Cochise College

Flexible Benefits Plan

Summary Plan Description / Plan Document

Amended and Restated
Effective July 1, 2014

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INTRODUCTION

The *employer* has adopted this *Plan* effective July 1, 2014, to recognize the contribution made to the *employer* by its *employees*. Its purpose is to reward them by providing *benefits* for those *employees* who shall qualify hereunder and their *dependents*. The concept of this *Plan* is to allow *employees* to choose among different types of *benefits* based on their own particular goals, desires and needs. The *Plan* shall be known as the Cochise College Flexible Benefits Plan (*Plan*).

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

The *employer* also intends that, for purposes of the annual report requirement (Form 5500), this document is considered a "wrap" plan and the terms of the underlying plans for which *participants* are making contributions through this *Plan* are hereby incorporated by reference.

A. Quick Reference Chart - For Help or Information

When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Chart:

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Employer	Cochise County Community College District d.b.a. Cochise College (520) 515-3623 **Mailing Address** 901 N Colombo Avenue Sierra Vista, AZ 85635 **Physical Address** 901 N Colombo Ave Sierra Vista, AZ 85635
Flexible Benefits Claims Administrator • Claim Forms (Flex) • Flex Claims and Appeals	AmeriBen PO Box 7186 Boise, ID 83707 **Phone:** (855) 258-6455 **Fax:** (800) 723-4703 **www.ameriben.com**
Plan Consultant and Privacy Officer	Erin P. Collins and Associates, Inc. 1115 Stockton Hill Road, Suite 101 Kingman, AZ 86401 (928) 753-4700

SECTION I—PARTICIPATION

A. Eligibility

Any *eligible employee* shall be eligible to participate hereunder as of the date he or she satisfies the eligibility conditions for the *employer's* group medical plan, the provisions of which are specifically incorporated herein by reference.

B. Effective Date of Participation

An *eligible employee* shall become a *participant* effective as of the date on which he or she satisfies the requirements pursuant to this **Participation** section.

C. Application to Participate

An *employee* who is eligible to participate in this *Plan* shall, during the applicable *election period*, complete an application and election-of-benefits form which the *Plan Administrator* shall furnish to the *employee*. The election made on such form shall be irrevocable until the end of the applicable *plan year* unless the *participant* is entitled to change his or her *benefit* elections pursuant to the **Participant Elections** section.

An *eligible employee* shall also be required to execute a *salary redirection agreement* during the *election period* for the *plan year* during which he or she wishes to participate in this *Plan*. Any such *salary redirection agreement* shall be effective for the first pay period beginning on or after the *employee's* effective date of participation pursuant to this **Participation** section.

D. Termination of Participation

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

1. **Termination of employment**. The participant's termination of employment, subject to the provisions of the Termination of Employment subsection.
2. **Death.** The *participant's* death, subject to the provisions of the Death subsection
3. **Termination of this Plan**. The termination of this *Plan*, subject to the provisions in the **Amendment or Termination of Plan** section.

E. Termination of Employment

If a *participant's* employment with the *employer* is terminated for any reason other than death, his or her participation in the *Plan* shall be governed in accordance with the following:

1. **Health Care Flexible Spending Account Benefit.** With regard to the *Health Care Flexible Spending Account*, the *participant's* participation in the *Plan* shall cease and no further *salary redirection* contributions shall be made. However, such *participant* may submit claims for expenses that were incurred during the portion of the *plan year* before the end of the period for which payments to the *Health Care Flexible Spending Account* have already been made for claims incurred prior to such termination and submitted within sixty (60) days after the date of termination.
2. **Dependent Care Flexible Spending Account Benefit.** With regard to the *Dependent Care Flexible Spending Account Benefit*, the *participant's* participation in the *Plan* shall cease and no further *salary redirection* contributions shall be made. However, such *participant* may submit claims for *employment-related dependent care expense* reimbursements for claims incurred prior to such termination and submitted within sixty (60) days after the date of termination, based on the level of the *participant's Dependent Care Flexible Spending Account* as of the date of termination.
3. **COBRA Applicability.** With regard to the *Health Care Flexible Spending Account*, the *participant* may submit claims for expenses that were incurred during the portion of the *plan year* before the end of the period for which payments to the *Health Care Flexible Spending Account* have already been made. Thereafter, the health benefits

under this *Plan* including the *Health Care Flexible Spending Account* shall be applied and administered consistent with such further rights a *participant* and his or her *dependents* may be entitled to pursuant to Code Section 4980B and the **Miscellaneous Provisions** section of the *Plan*.

F. Death

If a *participant* dies, his or her participation in the *Plan* shall cease. However, such *participant's spouse* or *dependents* may submit claims for expenses or benefits for the remainder of the *plan year* or until the *cafeteria plan benefit dollars* allocated to each specific *benefit* are exhausted. In no event may reimbursements be paid to someone who is not a *spouse* or *dependent*. If the *Plan* is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the *Health Care Flexible Spending Account Benefit*.

SECTION II—CONTRIBUTIONS TO THE PLAN

A. Salary Redirection

Benefits under the *Plan* shall be financed by *salary redirections* sufficient to support *benefits* that a *participant* has elected hereunder. The salary administration program of the *employer* shall be revised to allow each *participant* to agree to reduce his or her pay during a *plan year* by an amount determined necessary to purchase the elected *benefit options*. The maximum amount that can be contributed to each elected benefit (*Health Care Flexible Spending Account* or *Dependent Care Flexible Spending Account*) is not necessarily the same amount and is set by IRS regulations. The amount of such *salary redirection* shall be specified in the *salary redirection agreement* and shall be applicable for a *plan year*. Notwithstanding the above, for new *participants,* the *salary redirection agreement* shall only be applicable from the first day of the pay period following the *employee's* entry date up to and including the last day of the *plan year*. These contributions shall be converted to *cafeteria plan benefit dollars* and allocated to the funds or accounts established under the *Plan* pursuant to the *participants*' elections made under the **Participant Elections** section.

Any *salary redirection* shall be determined prior to the beginning of a *plan year* (subject to initial elections pursuant to the **Participant Elections** section) and prior to the end of the *election period* and shall be irrevocable for such *plan year*. However, a *participant* may revoke a *benefit* election or a *salary redirection agreement* after the *plan year* has commenced and make a new election with respect to the remainder of the *plan year*, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under the **Participant Elections** section of the *Plan* and consistent with the rules and regulations of the Department of the Treasury. *Salary redirection* amounts shall be contributed on a pro rata basis for each pay period during the *plan year*. All individual *salary redirection agreements* are deemed to be part of this *Plan* and incorporated by reference hereunder.

