchased to wear in hospital * Mobile telephone used for personal calls as well as calls to physician * Union dues for sick benefits for members * Contributions to state disability funds * Auto insurance providing medical coverage for all persons injured in or by the taxpayer’s automobile, where amounts allocable to taxpayer and dependent is not stated separately * Long-term care services * Funeral expenses |
| **Insurance** |  |
| *Allowable expenses:*   * None | *Expenses specifically disallowed by the IRS or courts:*   * Health insurance premiums (including individual and non-employer sponsored coverage and continuation premiums) * Long term care insurance premiums |