CITY OF JACKSONVILLE CAFETERIA PLAN

ARTICLE I. Introductory Provisions

CITY OF JACKSONVILLE ("the Employer") hereby establishes the CITY OF JACKSONVILLE Cafeteria Plan ("the Plan") effective January 1, 2023 ("the Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to allow an Eligible Employee to pay for his or her share of Contributions on a pre-tax salary reduction basis to an account for reimbursement of certain Medical Care Expenses (Health FSA Account) and to an account for reimbursement of certain Dependent Care Expenses (DCAP Account).

This Plan is intended to qualify as a "cafeteria plan" under Code § 125 and the regulations issued thereunder. The terms of this document shall be interpreted to accomplish that objective.

The Health FSA Component is intended to qualify as a "self-insured medical reimbursement plan" under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b). The DCAP Component is intended to qualify as a "dependent care assistance program" under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a).

Although reprinted within this document, the different components of this Plan shall be deemed separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed on such components by the Code. The Health FSA Component, if any, shall also be deemed a separate plan for purposes of applicable provisions of HIPAA and COBRA.

ARTICLE II. Definitions

"**Account(s)"** means the Health FSA Accounts and the DCAP Accounts described in Section 7.5 for Health FSAs and Section 8.5 for DCAPs.

"**Benefits"** means the Health FSA Benefits and the DCAP Benefits offered under the Plan.

"**Change in Status"** has the meaning described in Section 4.6.

"**COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Code"** means the Internal Revenue Code of 1986, as amended.

"**Contributions"** means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 7.2 for Health FSA Benefits and Section 8.2 for DCAP Benefits.

"**Committee"** means the Benefits Committee appointed by the Board of Directors of CITY OF JACKSONVILLE

"**Compensation"** means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

"**DCAP"** means dependent care assistance program.

"**DCAP Account"** means the account described in Section 8.5.

"**DCAP Benefits"** has the meaning described in Section 8.1.

"**DCAP Component"** means the Component of this Plan described in Article VIII.

"**Dependent"** means: (a) for purposes of accident or health coverage and to the extent funded for purposes of the Health FSA Component , 1) any individual who is a tax dependent of the Participant as defined in Code § 105(b), 2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCAP Component, a dependent means a Qualifying Individual as defined in Section 8.3(c).

The Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"**Dependent Care Expenses"** has the meaning described in Section 8.3.

"**Earned Income"** means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any DCAP established under Code § 129; or (b) any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity or pursuant to workers' compensation.

"**Effective Date"** of this Plan has the meaning described in Article 1.

"**Election Form/Salary Reduction Agreement"** means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Health FSA Benefits and DCAP Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

"**Eligible Employee"** means an Employee eligible to participate in this Plan, as provided in Section 3.1.

"**Employee"** means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; any self-employed individual; any partner in a partnership; and any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"**Employer"** means CITY OF JACKSONVILLE, and any Related Employer that adopts this Plan with the approval of CITY OF JACKSONVILLE. Related Employers that have adopted this Plan, if any, are listed in Appendix A of this Plan. However, for purposes of Article XIV and Section 15.3, "Employer" means only CITY OF JACKSONVILLE.

"**Employment Commencement Date"** means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"**FMLA"** means the Family and Medical Leave Act of 1993, as amended.

"**General-Purpose Health FSA Option"** has the meaning described in Section 7.3(b).

"**Grace Period"** means the period that begins immediately following the close of a Plan Year and ends on the day that is two months plus 15 days following the close of that Plan Year.

"**Health FSA"** means health flexible spending arrangement, which consists of four options (if applicable): the General- Purpose Health FSA Option; the Limited (Vision/Dental/Preventive Care) Health FSA Option; the Employee- Only Health FSA Option; and the Employee-Plus-Children Health FSA Option.

"**Health FSA Account"** means the account described in Section 7.5.