B. Application of Contributions

As soon as reasonably practical after each payroll period, the *employer* shall apply the *salary redirection* to provide the *benefits* elected by the affected *participants*. Any contribution made or withheld for the *Health Care Flexible Spending Account* and the *Dependent Care Flexible Spending Account* shall be credited to such fund or account.

C. Periodic Contributions

Notwithstanding the requirement provided above and in other sections of this *Plan* that *salary redirections* be contributed to the *Plan* by the *employer* on behalf of an *employee* on a level and pro rata basis for each payroll period, the *employer* and *Plan Administrator* may implement a procedure in which *salary redirections* are contributed throughout the *plan year* on a periodic basis that is not pro rata for each payroll period.

SECTION III—BENEFITS

A. Benefit Options

This section highlights the optional choices available and offered by this Cafeteria Plan.

Each *participant* may elect to participate in, or waive participation in, the Cafeteria Plan and may designate, subject to *Plan* and IRS limits on each *benefit*, the amount of his or her total combined maximum *cafeteria plan benefit dollars* to be applied to any one (1) or more of the following optional *benefits*:

1. Health Care Flexible Spending Account Benefit
2. Dependent Care Flexible Spending Account Benefit
3. Premium Conversion Plan

   In addition, each *participant* shall have a sufficient portion of his or her *salary redirections* applied to the following *benefits* unless the *participant* elects not to receive such *benefits*:

   a. Employer Health Insurance Benefit

   b. Employer Dental Insurance Benefit

B. Health Care Flexible Spending Account Benefit

Each *participant* may elect to participate in the *Health Care Flexible Spending Account Benefit*, in which case the **Health Care Flexible Spending Account Benefit** section shall apply.

C. Dependent Care Flexible Spending Account Benefits

Each *participant* may elect to participate in the *Dependent Care Flexible Spending Account Benefit*, in which case the **Dependent Care Flexible Spending Account Benefit** section shall apply.

D. Premium Conversion Plan OR Salary Redirection Plan Benefit

1. **Coverage for Participant and Dependents.** Each *participant* may elect to be covered under a health and/or dental contract(s) for the *participant*, his or her *spouse*, and his or her *dependents*.
2. **Employer selects contracts.** The *employer* may select suitable health contracts for use in providing this health insurance and/or dental insurance self-funded benefit, which policies will provide uniform benefits for all *participants* electing this *benefit*.
3. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health and/or dental contract(s) shall be determined therefrom, and such contract shall be incorporated herein by reference.

E. Nondiscrimination of Requirements

1. **Intent to be nondiscriminatory.** It is the intent of this *Plan* to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.
2. **25% concentration test.** It is the intent of this *Plan* not to provide qualified benefits as defined under Code Section 125 to *key employees* in amounts that exceed 25% of the aggregate of such *benefits* provided for all *eligible employees* under the *Plan*. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.
3. **Adjustment to avoid test failure.** If the *Plan Administrator* deems it necessary to avoid discrimination or possible taxation to *key employees* or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or

non-taxable *benefits* in order to assure compliance with this section. Any act taken by the *Plan Administrator* under this section shall be carried out in a uniform and nondiscriminatory manner. If the *Plan Administrator* decides to reject any election or reduce contributions or non-taxable *benefits*, it shall be done in the following manner. First, the non-taxable *benefits* of the affected *participant* (either an employee who is highly compensated or a *key employee*, whichever is applicable) who has the highest amount of non-taxable *benefits* for the *plan year* shall have his or her non-taxable *benefits* reduced until the discrimination tests set forth in this section are satisfied or until the amount of his or her non-taxable *benefits* equals the non-taxable *benefits* of the affected *participant* who has the second highest amount of non-taxable *benefits*. This process shall continue until the nondiscrimination tests set forth in this section are satisfied. With respect to any affected *participant* who has had *benefits* reduced pursuant to this section, the reduction shall be made proportionately among *Health Care Flexible Spending Account Benefit* and *Dependent Care Flexible Spending Account Benefit*. Contributions which are not utilized to provide *benefits* to any *participant* by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

SECTION IV—PARTICIPANT ELECTIONS

A. Initial Elections

An *employee* who meets the eligibility requirements of this *Plan* on the first day of, or during, a *plan year* may elect to participate in this *Plan* for all or the remainder of such *plan year*, provided the *employee* elects to do so on or before the *employee's* effective date of participation pursuant to the **Participation** section.

B. Subsequent Annual Elections

During the *election period* prior to each subsequent *plan year*, each *participant* shall be given the opportunity to elect, on an election of benefits form to be provided by the *Plan Administrator*, which *benefit options* he or she wishes to select. Any such election shall be effective for any *benefit* expenses incurred during the *plan year* which follows the end of the *election period*. With regard to subsequent annual elections, the following options shall apply:

1. A *participant* or *employee* who failed to initially elect to participate may elect different or new *benefits* under the *Plan* during the *election period*.
2. A *participant* may terminate his or her participation in the *Plan* by notifying the *Plan Administrator* in writing during the *election period* that he or she does not want to participate in the *Plan* for the next *plan year*, or by not electing any *benefit options*.
3. An *employee* who elects not to participate for the *plan year* following the *election period* will have to wait until the next *election period* before again electing to participate in the *Plan*, except as provided for in the **Participant Elections** section.

C. Failure to Elect

Any *participant* failing to complete an election-of-benefits form pursuant to the **Participant Elections** section by the end of the applicable *election period* shall be deemed to have elected not to participate in the *Plan* for the upcoming *plan year*. No further *salary redirections* shall therefore be authorized for such subsequent *plan year*.

D. Change in Status

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

   In general, a change in election is not consistent if the change in status is the *participant's* divorce, annulment or legal separation from a *spouse*, the death of a *spouse* or *dependent*, or a *dependent* ceasing to satisfy the eligibility requirements for coverage, and the *participant's* election under the *Plan* is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the *participant*, *spouse* or *dependent* gains or loses eligibility for coverage, then a *participant's* election under the *Plan* to cease or decrease coverage for that individual under the *Plan* corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

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

   Any new election shall be effective at such time as the *Plan Administrator* shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the *Plan Administrator*. For the

purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

a. **Legal Marital Status:** Events that change a *participant's* legal marital status, including marriage, divorce, death of a *spouse*, legal separation, or annulment.

b. **Number of Dependents:** Events that change a *participant's* number of *dependents*, including birth, adoption, placement for adoption, or death of a *dependent*.

