

# Plan Document: Appendix B

## Medical or Medical-Related Expense Reimbursement Benefits Plan (Health Flexible Spending Account, or FSA)

All terms and conditions stated in the Plan Document and Appendix B are applicable to this Medical or Medical-Related Expense Reimbursement Benefits Plan (Health FSA) unless specifically changed by this Appendix B.

All capitalized terms in this Appendix B are defined exactly as in the Plan Document, Article III, Definitions.

This Plan is intended to provide reimbursement for certain medical expenses incurred by Participants and not otherwise covered by insurance or by the Employer. The Employer intends that the Plan qualify as an accident and health plan under Section 105 and 106 of the Internal Revenue Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participant incomes under Section 105(b) of the Code.

The Health FSA is an Employer Sponsored Welfare Plan as defined by ERISA (Employee Retirement Income Security Act of 1974) and is subject to ERISA. The Employer will provide a Summary Plan Description within 90 days of enrollment or on request. The Summary Plan Description will identify the Plan Administrator for this Plan.

**Maximum Contribution.** The maximum salary reduction that a Participant can make per Plan Year will be communicated in the Enrollment Communications that are provided to each Eligible Employee at open enrollment or at the time a new or existing Employee becomes eligible for enrollment in the Plan. Beginning Plan Years on and after January 1, 2013, a Participant's salary reduction cannot exceed the greater of these two: either the maximum salary reduction communicated in the Enrollment Communications or the maximum limit per Code Section 125(i), indexed for inflation.

**Qualified Expenses.** A medical expense incurred during a Plan Year by a Participant, the Participant's Spouse, or the Participant's Dependents while the Participant is covered under this Plan. Medical ex-

penses are reimbursable only to the extent allowed as a medical expense under Section 213(d) of the Internal Revenue Code. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

**Benefits.** Benefits are provided from the Employer's general assets. There are no segregated funds established for this Plan. The amount of the Participant's annual election is available on each day of the Plan Year in which the Employee is a Participant.

A Participant is entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's annual election, and Employer contributions, if any. The amount of a Participant's annual election will be uniformly available during the Plan Year.

**Claims.** A claim under this Health FSA can be reimbursed only if the Participant provides a written statement from an independent third party stating that the medical expense has been incurred, the amount of the expense, and that the medical expense has not been reimbursed nor is it reimbursable under any other health plan coverage. If claims are submitted electronically, the Participant will sign a certification upon Enrollment or acceptance of an electronic card that claims submitted under the card have not been reimbursed by any other insurance or self-insured plan, and that the Participant is not seeking reimbursement under any other insured or self-insured plan.

Each claim will be substantiated by the submission of a third-party statement that shows that the claim is for a Qualified Benefits Expense, or by automated means that comply with guidelines established under IRS Rev. Rul. 2003-43.

Services purchased under a prefunded debit card can be automatically substantiated as allowed under IRS Notice 2006-69, including claims that are automatically substantiated using the Inventory Information Approval System (IIAS), amounts that are a multiple of a health plan copayment (up to five multiple copayments).

**Death of Participant.** In the event of the death of the Participant prior to the payment of any claims, payment will be made in the following priority:

- (a) Executor of the Estate of the deceased Participant,
- (b) Spouse, or,
- (c) Family member held responsible for payment of deceased's medical bills.

**Amounts Paid in Error.** Upon any benefits payment made in error, the Plan Sponsor will inform the Participant that they are required to repay the amount that has been paid in error to or on the behalf of a Participant. This includes and is not limited to amounts exceeding the Participant's annual election, amounts for services that are determined not to be Qualified Expenses, or amounts that are not substantiated (as when a Participant does not provide adequate documentation to substantiate a claim upon request). The Employer may take reasonable steps to recoup such an amount, including reducing the amount of future benefits reimbursements by the amount paid in error.

**Change in Enrollment.** No Participant in the Plan will be allowed to alter or discontinue the Participant's elections during a Plan Year except when due to and consistent with a Change in Status Event. Change In Status enrollment requests must be made within 30 days of the Change In Status Event and be consistent with the actual Change in Status.

The new Benefits Enrollment Form, if determined by the Employer to be submitted in a timely fashion and consistent with the Status Change, will be effective prospectively and will apply only to those Benefits accruing to the Participant, the Participant's Spouse or the Participant's Dependents after the effective date of the new Benefits Enrollment Form. With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" will mean submitted no later than the last day of such special enrollment period. The Employer will determine if the new Benefits Enrollment Form has been timely submitted consistent with the nature of the Change in Status.