"**Health FSA Benefits"** has the meaning described in Section 7.1.

"**Health FSA Component"** means the Component of this Plan described in Article VII.

"**High Deductible Health Plan"** means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials provided separately by the employer. The High Deductible Health Plan may or may not be the sole Medical Insurance Plan eligible for pre-tax Salary Reduction funding hereunder.

"**HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**HRA"** means a health reimbursement arrangement as defined in IRS Notice 2002-45.

"**Limited (Vision/Dental/Preventive Care) Health FSA Option"** if offered by the employer, has the meaning described in Section 7.3(b).

"**Medical Care Expenses"** has the meaning defined in Section 7.3.

"**Nonelective Contribution(s)"** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Spouse and Dependents, if applicable, under one or more of the Reimbursement Account benefits offered under the Plan. The amount of Employer contribution that is applied towards the cost of the Reimbursement Account benefits(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's Dependent status, commencement or termination date of the Participant's employment

during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the SPD or enrollment material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Reimbursement Accounts offered under the Plan in a manner set forth in the SPD of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.

"**Open Enrollment Period"** with respect to a Plan Year means the month preceding the Plan Year, or such other period as may be prescribed by the Administrator.

"**Participant"** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Health FSA Benefits and DCAP Benefits, and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under the Medical Insurance Plan (if any) with after-tax dollars outside of this Plan and who have not elected any Health FSA Benefits and DCAP Benefits.

"**Period of Coverage"** means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

"**Plan"** means the CITY OF JACKSONVILLE Cafeteria Plan as set forth herein and as amended from time to time.

"**Plan Administrator"** means CITY OF JACKSONVILLE. The contact person is the Human Resources Manager or the equivalent thereof for CITY OF JACKSONVILLE, who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 13.1.

"**Plan Year"** means the 12-month period commencing January 1 and ending on December 31.

"**Prior Plan Year Health FSA Amounts"** has the meaning described in Section 7.4(f).

"**Qualifying Dependent Care Services"** has the meaning described in Section 8.3.

"**Qualifying Individual"** has the meaning described in Section 8.3.

"**Related Employer"** means any employer affiliated with CITY OF JACKSONVILLE that, under Code § 414(b), § 414(c), or § 414(m), is treated as a single employer with CITY OF JACKSONVILLE for purposes of Code § 125(g)(4).

"**Salary Reduction"** means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

"**Spouse"** means an individual who is treated as a spouse for federal tax purposes. Notwithstanding the foregoing, for purposes of the DCAP Component the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"**Student"** means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual: (a) is an Employee; (b) is working 25 or more hours per week; and (c) has been employed by the Employer for 0 consecutive , counting his or her Employment Commencement Date as the first such day. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective first of the month following the date of hire, or for any subsequent Plan Year, in accordance with the procedures described in Article IV.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

• the termination of this Plan; or

• the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Insurance Benefits and Section 7.8 for Health FSA Benefits. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 7.8 for Health FSA Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefitsand Section 8.8 for DCAP Benefits.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination.

3.4 FMLA Leaves of Absence

Under FMLA, the provisions of this section shall not be available to Eligible Employees for such Plan Years in which the Employer has 50 or fewer Employees. For Plan Years in which the Employer has more than 50 Employees, the Employer must make FMLA leave available to Eligible Employees for up to 12 weeks in connection with the birth or adoption of a child, or to care for a close relative, or because of a serious health condition of the Employee.

(a) Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health FSA Benefitson the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions. The Participant shall also be eligible to participate in an Employer's open enrollment, if any, while on leave.

An Employer may require participants to continue all Health FSA Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (for instance, on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

• with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

• with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

• under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Health

FSA Benefits, as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCAP Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules detailed in Article IV will apply.

Notwithstanding any provision to the contrary in this Plan, the Participant shall also be eligible to participate in an employer's open enrollment, if any, while on leave.