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

d. **Dependent satisfies or ceases to satisfy the eligibility requirements:** An event that causes the *participant's dependent* to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance.

e. **Residency:** A change in the place of residence of the *participant*, *spouse* or *dependent* that would lead to a change in status (such as a loss of HMO coverage).

For the *Dependent Care Flexible Spending Account Benefit*, a *dependent* becoming or ceasing to be a "*qualifying dependent*" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this section to the contrary, the attainment of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

2. **Special Enrollment Rights.** Notwithstanding subsection (a), the *participants* may change an election for accident or health coverage during a *plan year* and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such *participant* meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the *Plan* and communicated to *participants*). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

3. **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in *ERISA* Section 609) which requires accident or health coverage for a *participant's* child (including a foster child who is a *dependent* of the *participant*):

   a. the *Plan* may change an election to provide coverage for the child if the order requires coverage under the *participant's* plan; or

   b. the *participant* shall be permitted to change an election to cancel coverage for the child if the order requires the former *spouse* to provide coverage for such child, under that individual's plan and such coverage is actually provided.

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

5. **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package

option or other coverage option is eliminated, then the affected *participants* may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those *eligible employees* who are not participating in the *Plan* may opt to become *participants* and elect the new or newly improved benefit package option.

6. **Loss of coverage under certain other plans.** A *participant* may make a prospective election change to add group health coverage for the *participant*, the *participant's spouse* or *dependent* if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.
7. **Change in dependent care provider.** A *participant* may make a prospective election change that is on account of and corresponds with a change by the *participant* in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the *Dependent Care Flexible Spending Account Benefit* only if the cost change is imposed by a dependent care provider who is not related to the *participant*, as defined in Code Section 152(a)(1) through (8).
8. **Health Care Flexible Spending Account Benefit cannot Change due to insurance change.** A *participant* shall not be permitted to change an election to the *Health Care Flexible Spending Account Benefit* as a result of a cost or coverage change under any health insurance benefits.

SECTION V—HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

A. Establishment of Plan

This *Health Care Flexible Spending Account Benefit* is established for all *employees* to be reimbursed for IRS eligible *qualified medical expenses* through voluntary payroll reduction agreements with the *employer*. No taxes are deducted from your contributions.

B. Eligible Distributions

Generally, distributions from the *Health Care Flexible Spending Account* may be paid only to reimburse you for *qualified medical expenses* you incurred during the period of coverage. You are allowed to receive the maximum amount of reimbursement (the amount that you have elected to contribute for the year) at any time during the coverage period, regardless of the amount you have actually contributed. The maximum amount you can receive tax free is the total amount you elected to contribute to the *Health Care Flexible Spending Account* for the year. Please note that non-prescription medicine (other than insulin) purchased in a tax year beginning after December 31, 2010 are not considered *qualified medical expenses*. *Qualified medical expenses* are those incurred by the following persons:

1. you and your *spouse*;
2. all *dependents* you claim on your tax return;
3. any person you could have claimed as a *dependent* on your return except that:
    a. the person filed a joint return,
    b. the person had gross income of $3,700 or more, or
    c. you, or your *spouse* if filing jointly, could be claimed as a *dependent* on someone else's return;
4. your child under age twenty-seven (27) at the end of your tax year.

Please note that you cannot receive distributions from your *Health Care Flexible Spending Account* for any of the following:

1. amounts paid for health insurance premiums
2. amounts paid to long-term coverage or expenses
3. amounts that are covered under another health plan

C. Limitations

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

1. **Qualified Medical Expenses** means any expense for medical care within the meaning of the term 'medical care' as defined in 26 U.S.C. Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury Regulations thereunder, and not otherwise used by the *participant* as a deduction in determining his or her tax liability under the Code. See IRS Publication 502 (Medical and Dental Expenses) for a list of medical expenses that are included and excluded under Code Section 213. However, a *participant* may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the *participant's spouse* or individual policies maintained by the *participant* or his or her *spouse* or *dependent*. Furthermore, a *participant* may not be reimbursed for 'qualified long-term care services' as defined in 26 U.S.C. Section 7702B(c). The definitions as found in 26 U.S.C. Section 213(d) are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this *Health Care Flexible Spending Account Benefit*.
2. **Over-the-counter drugs/medications.** Due to the Patient Protection and Affordable Care Act adopted as part of the Federal Health Care Reform, over-the-counter drugs/medications will no longer be reimbursable without a prescription from a qualified medical provider. The new rule does not apply to any over-the-counter items that are not drugs or medicine, including contact lens supplies, reading glasses, equipment such as crutches, medical supplies such as bandages and diagnostic devices such as blood sugar test kits. These items will be continued to be reimbursable without a prescription.

D. Forfeitures

Plan your expenses carefully. Following the application of your carryover amount, if any, the amount in the *Health Care Flexible Spending Account* as of the end of any *plan year* (and after the processing of all claims for such *plan year* pursuant to this **Health Care Flexible Spending Account Benefit** section) shall be forfeited and credited to the benefit plan surplus. In such event, the *participant* shall have no further claim to such amount for any reason, subject to the **Benefits and Rights** section.

E. Limitation on Allocations

Notwithstanding any provision contained in this Cafeteria Plan to the contrary, the maximum amount that may be allocated to the *Health Care Flexible Spending Account* by a *participant* in or on account of any *plan year* is $2,500. The minimum amount that may be allocated to the *Health Care Flexible Spending Account* by a *participant* in or on account of any *plan year* is $100.

F. Nondiscrimination Requirements

1. **Intent to be nondiscriminatory.** It is the intent of this *Health Care Flexible Spending Account Benefit* not to discriminate in violation of the Code and the Treasury regulations thereunder.

2. **Adjustment to avoid test failure.** If the *Plan Administrator* deems it necessary to avoid discrimination under this *Health Care Flexible Spending Account Benefit*, it may, but shall not be required to, reject any elections or reduce contributions or *benefits* in order to assure compliance with this section. Any act taken by the *Plan Administrator* under this section shall be carried out in a uniform and nondiscriminatory manner. If the *Plan Administrator* decides to reject any elections or reduce contributions or *benefits*, it shall be done in the following manner. First, the *benefits* designated for the *Health Care Flexible Spending Account* by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the *plan year* shall be reduced until the nondiscrimination tests set forth in this section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the *Health Care Flexible Spending Account* for the *plan year*. This process shall continue until the nondiscrimination tests set forth in this section or the Code are satisfied.