**Limited Coverage under this Plan (Spouse covered under an HSA).** Section 1201 of the Medicare Prescription Drug, Improvement & Modernization Act of 2003, added Section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts (HSAs) for taxable years beginning on

or after December 31, 2003. In order to allow an Employee's Spouse to contribute to an HSA Account, an Employee is required to submit a written request to the Benefits Coordinator requesting "single" or "Parent and Child(ren)" enrollment in this Health FSA. Qualified Expenses are limited to covered services or supplies provided to the Employee and Dependents that are not covered under the Spouse's HSA. No claims for family members covered under the HSA can be submitted under this Plan.

**Nondiscrimination.** The Plan is not intended to discriminate in favor of highly compensated individuals regarding eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. The Plan Administrator may take such actions as excluding certain highly compensated employees from participation in the Plan or adjusting elections midyear, if in the Employer's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

**Carryover.** The Allowed Carryover Maximum will be communicated in the Enrollment Communications provided to each Eligible Employee at open enrollment or when a new or existing Employee becomes eligible for enrollment in the Plan. The Carryover Maximum will be the lesser of the amount communicated in the Enrollment Communications or \$500.

The Allowed Carryover will be the lesser of the Allowed Carryover Maximum or the unused benefit balance at the end of the Runout Period. A Runout Period immediately follows the end of a Plan Year during which a Participant may request reimbursement of expenses incurred for qualified benefits during the Plan Year. The duration of any Runout Periods will be detailed in the Summary Plan Description provided by the Employer.

The amount carried over has no effect on the ability to elect the maximum salary reduction allowed under the Plan for the new Plan Year. If a Participant elects the maximum salary reduction allowed under the Plan then the amount carried over will be in addition to that election.

**Forfeiture (Use-it-or-lose-it Rule) and Runout Period.** Participant forfeits any unused amount in excess of the Allowed Carryover Maximum that remains unused at end of the Plan Year's Runout Period.

Participants who terminate coverage under this Plan during the Plan Year forfeit any amount of their annual elections that exceeds claims reimbursed during any Plan Year.

A Participant who is covered through the end of the Plan Year will have a Runout Period in which to submit eligible claims. A Participant who terminates coverage during the Plan Year has a Runout Period in which to submit eligible claims. The duration of these Runout Periods will be provided in the Summary Plan Description provided by the employer.

Upon such forfeiture, the Participant's accrual will be reduced to zero. Forfeiture of Plan benefit amounts may be (a) reallocated to existing Participants in any reasonable manner (reallocation must in no way relate to prior claims history) or (b) applied towards the cost of administering the Plan.

**COBRA Continuation Coverage.** The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") as amended from time to time, does not apply to any group health plan of the Employer for any calendar year if all employers maintaining the Plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Any Participant eligible for COBRA continuation coverage under this Plan, shall be allowed to continue to participate in the Plan until the end of the Plan Year in which the qualifying event occurred, as long as such Participant complies with the provisions set out in COBRA. A Participant is eligible for COBRA coverage only when the cost to continue to the end of the Plan Year exceeds the remaining benefit.

The Employer shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Internal Revenue Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

**Plan Administrator's Duties.** The Plan Administrator, identified in the Summary Plan Description, will have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member). The Plan Administrator's decision will be final, binding, and conclusive on all parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude all individuals who are not considered Employees for purposes of the Employer's payroll system, and the Plan Administrator is authorized to do so, despite the fact that its decision may result in the loss of the Plan's tax qualification.

In addition, the Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefits determinations as

it may determine at its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations regarding whether any individual is eligible and entitled to receive any benefits under the Plan.

The Plan Administrator is responsible for the administration of the Plan. In addition to any rights, duties or powers specified throughout the Plan, the Plan Administrator will have the following rights, duties and powers:

- (a) to interpret the Plan; to determine the amount, manner, and time for payment of any benefits under the Plan; and to construe or remedy any ambiguities, inconsistencies, or omissions under the Plan;
- (b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;
- (c) to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;
- (d) to develop appellate and review procedures for any Participant, Spouse, Dependent, or beneficiary denied benefits under the Plan;
- (e) to provide the Employer with such tax or other information it may require in connection with the Plan;
- (f) to employ any agents, attorneys, accountants or other parties (who may also be Employees of the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;
- (g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year pertinent information regarding the administration of the Plan, to report any significant problems as to the administration of the Plan, and to make recommendations for modifications regarding procedures and benefits, or any other change which might ensure the efficient administration of the Plan.

**The Privacy Rule.** Protected Health Information ("PHI") is defined as information that is created or received by the Employer which relates to the past, present, or future physical or mental health or condition of a Participant; or, the provision of healthcare to a Participant; or the past, present, or future payment

for the provision of healthcare to a Participant; and that identifies the Participant. The test is whether there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

**Access to PHI:** The Employer's access to PHI is restricted to the minimum information necessary to administer the Health FSA. This includes obtaining Participant elections and reimbursements for payroll administration. The Employer has access to PHI submitted for claims reimbursement when that claim is on an appeal from an adverse decision. Only the Benefits Coordinator and Employees trained in the federal privacy rule will have access to the PHI.

**Permitted And Required Uses And Disclosures of PHI By The Employer:** The Employer may use and disclose PHI for Plan administration functions only as permitted and required by this Plan Document, or as required by law. The Employer will not use or disclose PHI for employment-related actions or in connection with any other Employee benefits plan. When necessary, the Benefits Coordinator will disclose the PHI to consultants and experts as required by the Department of Labor for a full and fair review or to perform Plan non-discrimination testing as required by law.

**Complaints:** If a Participant has any complaints regarding the way in which the Employer has handled PHI said Participant may complain to the Benefits Coordinator. No response from the Benefits Coordinator is required. A copy of this complaint procedure shall be provided to the Participant upon request. The Benefits Coordinator will keep a copy of the complaint, applicable documentation, and disposition if any, for a period of 6 years from the end of the Plan Year in which the act occurred.

**No Retaliation:** No Employee will intimidate, threaten, coerce, discriminate against, or take other retaliatory action against Participants for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under the federal Privacy Rule.

**Firewall:** The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of the group health plan; and ensure

that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

Employer will do the following: (1) Ensure that any subcontractors or agents to whom the Plan Sponsor provides PHI agree to the same restrictions described above, (2) report to the health plan any use or disclosure that is inconsistent with this Plan Document or the federal Privacy Rule, (3) make the PHI information accessible to the Participants, (4) allow Participants to amend their PHI, (5) provide an accounting of its disclosures of PHI as required by the Privacy Rule, (6) make its practices available to the Secretary of Health and Human Services for determining compliance, and, (7) return and destroy all PHI when no longer needed, if feasible.

**The Federal Security Rule.** This rule is intended to bring the Plan into compliance with the "HIPAA Security Rule" as published on February 20, 2003 by the United States Department of Health and Human Services (HHS), and amended, including the final Security Standards under the Health Insurance Portability and Accountability Act of 1996 and the HITECH Act (Health Information Technology for Economic and Clinical Health Act) of the 2009.

The Electronic Media contemplated by the HIPAA Security Rule includes the following:

- (a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
- (b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

In order to send and receive Protected Health Information ("PHI" as defined in the Plan Document) necessary for Plan administration by Electronic Media, the Employer will do the following:



- (a) implement reasonable and appropriate safeguards for electronic PHI created, received, maintained or transmitted to or by the Employer on behalf of the group health plan;
- (b) ensure that electronic “firewalls” are in place to secure the electronic PHI;
- (c) ensure that all agents and subcontractors with access to electronic PHI comply with the security requirements; and
- (d) report to the group health Plan any security incident of which it becomes aware.

**Employee Retirement Income Security Act (ERISA).**

The Health FSA is defined as a welfare benefits Plan subject to the ERISA Reporting requirements.

**Summary Plan Description.** The SPD informs Employees of their rights under the Plan. It must be provided to all Participants of all welfare benefits plans, regardless of size. New Participants must receive the SPD within 90 days of becoming Participants or receiving benefits.

**Summary of Material Modification.** The SMM informs Employees of any changes to the Plan. Participants must receive a SMM reflecting any such changes. However, a SMM is not required if a change is described in the SPD and is redistributed.

**Summary Annual Report.** A SAR is the highlight of the financial information detailed on IRS Form 5500. The SAR is to be distributed to Plan Participants within nine months following the end of the Plan Year. Unfunded Plans with fewer than 100 Participants at the beginning of the Plan Year are exempt from the SAR distribution rules.

**IRS Form 5500.** Form 5500 is required under ERISA Section 104, applicable to welfare benefits plans. Unfunded plans with fewer than 100 Participants are exempt from the filing requirement if Plan assets are not held in trust.