ARTICLE IV. Method and Timing of Elections; Irrevocability of Elections

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in Article IV.

Benefits shall be subject to the additional requirements, if any, specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in Article IV.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described in Article IV.

For the Premium Only Plan only, if an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Medical Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described in Article IV), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election,

the Employer's portion of the Contribution will also be paid outside of this Plan.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article IV), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

Unless otherwise noted in this section, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding: participation in this Plan;

• Salary Reduction amounts; or

• election of particular Benefit Package Options (including the various Health FSA Options).

4.5 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election.* Except for new elections made pursuant to a loss in coverage under Medicaid or a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act, a Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.6 or 4.7, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.7(d) through 4.7(i), within 30 days after the events described in such Sections).

A Participant who experiences a loss in coverage under Medicaid or a state children's health insurance program (SCHIP) may make a new election within 60 days of the occurrence.

Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 4.5 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.7(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components see Section 7.4 and Section 8.4 respectively.

4.6 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 4.7, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment.

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption.

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan.

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance.

4.7 Other Events Permitting Exception to Irrevocability Rule for Other Benefits (Except as Otherwise Indicated)

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

(a) Open Enrollment Period (Applies to Health FSA, DCAP Benefits) A Participant may change an election during the Open Enrollment Period.

(b) Termination of Employment (Applies to Health FSA, DCAP Benefits) A Participant's

election will terminate under the Plan upon termination of employment in accordance with Sections 3.2 and 3.3, as applicable.

(c) Leaves of Absence (Applies to Health FSA, DCAP Benefits) A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) Change in Status (Applies to Health FSA as Limited Below, DCAP Benefits as Limited Below) A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.6), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may be made to reduce Health FSA coverage during a Period of Coverage or to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for: (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant

remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(3) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if: (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

(e) *HIPAA Special Enrollment Rights (Does Not apply to Health FSA or DCAP Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

• a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

• a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment

right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of this Section 4.7(e), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) *Certain Judgments, Decrees and Orders (Applies to Health FSA Benefits, but Not to DCAP Benefits).* If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid (Applies to Health FSA Benefits as limited below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA

coverage may commence or increase.

(h) *Change in Cost (Applies to DCAP Benefits as Limited Below, but Not to Health FSA Benefits).* For purposes of this Section 4.7(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis

to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions (Sections 4.7 (h)(1) through 4.7(h)(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(d)(2)(A) through (G), incorporating the rules of Code §§ 152(f)(1) and 152(f)(4).

(i) *Change in Coverage (Applies to DCAPBenefits as Limited Below, but Not to Health FSA Benefits).* The definition of "similar coverage" under Section 4.7(h) applies also to this Section 4.7(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment with a Loss of Coverage.* If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another

Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 4.7(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

• a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

• a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

• any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the

applicable Benefit Package Option(s).

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(5) *DCAP Coverage Changes.* 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 service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

(6) *Revocation of Medical Coverage Due to Reduction in Hours.* A participant may revoke his or her major medical coverage, along with that of any related individuals, if the Participant experiences a reduction of hours such that he or she will be reasonably expected to work fewer than 30 hours a week on a regular basis and the Participant intends to enroll, along with any such related individuals, in another medical plan no later than the first day of the second full month following the revocation.

(7) *Exchange Enrollment.* A Participant who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Medical Insurance Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Medical Insurance Plan coverage. If one or more of a Participant's related individuals are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period, the Participant may prospectively revoke an election for Medical Insurance Plan coverage for the individual or individuals (and switch to self-only coverage or family coverage including one or more other related individuals), provided that the Participant certifies that the individuals whose coverage is

being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of their Medical Insurance Plan coverage.

(5) *Revocation of Medical Coverage Due to Reduction in Hours.* A participant may revoke his or her major medical coverage, along with that of any related individuals, if the Participant experiences a reduction of hours such that he or she will be reasonably expected to work fewer than 30 hours a week on a regular basis and the Participant intends to enroll, along with any such related individuals, in another medical plan no later than the first day of the second full month following the revocation.