G. Coordination with Cafeteria Plan

All *participants* under the Cafeteria Plan are eligible to elect *benefits* under this *Health Care Flexible Spending Account Benefit* if they elect to participate. Other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Cafeteria Plan.

H. Health Care Flexible Spending Account Claims

1. **Expenses must be incurred during Plan Year.** All eligible medical expenses or expenses for dental, vision, or preventative care incurred by a *participant*, his or her *spouse,* and his or her *dependents* during the *plan year* shall be reimbursed during the *plan year* subject to the **Participation** section, even though the submission of such a claim occurs after his or her participation hereunder ceases; but provided that the medical expenses were incurred during the applicable *plan year*. Medical expenses are treated as having been incurred when the *participant* is provided with the medical care that gives rise to the medical expenses, not when the *participant* is formally billed or charged for, or pays for the medical care.

2. **Reimbursement available throughout Plan Year.** The *Plan Administrator* shall direct the reimbursement to each eligible *participant* for all allowable medical expenses, up to a maximum of the amount designated by the *participant* for the *Health Care Flexible Spending Account Benefit* for the *plan year*. Reimbursements shall be made available to the *participant* throughout the year without regard to the level of *cafeteria plan benefit dollars* which have been allocated to the fund at any given point in time. Furthermore, a *participant* shall be entitled to

reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the *participant* and/or his or her *spouse* or *dependents*.

3. **Payments.** Reimbursement payments under this *Plan* shall be made directly to the *participant*. However, in the *Plan Administrator's* discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the *Plan Administrator* on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the medical expense has been incurred and the amount of such expense. Furthermore, the *participant* shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the *Health Care Flexible Spending Account*, such amount will not be claimed as a tax deduction. The *Plan Administrator* shall retain a file of all such applications.
4. **Claims for reimbursement.** Claims for the reimbursement of medical expenses incurred in any *plan year* shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a *participant* fails to submit a claim within the sixty (60) days after the end of the *plan year*, those medical expense claims shall not be considered for reimbursement by the *Plan Administrator*.

I. Annual Carryover Provision

As a *participant* utilizing the *Health Care Flexible Spending Account Benefit* you are entitled to carryover unused *Health Care Flexible Spending Account* funds at the end of each *plan year*, up to, but not to exceed $500. The carryover funds must be unused *Health Care Flexible Spending Account* funds and can be used for qualified §213(d) medical expenses (excluding health insurance and long-term care services or insurance) incurred during the following *plan year*(s), but not for expenses incurred during the previous *plan year* in which the funds were contributed and unused. The carryover funds cannot be cashed out or converted to any other taxable or nontaxable benefit. The carryover amounts do not compound from year to year.

Any unused *Health Care Flexible Spending Account* funds in excess of the carryover maximum allowed of $500 are forfeited. Any unused amount remaining in your *Health Care Flexible Spending Account* as of termination of employment is also forfeited, subject to continuation rights pursuant to COBRA.

This carryover amount cannot be used for dependent care assistance, but must be used for health care reimbursement.

This carryover amount does not count toward, nor does it reduce your ability to elect the maximum contribution amount of $2,500 from year to year, should you wish to elect the maximum contribution amount.

For purposes of this subsection, 'unused funds' shall be understood to mean, the amount remaining unused as of the end of the *plan year* is the amount unused after medical expenses have been reimbursed at the end of the plan's run-out period for the current *plan year*.

Please note that there is no annual carryover provision applicable to the Dependent Care Flexible Spending Account Benefit.

J. Qualified Reservist Distribution

1. A *participant* may request a Qualified Reservist Distribution, provided the following provisions are satisfied. 'Qualified Reservist Distribution' means any distribution to a *participant* of all or a portion of the balance in the *participant's Health Care Flexible Spending Account Benefit* if:
    a. Such *participant* was an individual who was [by reason of being a member of a reserve component (as defined in Section 101 of Title 37, United States Code)] ordered or called to active duty for a period of 180 days or more or for an indefinite period.
    b. A *participant* may have been called prior to June 18, 2008, provided the individual's active duty continues after June 18, 2008 and the period of duty complies with item (1).
    c. The distribution is made during the period beginning on the date of the order or call that applies to the *participant* and ending on the last day of the *plan year* which includes the date of such order or call.
    d. The Qualified Reservist Distribution option is offered to all *participants* who qualify under this Article.

e. Qualified Reservist Distributions may only be made if the *participant* is ordered or called to active duty, not the *participant's spouse* or *dependents*.

f. Under Section 101 of the Title 37 of the United States Code, 'reserve component' means: (1) the Army National Guard, (2) the Army Reserve, (3) the Navy Reserve, (4) the Marine Corps Reserve, (5) the Air National Guard, (6) the Air Force Reserve, (7) the Coast Guard Reserve, or (8) the Reserve Corps of the Public Health Service.

2. **Conditions:** The following conditions apply:

   a. The *employer* must receive a copy of the order or call to active duty and may rely on the order or call to determine the period that the *participant* has been ordered or called to duty.

   b. Eligibility for a Qualified Reservist Distribution is not affected if the order or call is for 180 days or more or is indefinite, but the actual period of active duty is less than 180 days or is changed otherwise from the order or call.

   c. If the original order is less than 180 days, then no Qualified Reservist Distribution is allowed. However, if subsequent calls or orders increase the total days of active duty to 180 or more, then a Qualified Reservist Distribution will be allowed.

3. **Amount:** The amount a *participant* may be reimbursed from the *Health Care Flexible Spending Account* is the amount contributed by the *participant* to the *Health Care Flexible Spending Account* as of the date of the distribution request, less any reimbursements received as of the date of the distribution request.

4. **Procedure.** The *employer* must specify a process for requesting the distribution. The *employer* may limit the number of distributions processed for a *participant* to two (2) per *plan year*. The distribution request must be made on or after the call or order and before the last day of the *plan year*. The QRD shall be paid within a reasonable time but in no event more than sixty (60) days after the date of the request.

5. **Claims.** Claims incurred prior to the date of the request of the distribution shall be paid as any other claim. Claims incurred after the date of the distribution shall be paid on submission as any other claim.

SECTION VI—DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

A. Establishment of Program

This *Dependent Care Flexible Spending Account Benefit* is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. *Participants* who elect to participate in this program may submit claims for the reimbursement of *employment-related dependent care expenses*. All amounts reimbursed shall be paid from amounts allocated to the *participant's Dependent Care Flexible Spending Account*.

B. Employment-Related Dependent Care Expenses

The amounts paid for expenses of a *participant* for those services which if paid by the *participant* would be considered *employment-related dependent care expenses* under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a *qualifying dependent,* to the extent that such expenses are incurred to enable the *participant* to be gainfully employed for any period for which there are one or more *qualifying dependents* with respect to such *participant*. *Employment-related dependent care expenses* are treated as having been incurred when the *participant's qualifying dependents* are provided with the dependent care that gives rise to the *employment-related dependent care expenses*, not when the *participant* is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an *employment-related dependent care expense* shall be made subject to all of the following rules:

1. If such amounts are paid for expenses incurred outside the *participant's* household, they shall constitute *employment-related dependent care expenses* only if incurred for a *qualifying dependent* as defined (or deemed to be, as described in and pursuant to the definition of a *qualifying dependent*), or for a *qualifying dependent* as defined (or deemed to be, as described in and pursuant to the definition of a *qualifying dependent)* who regularly spends at least eight (8) hours per day in the *participant's* household.
2. If the expense is incurred outside the *participant's* home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any.
3. *Employment-related dependent care expenses* of a *participant* shall not include amounts paid or incurred to a child of such *participant* who is under the age of nineteen (19) or to an individual who is a *dependent* of such *participant* or such *participant's spouse*.

C. Dependent Care Flexible Spending Accounts

The *Plan Administrator* shall establish a *Dependent Care Flexible Spending Account* for each *participant* who elects to apply *cafeteria plan benefit dollars* to *Dependent Care Flexible Spending Account Benefits*.

D. Increases in Dependent Care Flexible Spending Accounts

A *participant's Dependent Care Flexible Spending Account* shall be increased each pay period by the portion of *cafeteria plan benefit dollars* that he or she has elected to apply toward his or her *Dependent Care Flexible Spending Account Benefit* pursuant to elections made under the **Participant Elections** section hereof.

E. Decreases in Dependent Care Flexible Spending Accounts

A *participant's Dependent Care Flexible Spending Account* shall be reduced by the amount of any *employment-related dependent care expense* reimbursements paid or incurred on behalf of a *participant* pursuant to this **Dependent Care Flexible Spending Account Benefit** section.

F. Allowable Dependent Care Assistance Reimbursement

Subject to limitations contained in this **Dependent Care Flexible Spending Account Benefit** section of this Program, and to the extent of the amount contained in the *participant's Dependent Care Flexible Spending Account*, a *participant* who incurs *employment-related dependent care expenses* shall be entitled to receive from the *employer* full reimbursement for the entire amount of such expenses incurred during the *plan year* or portion thereof during which he or she is a *participant*.

G. Forfeitures

The amount in a *participant's Dependent Care Flexible Spending Account* as of the end of any *plan year* (and after the processing of all claims for such *plan year* pursuant to this **Dependent Care Flexible Spending Account Benefit** section) shall be forfeited and credited to the benefit plan surplus. In such event, the *participant* shall have no further claim to such amount for any reason.

H. Limitation on Payments

Code Limits. Notwithstanding any provision contained in this section to the contrary, amounts paid from a *participant's Dependent Care Flexible Spending Account* in or on account of any taxable year of the *participant* shall not exceed the lesser of the *earned income* limitation described in Code Section 129(b) or $5,000 [$2,500 if a separate tax return is filed by a *participant* who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)]. The minimum amount that may be allocated to the *Dependent Care Flexible Spending Account* by a *participant* in or on account of any *plan year* is $100.

I. Nondiscrimination Requirements

1. **Intent to be nondiscriminatory.** It is the intent of this *Dependent Care Flexible Spending Account Benefit* that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).
2. **25% test for shareholders.** It is the intent of this *Dependent Care Flexible Spending Account Benefit* that not more than twenty-five 25% of the amounts paid by the *employer* for dependent care assistance during the *plan year* will be provided for the class of individuals who are shareholders or owners (or their *spouse*s or *dependents*), each of whom (on any day of the *plan year*) owns more than five 5% of the stock or of the capital or profits interest in the *employer*.
3. **Adjustment to avoid test failure.** If the *Plan Administrator* deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this section. Any act taken by the *Plan Administrator* under this section shall be carried out in a uniform and nondiscriminatory manner. If the *Plan Administrator* decides to reject any elections or reduce contributions or *benefits*, it shall be done in the following manner. First, the *benefits* designated for the *Dependent Care Flexible Spending Account* by the affected *participant* that elected to contribute the highest amount to such account for the *plan year* shall be reduced until the nondiscrimination tests set forth in this section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected *participant* who has elected the second highest contribution to the *Dependent Care Flexible Spending Account* for the *plan year*. This process shall continue until the nondiscrimination tests set forth in this section are satisfied. Contributions which are not utilized to provide *benefits* to any *participant* by virtue of any administrative act under this paragraph shall be forfeited.

J. Coordination with Cafeteria Plan

All *participants* under the Cafeteria Plan are eligible to receive *benefits* under this *Dependent Care Flexible Spending Account Benefit*. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and

termination of participation under this *Dependent Care Flexible Spending Account Benefit*. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Cafeteria Plan.

K. Dependent Care Flexible Spending Account Benefit Claims

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

1. The *dependent* or *dependents* for whom the services were performed.
2. The nature of the services performed for the *participant*, the cost of which he or she wishes reimbursement.
3. The relationship, if any, of the person performing the services to the *participant*.
4. If the services are being performed by a child of the *participant*, the age of the child.
5. A statement as to where the services were performed.
6. If any of the services were performed outside the home, a statement as to whether the *dependent* for whom such services were performed spends at least eight (8) hours a day in the *participant's* household.
7. If the services were being performed in a day care center, a statement:
    a. that the day care center complies with all applicable laws and regulations of the state of residence,
    b. that the day care center provides care for more than six (6) individuals (other than individuals residing at the center), and
    c. of the amount of fee paid to the provider.
8. If the *participant* is married, a statement containing the following:
    a. the *spouse's* salary or wages if he or she is employed, or
    b. if the *participant's spouse* is not employed, that:
        i. he or she is incapacitated, or
        ii. he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.
9. **Claims for Reimbursement.** If a *participant* fails to submit a claim within sixty (60) days after the end of the *plan year*, those claims shall not be considered for reimbursement by the *Plan Administrator*.