(6) *Exchange Enrollment.* A Participant who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Medical Insurance Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Medical Insurance Plan coverage. If one or more of a Participant's related individuals are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period, the Participant may prospectively revoke an election for Medical Insurance Plan coverage for the individual or individuals (and switch to self-only coverage or family coverage including one or more other related individuals), provided that the Participant certifies that the individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of their Medical Insurance Plan coverage.

A Participant entitled to change an election as described in this Section 4.7 must do so in accordance with the procedures described in Section 4.5.

4.8 RESERVED

4.9 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions (including Salary Reductions for HSA Benefits) for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will

reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

- Health FSA Benefits, as described in Article VII. The Health FSA election may be for:
    - General-Purpose Health FSA Option;
    - Limited (Vision/Dental/Preventive Care) Health FSA Option
- DCAP Benefits, as described in Article VIII.

In no event shall Benefits under the Plan be provided in the form of deferred compensation. Notwithstanding the foregoing, amounts remaining in a Participant's Health FSA Account can be used to reimburse the Participant for Medical Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year. Amounts remaining in a Participant's DCAP can be used to reimburse the Participant for Dependent Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year, as provided in Article VII.

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* The Employer may, but is not required to allocate Nonelective Contributions to one or more Reimbursement Accounts and to the extent set forth in the SPD or enrollment material, may allow a Participant to allocate his allotted share of Nonelective Contributions among the various Reimbursement Accounts in a manner set forth in the SPD or enrollment material.

(b) *Participant Contributions.* Participants who elect Health FSA Benefits and DCAP Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (Section 7.2 for Health FSA Benefits and Section 8.2 for DCAP Benefits, as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the Health FSA Component and DCAP Component to the extent permitted under Section 4.7, the Salary

Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 4.7, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

(b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Health FSA Benefits and the DCAP Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to 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 this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets , it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as described under Section 7.4(b) for Health FSA Benefits and Section 8.4(b) for DCAP Benefits.

ARTICLE VI. RESERVED

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the Health FSA (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article IV), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

7.2 Contributions for Cost of Coverage of Health FSA Benefits

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant and any Nonelective Contributions allocated thereto by the Employer, subject to the dollar limits set forth in Section 7.4(b). (For example, if the maximum $3,400.00 annual benefit amount is elected, then the annual Contribution amount is also $3,400.00.)

7.3 Eligible Medical Care Expenses for Health FSA

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force. In addition, certain individuals may receive reimbursement for Medical Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in their Health FSA Accounts for that Plan Year in accordance with Section 7.4(f).

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) *Medical Care Expenses.* "Medical Care Expenses" will vary depending on which Health FSA coverage option the Participant has elected.

• General-Purpose Health FSA Option. For purposes of this Option, "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, or any other accident or health plan.

If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.

Orthodontia Expenses. Orthodontia expenses will be reimbursed "as incurred and paid". See

below example:

Example: As Incurred and Paid (i.e., month by month) Rachel participates in a calendar-year Health FSA in 2024. In October 2024, she signs an agreement with an orthodontist to work on her son Ethan's teeth. During the first visit (November), Ethan is X-rayed and fitted for braces. During the second visit (December), the braces are installed. During 15 more monthly visits, the braces will be adjusted. Eventually (in 18 months, if everything goes as planned), the braces will be removed. For these services, the orthodontist charges $5000. Rachel is required to pay a $2000 down payment and $200 for each month thereafter. Under the incurred and paid option, Rachel can be reimbursed the $2000 in 2024, $2400 in 2025 (12 X $200) and $600 in 2026 (3 X $200).

PLEASE NOTE: “Down” payments for orthodontia are immediately reimbursable.

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. In addition, a Participant who has an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant’s Health FSA Account is $0 as of the last day of that Plan Year. For this purpose, a Participant’s Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

7.4 Maximum and Minimum Benefits for Health FSA

(a) *Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant’s Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8or is entitled to submit expenses incurred during a Grace Period as provided in Section 7.4(f). Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant’s election is effective(or during a Grace Period, if applicable under Section 7.4(f)), provided that the other requirements of this Article VII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $3,400.00, subject to the terms of

Section 7.5(c). The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $5.00. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) *Changes.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then the Participant's maximum dollar limit will be prorated based on a percentage of the Plan Year remaining.

Changes Made by Employer and/or Mandated by the Patient Protection and Affordable Care Act (PPACA). For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. Furthermore, in accordance with PPACA mandates, notwithstanding anything else in this document to the contrary, at no time shall any Participant be able to salary-reduce more than $3,300 for the 2025 calendar year, or $3,400 for the 2026 calendar year, with regard to the Health FSA subject only to any increases to such limit declared by the Internal Revenue Service in future years. If a Participant enters the Health FSA Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then the Participant's maximum dollar limit will be prorated based on a percentage of the Plan Year remaining.

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article IV (other than under Section 4.7(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 4.7(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(f) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 7.4(b), an individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year Health FSA Amounts") if he or she is either:

(1) a Participant with Health FSA coverage that is in effect on the last day of that Plan Year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

• Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to reimburse Dependent Care Expenses.

• Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 7.7 will be reimbursed first from any available Prior Plan Year Health FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Medical Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year Health FSA Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year Health FSA Amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Health FSA Amounts.

• Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than 3 month(s) following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health FSA Amounts.

Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.6(b).

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose.

The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) *Crediting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred

during such period (or for reimbursement of Medical Care Expenses incurred during any Grace Period to which he or she is entitled as provided in Section 7.4(f)) .

(c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage (or during the Grace Period, if applicable); it is not based on the amount credited to the Health FSA Account at a particular point in time except as provided in Section 7.4(f) . Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Unused Funds

(a) Use-It-or-Lose-It Rule

Except as otherwise provided in Section 7.4(f) (regarding certain individuals who may be reimbursed from Prior Plan Year Health FSA Amounts for expenses incurred during a Grace Period), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) *Use of Forfeitures.*

All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for Health FSA

(a) *Timing.*

Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a

Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.*

A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 3 month(s) following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 1 month(s) after the date that eligibility ceases, as described in Section 7.8) setting forth:

• the person(s) on whose behalf Medical Care Expenses have been incurred;

• the nature and date of the Expenses so incurred;

• the amount of the requested reimbursement;

• a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and

• other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XIII.

(d) *Claims Ordering; No Reprocessing.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not

be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled as provided in Section 7.4(f)), provided that the Participant (or the Participant's estate) files a claim within 1 month(s) after the date that the Participant ceases to be a Participant.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA.

Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5(a) and Section 7.5(b) without regard to Section 7.5(c), they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Notwithstanding the foregoing, a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of a Plan Year may be entitled to reimbursement of Medical Care Expenses incurred during the Grace Period following that Plan Year in accordance with the provisions of Section 7.4(f).

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility

requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

7.9 RESERVED

7.10 Coordination of Benefits With HSA, HRA, etc.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

A general-purpose health FSA constitutes family coverage because it is available to pay or reimburse the qualified medical expenses of the employee and the employee's spouse and dependents. Consequently, if either spouse participates in a general-purpose health FSA, neither spouse will be eligible to contribute to an HSA either through the spouse's employer or individually through a bank. Likewise, the fact that an adult child's qualified medical expenses could be reimbursed by a parent's general-purpose health FSA (i.e., because the child is under age 27 as of the end of the taxable year) will prevent the adult child from being HSA-eligible.

If the Employer ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the Participant will need to refer to the HRA Summary Plan Description for ordering rules.

7.11 Coordination of Benefits With HSA, HRA, etc.

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the taxable year) will prevent the adult child from being HSA-eligible.