A complete list of allowable dependent care expenses can be found in IRS Publication 503 Child and Dependent Care Expenses or on the IRS Web site at **www.irs.gov**.

SECTION VII—BENEFITS AND RIGHTS

A. Claim for Benefits

1. **Dependent Care Flexible Spending Account Benefit Claims.** Any claim for *Dependent Care Flexible Spending Account Benefit* shall be made to the *Plan Administrator*. For the *Dependent Care Flexible Spending Account Benefit*, if a participant fails to submit a claim within sixty (60) days after the end of the *plan year*, those claims shall not be considered for reimbursement by the *Plan Administrator*. If the *Plan Administrator* denies a claim, the *Plan Administrator* may provide notice to the *participant* or beneficiary, in writing, within ninety (90) days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

    a. specific references to the pertinent *Plan* provisions on which the denial is based;

    b. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

    c. an explanation of the *Plan's* claim procedure.

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

    a. request a review upon written notice to the *Plan Administrator*;

    b. review pertinent documents; and

    c. submit issues and comments in writing.

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

4. **Health Care Flexible Spending Account Benefit Claims.** If a *participant* fails to submit a claim under the *Health Care Flexible Spending Account Benefit* within sixty (60) days after the end of the *plan year*, those claims shall not be considered for reimbursement by the *Plan Administrator*. Once a claim is submitted, the following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the *Plan*	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by *participant*	45 days
Review of claim denial	60 days

The *Plan Administrator* will provide written or electronic notification of any claim denial. The notice will state:

    a. The specific reason or reasons for the denial.

    b. Reference to the specific *Plan* provisions on which the denial was based.

    c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

    d. A description of the *Plan's* review procedures and the time limits applicable to such procedures.

e. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

f. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the *participant* receives a denial, the *participant* shall have 180 days following receipt of the notification in which to appeal the decision. The *participant* may submit written comments, documents, records, and other information relating to the claim. If the *participant* requests, the *participant* shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

a. was relied upon in making the claim determination;

b. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

c. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all claimants; or

d. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the *Plan* who is neither the individual who made the adverse determination nor a subordinate of that individual.

5. **Forfeitures.** Any balance remaining in the *participant's Dependent Care Flexible Spending Account Benefit* or *Health Care Flexible Spending Account Benefit* as of the end of the time for claims reimbursement for each *plan year* shall be forfeited and deposited in the benefit plan surplus of the *employer* pursuant to the **Health Care Flexible Spending Account Benefit** or **Dependent Care Flexible Spending Account Benefit** sections, whichever is applicable, unless the *participant* had made a claim for such *plan year*, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his or her account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the *plan year* shall be forfeited and credited to the benefit plan surplus.

B. Application of Benefit Plan Surplus

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

C. Named Fiduciary

The *Plan Administrator* shall be the named fiduciary and shall be responsible for the management and control of the operation and administration of the *Plan*.

D. General Fiduciary Responsibilities

The *Plan Administrator* shall discharge their duties with respect to this *Plan* solely in the interest of the *participants* and their beneficiaries and

1. for the exclusive purpose of providing *benefits* to *participants* and their beneficiaries and defraying reasonable expenses of administering the *Plan*;
2. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
3. in accordance with the documents and instruments governing the *Plan*.

E. Non-Assignability of Rights

The right of any *participant* to receive any reimbursement under the *Plan* shall not be alienable by the *participant* by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

SECTION VIII—ADMINISTRATION

A. Plan Administration

The *employer* shall be the *Plan Administrator*, unless the *employer* elects otherwise. The *employer* may appoint any person, including, but not limited to, the *employees* of the *employer*, to perform the duties of the *Plan Administrator*. Any person so appointed shall signify acceptance by filing written acceptance with the *employer*. Upon the resignation or removal of any individual performing the duties of the *Plan Administrator*, the *employer* may designate a successor.

If the *employer* elects, the *employer* shall appoint one or more *Plan Administrator*s. Any person, including, but not limited to, the *employees* of the *employer*, shall be eligible to serve as a *Plan Administrator*. Any person so appointed shall signify acceptance by filing written acceptance with the *employer*. A *Plan Administrator* may resign by delivering a written resignation to the *employer* or be removed by the *employer* by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery to the *Plan Administrator* if no date is specified. The *employer* shall be empowered to appoint and remove the *Plan Administrator* from time to time as it deems necessary for the proper administration of the *Plan* to ensure that the *Plan* is being operated for the exclusive benefit of the *employees* entitled to participate in the *Plan* in accordance with the terms of the Act, the *Plan*, and the Code.

The operation of the *Plan* shall be under the supervision of the *Plan Administrator*. It shall be a principal duty of the *Plan Administrator* to see that the *Plan* is carried out in accordance with its terms, and for the exclusive benefit of *employees* entitled to participate in the *Plan*. The *Plan Administrator* shall have full power to administer the *Plan* in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the *Plan*. The *Plan Administrator* may establish procedures, correct and defect, supply and information, or reconciles and inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the *Plan*. The *Plan Administrator* shall have all powers necessary or appropriate to accomplish the *Plan Administrator's* duties under the *Plan*. The *Plan Administrator* shall be charged with the duties of the general administration of the *Plan* as set forth under the *Plan*, including, but not limited to, in addition to all other powers provided by this *Plan*.

To make and enforce such rules and regulations as the *Plan Administrator* deems necessary or proper for the efficient administration of the *Plan:*

1. To interpret the *Plan*, the *Plan Administrator's* interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the *Plan*.
2. To decide all questions concerning the *Plan* and the eligibility of any person to participate in the *Plan* and to receive benefits provided by operation of the *Plan*.
3. To reject elections or to limit contributions or *benefits* for certain highly compensated *participants* if it deems such to be desirable in order to avoid discrimination under the *Plan* in violation of applicable provisions of the Code.
4. To provide *employees* with a reasonable notification of their benefits available by operation of the *Plan* and to assist any *participant* regarding the *participant's* rights, benefits or elections under the *Plan*.
5. To keep and maintain the plan documents and all other records pertaining to and necessary for the administration of the *Plan*.
6. To review and settle all claims against the *Plan*, to approve reimbursement requests, and to authorize the payment of benefits if the *Plan Administrator* determines such shall be paid if the *Plan Administrator* decides in its discretion that the applicant is entitled to them. This authority specifically permits the *Plan Administrator* to settle disputed claims for benefits and any other disputed claims made against the *Plan*.
7. To establish and communicate procedures to determine whether a medical child support order is qualified.
8. To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the *Plan*.

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

B. Examination of Records

The *Plan Administrator* shall make available to each *participant*, *eligible employee*, and any other *employee* of the *employer* such records as pertain to their interest under the *Plan* for examination at reasonable times during normal business hours.

C. Payment of Expenses

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

D. Indemnification of Plan Administrator

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

E. Insurance Control Clause

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

SECTION IX—AMENDMENT OR TERMINATION OF PLAN

A. Amendment

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

B. Termination

The *employer* reserves the right to terminate this *Plan*, in whole or in part, at any time. In the event the *Plan* is terminated, no further contributions shall be made.

No further additions shall be made to the *Health Care Flexible Spending Account* or *Dependent Care Flexible Spending Account*, but all payments from such fund shall continue to be made according to the elections in effect until ninety (90) days after the termination date of the *Plan*. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

SECTION X—MISCELLANEOUS PROVISIONS

A. Plan Interpretation

All provisions of this Cafeteria Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This *Plan* shall be read in its entirety and not severed except as provided in the **Amendment or Termination of Plan** section

B. Gender and Number

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

C. Written Document

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

D. Exclusive Benefit

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

E. Participant's Rights

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

F. Action by the Employer

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

G. No Guarantee of Tax Consequences

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

H. Indemnification of Employer by Participants

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

compensation, plus the *participant's* share of any Social Security tax that would have been paid on such *compensation*, less any such additional income and Social Security tax actually paid by the *participant*.

I. Funding

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

J. Annual Statement of Benefits

On or before January 31st of each calendar year, the *employer* shall furnish to each *employee* who was a *participant* and received benefits under this *Plan* during the prior calendar year, a statement of all such benefits paid to or on behalf of such *participant* during the prior calendar year. This statement is set forth on the *participant's* form W-2.

K. Governing Law

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

L. Severability

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

M. Captions

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

N. Continuation of Coverage (COBRA)

Notwithstanding anything in the *Plan* to the contrary, in the event any benefit under this *Plan* subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each *participant* will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This section shall only apply if the *employer* employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

O. Family and Medical Leave Act

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

P. Health Insurance Portability and Accountability Act (HIPAA)

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

Q. Uniform Services Employment and Reemployment Rights Act USERRA

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

R. Compliance With HIPAA Privacy Standards

1. **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Compliance With HIPAA Privacy Standards subsection shall apply.

2. **Disclosure of PHI.** The *Plan* shall not disclose Protected Health Information to any member of the *employer's* workforce unless each of the conditions set out in this Compliance With HIPAA Privacy Standards subsection are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

3. **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the *employer's* workforce shall be used or disclosed by them only for purposes of *Plan* administrative functions. The *Plan's* administrative functions shall include all *Plan* payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill *Plan* responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information will not be used or disclosed for underwriting purposes.

4. **PHI disclosed to certain workforce members.** The *Plan* shall disclose Protected Health Information only to members of the *employer's* workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the *Plan*. "Members of the *employer's* workforce" shall refer to all employees and other persons under the control of the *employer*. The *employer* shall keep an updated list of those authorized to receive Protected Health Information.

   An authorized member of the *employer's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the *Plan*.

   In the event that any member of the *employer's* workforce uses or discloses Protected Health Information other than as permitted by this Compliance With HIPAA Privacy Standards subsection and the Privacy Standards, the incident shall be reported to the *Plan's* privacy officer. The privacy officer shall take appropriate action, including:

   a. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

   b. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

   c. mitigation of any harm caused by the breach, to the extent practicable; and

   d. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

5. **Certification.** The *employer* must provide certification to the *Plan* that it agrees to:

   a. Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

   b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the *Plan*, agrees to the same restrictions and conditions that apply to the *employer* with respect to such information;

   c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *employer*;

d. Report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Compliance With HIPAA Privacy Standards subsection, or required by law;

e. Make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the Privacy Standards;

f. Make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. Make available the Protected Health Information required to provide an accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the Privacy Standards;

h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the Privacy Standards;

i. If feasible, return or destroy all Protected Health Information received from the *Plan* that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

j. Ensure the adequate separation between the *Plan* and members of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (4.) above.

S. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

1. **Implementation.** The *employer* agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the *employer* creates, maintains or transmits on behalf of the *Plan*. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. **Agents or subcontractors shall meet security standards.** The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. **Employer shall ensure security standards.** The *employer* shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Compliance With HIPAA Privacy Standards subsection.

T. Genetic Information Nondiscrimination Act (GINA)

Notwithstanding anything in the *Plan* to the contrary, the *Plan* will comply with the Genetic Information Nondiscrimination Act.

U. Women's Health and Cancer Rights Act

Notwithstanding anything in the *Plan* to the contrary, the *Plan* will comply with the Women's Health and Cancer Rights Act of 1998.

V. Newborns' and Mothers' Health Protection Act

Notwithstanding anything in the *Plan* to the contrary, the *Plan* will comply with the Newborns' and Mothers' Health Protection Act.

W. Claims Submission

Claims for expenses should be submitted to:

AmeriBen
PO Box 7186
Boise, ID 83707
Phone: (855) 258-6455
Fax: (800) 723-4703
www.ameriben.com

SECTION XI—DEFINED TERMS

Affiliated Employer

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

Benefit or Benefit Options

Any of the optional benefit choices available to a *participant* as outlined in the **Benefits** section.

Cafeteria Plan Benefit Dollars

The amount available to *participants* to purchase *benefit options* as provided under the **Benefits** section. Each dollar contributed to this *Plan* shall be converted into one cafeteria plan benefit dollar.

Code

The Internal Revenue Code of 1986, as amended or replaced from time to time.

Compensation

The amounts received by the *participant* from the *employer* during a *plan year*.

Dependent

Any individual who qualifies as a dependent under Code Section 152 [as modified by Code Section 105(b)].

Dependent shall include any child of a *participant* who is covered under an *insurance contract*, as defined in the Contract, as allowed by reason of the Patient Protection and Affordable Care Act of 2010.

Dependent Care Flexible Spending Account

The account established for a *participant* pursuant to the **Dependent Care Flexible Spending Account Benefit** section to which part of his or her *cafeteria plan benefit dollars* may be allocated and from which *employment-related dependent care expenses* of the *participant* may be reimbursed for the care of the *qualifying dependents* of *participants*.

Dependent Care Flexible Spending Account Benefit

The program of benefits contained in the **Dependent Care Flexible Spending Account Benefit** section, which provides for the reimbursement of eligible expenses for the care of the *qualifying dependents* of *participants*.

Earned Income

Earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the *employer* for dependent care assistance to the *participant*.

Effective Date

Original effective date: February 1, 2002

Amended and restated effective: July 1, 2014

Election Period

The period immediately preceding the beginning of each *plan year* established by the *Plan Administrator*, such period to be applied on a uniform and nondiscriminatory basis for all *employees* and *participants*. However, an *employee's* initial election period shall be determined pursuant to the **Participant Elections** section.

Eligible Employee

Any *employee* who has satisfied the provisions of the **Participation** section.

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

Employee

Any person who is employed by the *employer*. The term employee shall include leased employees within the meaning of Code Section 414(n)(2).

Employer

Cochise County Community College District d.b.a. Cochise College and any successor which shall maintain this *Plan*; and any predecessor which has maintained this *Plan*. In addition, where appropriate, the term employer shall include any participating, affiliated, or adopting employer.

Employment-Related Dependent Care Expenses

The amounts paid for expenses of a *participant* for those services which if paid by the *participant* would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a *qualifying dependent*, to the extent that such expenses are incurred to enable the *participant* to be gainfully employed for any period for which there are one or more *qualifying dependents* with respect to such *participant*. employment-related dependent care expenses are treated as having been incurred when the *participant's qualifying dependents* are provided with the dependent care that gives rise to the employment-related dependent care expenses, not when the *participant* is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an employment-related dependent care expense shall be made subject to all of the following rules:

4. If such amounts are paid for expenses incurred outside the *participant's* household, they shall constitute employment-related dependent care expenses only if incurred for a *qualifying dependent* as defined (or deemed to be, as described in and pursuant to the definition of a *qualifying dependent*), or for a *qualifying dependent* as defined (or deemed to be, as described in and pursuant to the definition of a *qualifying dependent)* who regularly spends at least eight (8) hours per day in the *participant's* household.
5. If the expense is incurred outside the *participant's* home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any.
6. Employment-related dependent care expenses of a *participant* shall not include amounts paid or incurred to a child of such *participant* who is under the age of nineteen (19) or to an individual who is a *dependent* of such *participant* or such *participant's spouse*.

Health Care Flexible Spending Account

The account established for a *participant* pursuant to the **Health Care Flexible Spending Account Benefit** section to which part of his or her *cafeteria plan benefit dollars* may be allocated and from which *qualified medical expenses* incurred by a *participant*, his or her *spouse*, and his or her *dependents* may be reimbursed.

Health Care Flexible Spending Account Benefit

The program of benefits contained in the **Health Care Flexible Spending Account Benefit** section, which provides for all *employees* to be reimbursed for IRS eligible *qualified medical expenses*.

Insurance Contract

Any contract issued by an *insurer* underwriting a *benefit*.

Insurer

Any insurance company that underwrites a *benefit* under this *Plan* or, with respect to any self-funded benefits, the *employer*.

Key Employee

An *employee* described in Code Section 416(i)(1) and the Treasury regulations thereunder.

Participant

Any *eligible employee* who elects to become a *participant* pursuant to the **Participation** section and has not for any reason become ineligible to participate further in the *Plan*.

Plan

This instrument, including all amendments thereto.

Plan Administrator

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

Plan Year

The twelve (12)-month period beginning July 1 and ending June 30. The plan year shall be the coverage period for the *benefits* provided for under this *Plan*. In the event a *participant* commences participation during a *plan year* then the initial coverage period shall be that portion of the plan year commencing on such *participant's* date of entry and ending on the last day of such plan year.

Premium Expenses or Premiums

The *participant's* cost for the self-funded *benefits* described in the Benefit Options subsection.

Premium Expense Reimbursement Account

The account established for a *participant* pursuant to this *Plan* to which part of his or her *cafeteria benefit plan dollars* may be allocated and from which *premiums* of the *participant* may be paid or reimbursed. If more than one type of insured or self-funded *benefit* is elected, sub-accounts shall be established for each type of insured or self-funded benefit.

Qualified Medical Expenses

Any expense for medical care within the meaning of the term 'medical care' as defined in 26 U.S.C. Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury Regulations thereunder, and not otherwise used by the *participant* as a deduction in determining his or her tax liability under the Code. See IRS Publication 502 (Medical and Dental Expenses) for a list of medical expenses that are included and excluded under Code Section 213. However, a *participant* may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the *participant's spouse* or individual policies maintained by the *participant* or his or her *spouse* or *dependent*. Furthermore, a *participant* may not be reimbursed for 'qualified long-term care services' as defined in 26 U.S.C. Section 7702B(c). The definitions as found in 26 U.S.C. Section 213(d) are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this *Health Care Flexible Spending Account Benefit*.

Qualifying Dependent

For *Dependent Care Flexible Spending Account* purposes:

1. a *participant's dependent* [as defined in Code Section 152(a)(1)] who has not attained age thirteen (13);
2. a *dependent* or the *spouse* of a *participant* who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the *participant* for more than one-half of such taxable year; or
3. a child that is deemed to be a *qualifying dependent* described in item (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

Salary Redirection

The contributions made by the *employer* on behalf of *participants* pursuant to the **Contributions to the Plan** section. These contributions shall be converted to *cafeteria plan benefit dollars* and allocated to the funds or accounts established under the *Plan* pursuant to the *participants*' elections made under the **Participant Elections** section.

Salary Redirection Agreement

An agreement between the *participant* and the *employer* under which the *participant* agrees to reduce his or her *compensation* or to forego all or part of the increases in such *compensation* and to have such amounts contributed by the *employer* to the *Plan* on the *participant's* behalf. The salary redirection agreement shall apply only to *compensation* that has not been actually or constructively received by the *participant* as of the date of the agreement (after taking this *Plan* and Code Section 125 into account) and, subsequently does not become currently available to the *participant*.

Spouse

The legally married husband or wife of a *participant*, unless legally separated by court decree.

SECTION XII—ADOPTION

Cochise Community College District, dba Cochise College, hereby adopts the provisions of this *Plan*, and its duly authorized officer has executed this Plan Document and Summary Plan Description effective the first day of July, 2014.

By: Wendy Davis Date: June 25, 2014

Title: Vice President for Human Resources