If the Employer ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the Health FSA and the HRA, the Participant will need to refer to the HRA Summary Plan Description for ordering rules.

ARTICLE VIII. DCAP Component

8.1 DCAP Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contribution for such benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article IV), such election of DCAP Benefits is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 Contributions for Cost of Coverage for DCAP Benefits

The annual Contribution for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 8.4(b). (For example, if the maximum $7,500.00 annual benefit amount is elected, then the annual Contribution amount is also $7,500.00.)

8.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force. In addition, certain individuals may receive reimbursement for Dependent Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in their DCAP Accounts for that Plan Year in accordance with Section 8.4(f).

(a) *Incurred.*

A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) *Dependent Care Expenses.*

"Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code § 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services—provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it

otherwise meets the requirements of this Article VIII.

(c) *Qualifying Individual.*

"Qualifying Individual" means:

• a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code § 152(a)(1);

• a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

• a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

(d) *Qualifying Dependent Care Services.*

"Qualifying Dependent Care Services" means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed—

• in the Participant's home; or

• outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household.

In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(e) *Exclusion.*

Dependent Care Expenses do not include amounts paid to:

• an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;

• a Participant's Spouse;

• a Participant's child (as defined in Code § 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or

• a parent of a Participant's under age 13 qualifying child (as defined in Code § 152(a)(1)).

8.4 Maximum and Minimum Benefits for DCAP

(a) *Maximum Reimbursement Available.*

The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 8.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements).) Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.*

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5.00. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $7,500.00 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

• the Participant's Earned Income for the calendar year;

• the Earned Income of the Participant's Spouse for the calendar year (note: a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense; and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or

• either $7,500.00 or $3,750 for the calendar year, as applicable:

(1) *$7,500.*00 for the calendar year if one of the following applies:

• the Participant is married and files a joint federal income tax return;

• the Participant is married, files a separate federal income tax return, and meets the following conditions: (1) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (i.e., the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP); (2) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (i.e., the Spouse maintained a separate residence); or

• the Participant is single or is the head of the household for federal income tax purposes; or

(2) $3,750 for the calendar year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5.00.

(c) *Changes.*

For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component mid-year or wishes to increase his or her election mid-year as permitted under Section 4.7, then the Participant's maximum dollar limit will be prorated based on a percentage of the Plan Year remaining.

(d) *Effect on Maximum Benefits If Election Change Permitted.*

Any change in an election under Article IV affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 8.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

(e) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 8.4(b), an individual may be reimbursed for Dependent Care Expenses incurred during a Grace Period

from amounts remaining in his or her DCAP Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year DCAP Amounts") if he or she is a Participant with DCAP coverage that is in effect on the last day of that Plan Year.

• Prior Plan Year DCAP Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year DCAP Amounts may not be used to reimburse Medical Care Expenses.

• Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 8.7 will be reimbursed first from any available Prior Plan Year Health DCAP Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the DCAP is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Dependent Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year DCAP Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year DCAP Amounts will be debited for any reimbursement of Dependent Care Expenses incurred during the Grace Period that is made from such Prior Plan Year DCAP Amounts.

• Claims for reimbursement of Dependent Care Expenses incurred during a Grace Period must be submitted no later than 3 month(s) following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year DCAP Amounts.

Any Prior Plan Year DCAP Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 8.6(b).

8.5 Establishment of DCAP Account

The Plan Administrator will establish and maintain a DCAP Account with respect to each Participant who has elected to participate in the DCAP Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) *Crediting of Accounts.*

A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.*

A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) *Available Amount Is Based on Credited Amount.*

As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements (i.e., it is based on the amount credited to the DCAP Account at a particular point in time). Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

8.6 Forfeiture of DCAP Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year.

The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the DCAP during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

8.7 Reimbursement Claims Procedure for DCAP

(a) *Timing.*

Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.*

A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the 3 month(s) following the close of the Plan Year in which the Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 1 month(s) after the date that eligibility ceases, as described in Section 9.8), setting forth:

• the person(s) on whose behalf Dependent Care Expenses have been incurred;

• the nature and date of the Expenses so incurred;

• the amount of the requested reimbursement;

• the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);

• a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;

• the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 8.4(b); and

• other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request.

(c) *Claims Denied.*

For reimbursement claims that are denied, see the appeals procedure in Article XIII.

8.8 Reimbursements From DCAP After Termination of Participation

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate.

Except as otherwise provided in Section 8.4(f) (regarding certain individuals who may be reimbursed from Prior Plan Year DCAP Amounts for expenses incurred during a Grace Period), the Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or

the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible (or during any Grace Period to which he or she is entitled as provided in Section 7.4(f)), provided that the Participant (or the Participant's estate) files a claim within 1 month(s) after the date that the Participant's employment terminates or the Participant otherwise ceases to be eligible.

8.9 Report to DCAP Participants

On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement (such as Form W-2) showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the DCAP Component, as the Plan Administrator deems appropriate.

ARTICLE IX. RESERVED

ARTICLE X. HIPAA PROVISIONS FOR HEALTH FSA

10.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA. When this health information is provided from the Health FSA to the Employer, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article X:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer shall have access to PHI from the Health FSA only as permitted under this Article X or as otherwise required or permitted by HIPAA.

10.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.

10.3 Permitted Uses and Disclosure of Summary Health Information

The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

10.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 10.5 and obtaining written certification pursuant to Section 10.7, the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration

functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

10.5 Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer shall:

• not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

• shall not knowingly allow the use or disclosure of Protected Health Information that relates to an individual's "reproductive health care" (as defined in 45 C.F.R. §160.103) in violation of 45 C.F.R. §164.502(a)(5)(iii) for either of the following purposes: (i) to conduct a criminal, civil, or administrative investigation into or to impose criminal, civil, or administrative liability against such individual or any involved person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care where such healthcare is lawful under the circumstances in which it is provided; or (ii) to identify such individual or any involved person for the purpose of conducting such investigation or imposing such liability;

• ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health FSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

• not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

• report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

• make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;

• make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

• make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

• make its internal practices, books, and records relating to the use and disclosure of PHI

received from the Health FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with HIPAA's privacy requirements;

• if feasible, return or destroy all PHI received from the Health FSA 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

• ensure that the adequate separation between the Health FSA and the Employer (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health FSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Health FSA any security incident of which it becomes aware.

10.6 Adequate Separation Between Plan and Employer

The Employer shall allow the following persons access to PHI: the Vice President of Human Resources; the Benefits Manager; assistants to the Vice President of Human Resources and the Benefits Manager; Human Resources and payroll staff performing Health FSA functions; the Benefits Committee; the Plan Administrator; and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section 10.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

10.7 Certification of Plan Sponsor

The Health FSA shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR §

164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.5.

ARTICLES XI and XII. RESERVED

ARTICLE XIII. Appeals Procedure

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. The Committee acts on behalf of the Plan Administrator with respect to appeals.

ARTICLE XIV. Recordkeeping and Administration

14.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

14.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

14.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

14.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

14.7 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such

insurance.

14.8 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

14.9 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV. General Provisions

15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits and Section 8.6 with respect to DCAP Benefits, and then by the Employer.

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of FL, to the extent not superseded by the Code or any other federal law.

15.5 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code , the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

15.6 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 this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe

that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

15.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

* * *

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the CITY OF JACKSONVILLE Cafeteria Plan, CITY OF JACKSONVILLE has caused this Plan to be executed in its name and on its behalf, on this 23rd day of October, 20 26.

CITY OF JACKSONVILLE

Employer Signature: Mary DiPerna

Title: Chief, Employee Benefits

Witness
Signature: