

STATE OF NORTH DAKOTA
FLEXCOMP PLAN DOCUMENT

Effective January 1, 2016

TABLE OF CONTENTS

	<u>Page</u>
ARTICLE I. PURPOSE OF PLAN	1
ARTICLE II. DEFINITIONS.....	2
ARTICLE III. ELIGIBILITY AND PARTICIPATION	7
ARTICLE IV. BENEFITS	18
ARTICLE V. FUNDING.....	19
ARTICLE VI. SALARY REDUCTION ELECTIONS.....	21
ARTICLE VII. PAYMENT OF CLAIMS	25
ARTICLE VIII. ADMINISTRATION.....	30
ARTICLE IX. APPEALS PROCEDURE	32
ARTICLE X. AMENDMENT OR TERMINATION OF THE PLAN	33
ARTICLE XI. GENERAL PROVISIONS	34

ARTICLE I. PURPOSE OF PLAN

The purpose of the State of North Dakota FlexComp Plan ("Plan") is to allow eligible Employees to pay medical, dental, vision, group term life, disability and cancer insurance premiums and other medical and dependent care expenses using pre-tax dollars.

The Board (pursuant to North Dakota Century Code Section 54-52-04) has, therefore, adopted the Plan as set forth herein and as amended from time to time, effective January 1, 2016 for the exclusive benefit of those Employees who are eligible to participate.

The Plan is intended to qualify as a cafeteria plan within the meaning of section 125 of the Internal Revenue Code of 1986, as amended and shall be construed in a manner consistent with that Section. The tax implications of this Plan, however, are subject to rulings, regulations and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, the Board does not represent or warrant to any Participant that any particular tax consequence will result from participation in this Plan. By participating in the Plan, each Participant understands and agrees that in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the Plan, the recipient of the benefit will be responsible for those amounts, without contribution from the Board.

This Plan is intended not to discriminate as to eligibility or benefits in favor of the prohibited group under sections 105, 125, and 129 of the Internal Revenue Code.

ARTICLE II. DEFINITIONS

The following words and phrases have the following meaning, unless a different meaning is plainly required by the text:

- 2.01 Board.** “Board” means the North Dakota Public Employees Retirement System (PERS) board.
- 2.02 Benefit Package Option.** “Benefit Package Option” means a qualified benefit under Code section 125(f) that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan.
- 2.03 Benefit Plan.** “Benefit Plan” means the life insurance, medical, dental, vision, cancer insurance and in some cases disability plans and any alternate medical coverage under a health maintenance organization approved by the Board.
- 2.04 Code.** “Code” means the Internal Revenue Code of 1986, as amended.
- 2.05 Dependent Care Center.** “Dependent Care Center” means any facility which:
- a. complies with all applicable laws and regulations of the State of North Dakota and unit of local government in which it is located;
 - b. provides care for more than six (6) individuals (other than individuals who reside at the center); and
 - c. receives a fee, payment or grant for providing services for any such individuals (regardless of whether such facility is operated for profit).
- 2.06 Dependent Child.** Except as otherwise stated herein, “Dependent Child” means a child who is the Participant’s “qualifying child” or “qualifying relative” as those terms are defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) and subject to the special rule in Code section 152(e) for divorced or separated parents. For purposes of payment of the Pre-Tax Premiums to a Benefit Plan, a Dependent Child must also satisfy the criteria for dependent status under the terms of the applicable Benefit Plan.

The following definition of Dependent Child shall apply to the Qualified Health Care Expense account, notwithstanding a child’s eligibility status under a Benefit Plan.

- a. With respect to the Participant’s Qualified Health Care Expense account, a Dependent Child includes an Employee’s child (within the meaning of Code section 152(f)(1)) who has not attained age twenty-seven (27) as of the end of the calendar year.
- b. Under Code section 152(f)(1), a child is the son, daughter, stepson, or stepdaughter of the Employee, and a child includes both a legally adopted individual of the Employee and an individual who is lawfully placed with the Employee for legal adoption by the Employee.

- c. A child also includes an “eligible foster child,” defined as an individual who is placed with the Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Other than the foregoing conditions, a Dependent Child need not satisfy any other age limit, student status, residency, support or other test in order to be eligible for coverage and reimbursement of Qualified Health Care Expenses.

Notwithstanding the foregoing, a child named in a qualified medical child support order (QMCSO) as defined in section 609 of the Employee Retirement Security Income Act (ERISA) shall be a Dependent Child to the extent specified in the QMCSO. The preceding sentence applies only to the Pre-Tax Premiums for a Benefit Plan and the Qualified Health Care Expense accounts under this Plan.

2.07 Earned Income. “Earned Income” means earned income as set forth in Code section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

2.08 Employee. “Employee” means employees of the State of North Dakota and district health units that are eligible to participate in the Plan. In addition, members of the Legislative Assembly are considered employees and eligible to participate in the Plan. Employees of higher education and political subdivisions are excluded from participation in the Plan.

Eligible employees who are eighteen (18) years of age, whose services are not limited in duration, who are filling an approved and regularly funded position, and who are employed at least seventeen and one-half (17 ½) per week and at least five (5) months each year, or those first employed after August 1, 2003 who are employed at least twenty (20) hours per week and at least twenty (20) weeks each year, are eligible to participate in the Plan.

2.09 Employer. “Employer” means the State of North Dakota, excluding higher education, and any participating district health units as defined in Section 54-52.3-01 of the North Dakota Century Code.

2.10 Grace Period. “Grace Period” shall mean the period that begins immediately following the close of a Plan Year and ends on the day that is two (2) months plus fifteen (15) days following the close of that Plan Year.

2.11 Health Care Expense. “Health Care Expense” means expenses incurred by a Participant, payment of which is reimbursable under Code section 105. For over-the-counter (OTC) drugs and medicines (other than insulin) which are for medical care as defined in Code section 213(d) will not be reimbursable as a Health Care Expense unless the Participant, Spouse or Dependent Child has a prescription for such drug or medicine. However, OTC products that are not considered drugs or medicines continue to be reimbursable if the product is for medical care as defined in Code section 213(d) and is not merely for good health or for cosmetic purposes.

2.12 Health Savings Account (HSA). “Health Savings Account” or “HSA” means a health savings account established under Code section 223 as an individual trust or custodial

account, each separately established and maintained by an Employee with a qualified trustee or custodian.

- 2.13 **Participant.** “Participant” means an eligible Employee who is participating in the Plan.
- 2.14 **Plan.** “Plan” means the State of North Dakota FlexComp Plan, as set forth herein.
- 2.15 **Plan Administrator.** “Plan Administrator” means the North Dakota Public Employees Retirement System (PERS) with the authority and responsibility to manage and direct the operation and administration of the Plan. Plan Administrator includes any designated agent to which specified administrative functions under the Plan have been delegated, to the extent of such delegation.
- 2.16 **Plan Year.** “Plan Year” means a twelve (12) consecutive month period beginning January 1 and ending December 31.
- 2.17 **Pre-tax Premium(s).** “Pre-tax Premium(s)” means the cost of life, disability, medical, dental, vision and cancer insurance under the Benefit Plan which a Participant is required, as a condition for coverage, to defray. The amount of the Pre-tax Premium(s) under the Benefit Plan shall be approved by the Board in accordance with the Board’s policies that are applied to all Employees in a consistent manner.
- 2.18 **Qualified Beneficiary.** “Qualified Beneficiary” means an individual who, on the day before a Qualifying Event defined in Section 2.21, is a Spouse or Dependent Child of a Participant. A person who becomes a new Spouse of an existing Qualified Beneficiary during a period of continuation coverage is not a Qualified Beneficiary.

In the case of a Qualifying Event described in section 2.21, subsection b., (termination of coverage due to termination of employment or reduction in hours), Qualified Beneficiary means an individual, who on the day before such Qualifying Event, is a Participant.

A newborn child, adopted child of a Qualified Beneficiary or a child placed for adoption with a Qualified Beneficiary who was not a covered Employee will be entitled to the same continuation coverage period available to the Qualified Beneficiary, however, such child shall not become a Qualified Beneficiary. A newborn child of a Qualified Beneficiary or child placed for adoption with a Qualified Beneficiary who was a covered Employee shall become a Qualified Beneficiary in his/her own right and shall be entitled to benefits as a Qualified Beneficiary. A child of a covered Employee who is receiving benefits under the Plan because of a qualified medical child support order (QMCSO), as defined in ERISA section 609, during the Employee’s period of employment, is entitled to the same continuation rights under Section 3.07 as an eligible child.

A Qualified Beneficiary must notify the Board within thirty (30) days of the child’s birth, adoption or placement for adoption in order to add the child to the continuation coverage.

- 2.19 **Qualified Dependent Care Expense.** “Qualified Dependent Care Expense” means any employment-related dependent care expense eligible for reimbursement under the Plan as determined under Code sections 129(e)(1) and 21(b)(2). Such expense includes

amounts paid for household services and for the care of Qualifying Individuals enabling the Employee to be gainfully employed.

2.20 Qualified Health Care Expense. “Qualified Health Care Expense” means any Health Care Expense which is not otherwise reimbursable under the Benefit Plan or other plan or entity, but not including any Pre-tax Premium or the premiums paid for any other health insurance coverage.

2.21 Qualifying Event. “Qualifying Event” means any of the following with respect to continued participation in the Qualified Health Care Expense accounts or Benefit Plan under Section 3.07:

- a. termination of coverage due to the death of a Participant.
- b. termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a Participant.
- c. the divorce or legal separation of a Participant from his/her Spouse.
- d. a Participant’s commencement of entitlement to Medicare coverage during an eighteen (18) month continuation period.
- e. a Dependent Child ceasing to be a Dependent Child.

2.22 Qualifying Individual. “Qualifying Individual” means, for purposes of a Qualified Dependent Care Expense account, any individual who is:

- a. the Participant’s “qualifying child” as defined in Code section 152(c) and who has not attained age thirteen (13); or
- b. the Participant’s “qualifying child” or “qualifying relative” as defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof), who (i) is physically or mentally incapable of caring for himself or herself; and (ii) has the same principal place of abode as the Participant for more than one-half of the Plan Year; or
- c. the Participant’s Spouse if the Spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of the Plan Year.

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

2.23 Salary Reduction Agreement. “Salary Reduction Agreement” means a written agreement by a Participant to reduce his/her salary or wage to pay for applicable Pre-tax

Premiums or to fund a Qualified Health Care Expense account or Qualified Dependent Care Expense account.

2.24 **Spouse.** “Spouse” means the legal spouse of a Participant but shall not include an individual legally separated from a Participant under a decree of divorce or of separate maintenance. No later than June 26, 2015, for all purposes under this Plan, the term “Spouse” shall include an individual married to a person of the same sex if the individual was lawfully married to a Participant under applicable laws, and the term “marriage” shall include such a marriage between individuals of the same sex that was validly entered into in a state whose laws authorize the marriage of two individuals of the same sex regardless of where such individuals are domiciled.

2.25 **Student.** “Student” means an individual who, during each of five (5) calendar months during a taxable year is a full-time student at an educational institution which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

- 3.01 **Eligibility.** All Employees eligible to participate in the Benefit Plan are eligible to participate in the Plan for purposes of payment of Pre-tax Premiums under section 4.01. All Employees are eligible to participate in the Plan for purposes of payment of eligible Qualified Health Care Expenses under Section 4.02, except that an Employee with any contributions to a Health Savings Account in a Plan Year cannot participate in the Qualified Health Care Expense Account portion of the Plan for such Plan Year. All Employees are eligible to participate in the Plan for purposes of payment of work-related Qualified Dependent Care Expenses under Section 4.03.

An Employee must be eligible on the first day of the Plan Year to be a Participant in the Plan on that day. Employees who become eligible during the Plan Year shall be allowed to participate the first day of the month following their permanent full-time employment. However, the election period will be extended sixty (60) days from a new Employee's date of hire. An election during the extended sixty (60) day period will not be effective until the first contribution is received.

- 3.02 **Participation.** Participation is established on a Plan Year to Plan Year basis. Each eligible Employee shall be a Participant in the Plan for a Plan Year as follows:

- a. For purposes of receiving Pre-tax Premium benefits under Section 4.01, participation will become effective when the appropriate Salary Reduction Agreement has been submitted as outlined in Article VI.

For the purpose of receiving employee supplemental life insurance Pre-Tax Premium benefits, participation will be automatic unless an employee elects not to participate under this Plan for the Plan Year for the purpose of Pre-Tax Premium. An Employee who is eligible to participate may elect not to participate by completing and submitting an appropriate declination form with the Employer within the election period established by the Board. An Employee who elects not to participate with regard to payment of Pre-tax Premiums for life insurance shall pay for such Pre-tax Premiums for life insurance under the Benefit Plan on an after-tax basis.

- b. For purposes of receiving reimbursement for Qualified Health Care Expenses and/or Qualified Dependent Care Expenses, participation will begin when the appropriate Salary Reduction Agreement(s) have been submitted and become effective under Article VI.

A Participant's Salary Reduction Agreement shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year.

- 3.03 **Changes in Participation Status.** With respect to the Benefit Plan, Qualified Health Care Expense accounts, and Qualified Dependent Care Expense accounts, a Participant may revoke or amend participation in the Plan during a Plan Year only on account of and consistent with a change in status or other circumstances allowed under applicable law or regulation.

Unless otherwise specified, a revocation or amendment of participation must be made within sixty (60) days after the change in status occurs and will be effective for the balance of the Plan Year in which the election is made, beginning with the first appropriate pay period after the election is received.

A Participant reducing his/her election, based on a change in status, cannot reduce his/her Salary Reduction Agreement election to the point where his/her contributions to a Qualified Health Care Expense account or a Qualified Dependent Care Expense account for the Plan Year are less than the amount already reimbursed for that Plan Year.

- a. Change in Status Events. *(Applies to the Benefit Plan, Qualified Health Care Expense accounts and Qualified Dependent Care Expense accounts.)*
 1. Change in the Participant's legal marital status, including marriage, divorce, death of Spouse, legal separation, or annulment.
 2. Change in number of the Participant's dependents under Code section 152, including birth, adoption, placement for adoption, or death.
 3. Change in the employment status of the Participant, Spouse, or Dependent Child, including the following:
 - (a) Termination or commencement of employment.
 - (b) A reduction or increase in hours of employment by the Employee, the Employee's Spouse or the Employee's Dependent Child, including a switch between part-time and full-time status or commencement of or return from an unpaid leave of absence.
 - (c) A change in employment status that results in the Participant, Spouse, or Dependent Child becoming or ceasing to be eligible for benefits under the individual's plan (such as switching from part-time to full-time or from full-time to part-time employment status).
 - (d) Any situation where the Employee, the Employee's Spouse or the Employee's Dependent Child has special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described in Section 3.04.
 4. Dependent Child satisfies (or ceases to satisfy) dependent eligibility requirements, such as attainment of age, Student status or any similar circumstances as provided under the Benefit Plan.
- b. Change in Residence. *(Applies to the Benefit Plan only.)* A change in residence of the Employee, Spouse, or Dependent Child is considered a status change event. An election change is permissible if the change in residence affects the Participant's eligibility for coverage.
- c. Change in Cost. *(Applies to the Benefit Plan and the Dependent Care Expense accounts.)* A Participant may make election changes as a result of changes in cost under the following circumstances:

1. If the cost of a qualified benefits plan increases (or decreases), the Plan may automatically make a prospective increase (or decrease) in Employee contributions for the Plan.
2. If the cost of a Benefit Package Option significantly increases or significantly decreases, a Participant may make a prospective increase or decrease in payments or revoke his/her election and, in lieu thereof, choose another Benefit Package Option providing similar coverage, prospectively. This paragraph only applies in the case of a dependent care assistance plan if the cost change is imposed by a dependent care provider who is not a relative of the Employee.

For purposes of a dependent care assistance program, a change in provider is a significant change in coverage similar to a Benefit Package Option becoming available, and may permit an election change under this Section 3.03.

- d. Change in Coverage. (*Applies to the Benefit Plan.*) A Participant may make election changes as a result of changes in coverage under the following circumstances:

1. If the coverage under the Benefit Plan is significantly curtailed without a loss of coverage, a Participant may revoke his/her election for that coverage. The Participant may make a new prospective election of coverage under another Benefit Package Option providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to Participants under the Benefit Plan so as to constitute reduced coverage to Participants generally.

If the coverage under the Benefit Plan is significantly curtailed and a loss of coverage occurs, a Participant may revoke his/her election. The Participant may make a new prospective election of coverage under another Benefit Package Option providing similar coverage or to drop coverage if no similar Benefit Package Option is available. A loss of coverage means a complete loss of coverage under the Benefit Package Option, or other coverage option, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation.

2. If the Benefit Plan adds a new Benefit Package Option or improves a Benefit Package Option, or other coverage option (or eliminates an existing option) a Participant may elect the newly added option (or elect another option if an option has been eliminated) prospectively and may make corresponding election changes with respect to other Benefit Package Options providing similar coverage. The Plan may permit eligible Employees who have not previously made an election to make an election on a prospective basis for coverage under a new or improved Benefit Package Option.

- e. With the exception of Qualified Health Care Expense accounts, a Participant may make a prospective election change under subsection c. or d. of this Section 3.03 that is on account of and corresponds with a change made under another employer plan, including a plan of the same employer or of another employer, if:

1. the other plan permits the Participant to make an election change that would be permitted under federal regulations; or
 2. the plan permits Participants to make an election for a period of coverage that is different from the period of coverage under this Plan.
- f. A Participant may make an election change on a prospective basis to add coverage under a Benefit Plan for the Employee, Spouse or Dependent Child if the Employee, Spouse or Dependent Child loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following:
1. a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act;
 2. a medical care program of an Indian Tribal government (as defined in Code section 7701(a)(40)), the Indian Health Service, or a tribal organization;
 3. a state health benefits risk pool; or
 4. a foreign government group health plan.
- g. Judgement, Decrees and Orders. (*Applies to the Benefit Plan and Qualified Health Care Expense accounts.*) In the case of a Benefit Plan that provides health or accident coverage, and for Qualified Health Care Expense accounts, a Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:
1. if a judgment, decree, or order (collectively, "Order") results from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order (QMCSO) defined in ERISA section 609) that requires accident or health coverage for an Employee's Dependent Child or for a foster child who is a dependent of the Employee; and
 2. the Employee changes his/her election to provide coverage for the Dependent Child or foster child if the Order requires coverage under the Employee's plan; or
 3. the Employee changes his/her election to revoke coverage for the Dependent Child or foster child if the Order requires the former spouse to provide coverage.
- h. Entitlement to Medicare and Medicaid. (*Applies to the Benefit Plan and Qualified Health Care Expense accounts.*) In the case of a Benefit Plan that provides health or accident coverage, and for Qualified Health Care Expense accounts, a Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:
1. if the Employee, Spouse, or Dependent Child becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage

consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); and

2. if the Employee changes his/her election to revoke coverage for that Employee, Spouse or Dependent Child under the Benefit Plan or Qualified Health Care Expense account.
- i. Consistency Rules Applicable to Change in Status Events. A Participant's mid-year election change under this Section 3.03 satisfies the requirements of the consistency rule if the election change is on account of and corresponds with a change in status event that affects the Participant's, Spouse's or Dependent Child's eligibility or loss of eligibility for coverage under an employer's plan.

If the change in status event is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent Child, or a Dependent Child ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel insurance coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent Child, or the Dependent Child that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances fails to correspond with the change in status event.

If a Participant, Spouse or Dependent Child gains eligibility for coverage under a cafeteria plan or qualified benefits plan of the employer of the Spouse or Dependent Child 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 other plan. The Plan may rely on the Participant's certification that such individual has obtained or will obtain coverage under the other plan unless the Plan has reason to believe that the Participant's certification is incorrect.

Notwithstanding the foregoing, for purposes of the Qualified Dependent Care Expense account, a Participant's mid-year election change under Section 3.03 satisfies the requirements of the consistency rule if the election change is on account of and corresponds with a change in status event that affects:

1. The Participant's, Spouse's or Dependent Child's eligibility for coverage under an employer's plan; or
2. Expenses described in Code section 129 (including employment-related expenses as defined in Code section 21(b)(1) with respect to dependent care assistance.

The Plan Administrator, in its sole discretion, shall determine, based on the surrounding facts and circumstances and prevailing Internal Revenue Service guidance, whether a requested change is on account of and corresponds with a change in status event.

- 3.04 HIPAA Special Enrollment Rights.** *(Applies to Benefit Plan only.)* A Participant may make a change to an annual election in the middle of a Plan Year if the change corresponds to a special enrollment event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Code section 9801(f), whether or not the change is permitted under any other section of this Plan as follows:

- a. Acquisition of a new Spouse or Dependent Child as a result of marriage, birth, adoption or placement for adoption; or
- b. Loss of eligibility under another group health plan or other health insurance by anyone who would otherwise be eligible under this Plan, including for (but not limited to) the following reasons:
 - 1. Voluntary or involuntary termination of employment or reduction in hours of employment, or death, divorce or legal separation, cessation of dependent status, or
 - 2. Loss of coverage through an HMO that does not provide benefits to individuals who do not reside, live or work in the service area, or
 - 3. Termination of employer contributions toward that other coverage, or
 - 4. If the other coverage was COBRA continuation coverage and the coverage was exhausted.
- c. Loss of eligibility for coverage under Title XIX of the Social Security Act (Medicaid) or under Title XXI of the Social Security Act that is coverage under a state children's health insurance program (SCHIP) or becoming eligible for a premium assistance subsidy from Medicaid or SCHIP.
- d. For individuals losing other coverage, an Employee may revoke participation in a Benefit Plan and make a new election if the Employee is eligible, but not enrolled, for coverage under the terms of the Benefit Plan (or a Spouse or Dependent Child of such an Employee if the Spouse or Dependent Child is eligible, but not enrolled, for coverage); and
 - 1. The Employee, Spouse or Dependent Child was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Employee.
 - 2. The Employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment.
 - 3. The Employee's, Spouse's or Dependent Child's coverage under a group health plan or health insurance was under a COBRA continuation provision and the coverage under such provision was exhausted, or not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or the Employer contributions towards such coverage were terminated.

Under this subsection d., a revocation or amendment of participation must be made within thirty (30) days after the date of exhaustion of coverage described in paragraph 1. or the termination of coverage or Employer contribution described in paragraph 3. and will be effective for the balance of the Plan Year in which the election is made, beginning on the first day of the month following the month in which the election is made.

- e. For acquisition of a Spouse or Dependent Child, a Participant may revoke participation in a Benefit Plan and make a new election if the individual is a Participant under the Benefit Plan (or has met any waiting period applicable to becoming a Participant under the Plan and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period); and
 - 1. A person becomes a Spouse or a Dependent Child of the Participant through marriage, birth, or adoption or placement for adoption, and
 - 2. The Participant elects to enroll himself/herself, the Spouse, and/or the Participant's Dependent Child or Children in the Plan, to the extent that the Spouse or Dependent Children are otherwise eligible for coverage.

Under this subsection e., a revocation or amendment of participation must be made within thirty (30) days after the date dependent coverage is made available or the date of the marriage, birth, or adoption or placement for adoption and will be effective for the balance of the Plan Year in which the election is made, and in the case of marriage, beginning with the first appropriate pay period after the election is received; or in the case of a Dependent Child's birth, as of the date of such birth; or in the case of a Dependent Child's adoption or placement for adoption, the date of such adoption or placement for adoption.

- f. An election change on account of birth, adoption or placement for adoption will be effective retroactive to the date of birth, adoption or placement for adoption, provided the request to change the annual election is made within thirty (30) days of the birth, adoption or placement for adoption. Except as otherwise provided for herein, election changes for other special enrollment events (e.g., marriage or loss of other health coverage) will be effective as soon as practicable once a request for such election changes has been received, provided the request to change the annual election is made within sixty (60) days of the event.
- g. Retroactive coverage of a newly acquired Dependent Child on account of birth, adoption or placement for adoption applies to the premium payment of Benefit Costs under section 4.01 and Qualified Health Care Expense accounts, but not to the Qualified Dependent Care Expense accounts. The effective date of coverage of a new Spouse or Dependent Child under the Qualified Dependent Care Expense account in accordance with Section 3.03 will be prospective for the balance of the Plan Year beginning as soon as practicable after the date the new benefit election form and Salary Reduction Agreement are received by the Plan Administrator.

- h. Payroll changes made in accordance with special enrollment under this Section 3.04 will be effective with the first pay period following approval of a request to change a salary reduction election amount even if the effective date of a Dependent Child's coverage is retroactive.

3.05 Additional Election Change Pursuant to IRS Notice 2014-55. *(Applies to the Benefit Plan only.)* An Employee who is eligible to enroll in a government sponsored exchange (marketplace coverage) during a marketplace special enrollment or open enrollment period may drop Benefit Plan coverage midyear, but only if the change corresponds to the Employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in marketplace coverage that is effective no later than the day after the last day of the original coverage. This means that Benefit Plan coverage is not to be terminated until marketplace coverage takes effect.

3.06 Termination of Participation.

- a. Pre-tax Premium(s). Participation with regard to Pre-tax Premium(s) provided under this Plan during a Plan Year terminates on the first to occur of the following:
 - 1. the end of the month following the month of termination of employment;
 - 2. the date the applicable Salary Reduction Agreement is revoked;
 - 3. the date the Plan is terminated; or
 - 4. the date of a change in employment status from permanent to temporary.
- b. Qualified Health Care Expenses. Participation with regard to Qualified Health Care Expenses provided under this Plan during a Plan Year terminates on the first to occur of the following:
 - 1. the last day of month in which a Participant ceases to be an Employee;
 - 2. the date the applicable Salary Reduction Agreement is revoked;
 - 3. the date the Plan is terminated; or
 - 4. the date of a change in employment status from permanent to temporary.
- c. Qualified Dependent Care Expenses. Participation with regard to Qualified Dependent Care Expenses provided under this Plan during a Plan Year terminates on the first to occur of the following:
 - 1. upon exhaustion of the account balance during the Plan Year in which the Employee ceases employment;
 - 2. the date the applicable Salary Reduction Agreement is revoked;

3. the date the Plan is terminated; or
4. the date of a change in employment status from permanent to temporary.

Notwithstanding any provision of the Plan to the contrary, a former Participant shall be entitled to submit a request for reimbursement of Qualified Health Care Expenses, in accordance with Article VII, as if he/she were a Participant, provided such Qualified Health Care Expenses were incurred while the former Participant participated in the Plan.

If participation terminates because the Participant ceases to be an Employee and the individual returns to eligible employment with the Employer in the same Plan Year within thirty (30) days of return to work, and without any other intervening event that would permit a Participant to revoke or amend participation, then the Employee will be required to take the same benefit election for the remaining portion of the Plan Year as he/she had before he/she terminated. Participation shall be effective the first of the month following such election.

If the individual returns to employment, with the Employer, after more than thirty (30) days he/she will not be eligible to participate in the Pre-tax Premium benefit, the Qualified Health Care Expense account or the Qualified Dependent Care Expense account for the remainder of the Plan Year.

Notwithstanding any provisions of the Plan to the contrary, a former Participant who is a Qualified Beneficiary may elect to continue coverage for Qualified Health Care Expenses by submitting the required self-payment premiums as set forth in Section 3.07.

3.07 Continuation Coverage.

- a. Eligibility. A Qualified Beneficiary may continue coverage under this Section 3.07 by making election to do so with the Employer and submitting the applicable self-payment contribution, subject to all conditions and limitations under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The amount of the monthly self-payment contribution will be established by the Plan Administrator and will be paid on an after-tax basis on a uniform and consistent basis. However, Employees who elect COBRA are permitted to pre-tax the COBRA premiums and pre-pay such premiums through the end of the current Plan Year from their final paychecks.
- b. Maximum Self-Payment Period. A Qualified Beneficiary may elect continuation coverage because of a Qualifying Event described in Section 2.21 only for the remainder of the Plan Year in which the Qualifying Event occurs.
- c. Procedures to Elect Self-Payment for Continuation Coverage.
 1. In the case of a Qualifying Event described in Section 2.21, a., b., or d., (death, termination of employment or reduction in hours, or the Employee's entitlement to Medicare) a Qualified Beneficiary will receive information concerning continuation coverage, including the self-payment rates, within forty-four (44) days of loss of coverage.

2. In the case of a Qualifying Event as described in Section 2.21, c. or e., (legal separation or divorce, or a child no longer qualifies as a Dependent Child) a Qualified Beneficiary must notify the Plan Administrator within sixty (60) days of the Qualifying Event. If notice is not received within sixty (60) days of the Qualifying Event, the Qualified Beneficiary will not be eligible for continuation coverage.

Following receipt of timely notice of a Qualifying Event and within fourteen (14) days of receipt of such notice, the Plan Administrator will provide the Qualified Beneficiary with information concerning continuation coverage and rates.

3. After notification of continuation coverage, the Qualified Beneficiary will have sixty (60) days to elect continuation coverage, after the **later** of:
 - (a) the date that the Qualified Beneficiary would lose coverage on account of the Qualifying Event; or
 - (b) the date that the Qualified Beneficiary is sent such notice.

If a Qualified Beneficiary chooses to waive coverage, a waiver of continuation coverage will be effective on the date that the waiver is received by the Plan Administrator.

A Qualified Beneficiary who, during the election period, waives continuation coverage can revoke the waiver at any time before the end of the election period. However, if a Qualified Beneficiary who waives continuation coverage later revokes the waiver, coverage will be effective on the date that the revocation of the waiver and election to continue is received by the Plan Administrator.

4. The first monthly payment (which will include premiums for all months since coverage terminated) must be received by the Plan Administrator within forty-five (45) days of the date the Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first day of the month for which coverage is elected, and shall be considered timely if received within thirty (30) days of the date due.
5. If premiums are not received in a timely manner, coverage will terminate. No claims will be paid until premium payment is received by the Plan Administrator in accordance with paragraph 4. above.
6. The election must specify which Qualified Beneficiaries are electing COBRA continuation coverage. If it does not specify the Qualified Beneficiaries, the election shall be deemed to be an election on behalf of all Qualified Beneficiaries.

d. Termination of Continuation Coverage. Continuation coverage as provided under this section will terminate on the **earliest** of the following dates, as applicable:

1. the date after election of continuation coverage that the Qualified Beneficiary first becomes covered under any other group medical coverage as an employee or dependent. In the event such other group medical coverage has a pre-existing condition clause or limitation, continuation

coverage will not terminate until exhaustion of the maximum period continuation coverage is allowed unless the pre-existing condition clause or limitation does not apply to the Qualified Beneficiary or is satisfied by the Qualified Beneficiary by reason of the provisions of Code section 9801.

2. the end of the period for which the last payment was made for coverage in a timely manner.
3. the end of the Plan Year in which the Qualifying Event occurs.
4. the date the Qualified Beneficiary becomes entitled to Medicare.
5. under any circumstance where a non-COBRA beneficiary would have benefits terminated for cause (e.g., fraud).
6. the date the Board ceases to provide any group health plan.

3.08 Death of a Participant. With respect to Qualified Dependent Care Expenses, if a Participant dies, his/her participation in the Plan shall cease. However, such Participant's estate (or the Participant's heirs, if there is no estate) may submit claims for expenses incurred prior to the Participant's death for the remainder of the Plan Year or until the account balance is exhausted.

With respect to Qualified Health Care Expenses, if a Participant dies, his/her participation in the Plan shall cease on the last day of such month. However, there are two ways for a deceased Participant's family members to access the money in the Participant's Qualified Health Care Expense account. Such Participant's estate (or the Participant's heirs, if there is no estate) may submit claims for expenses incurred prior to the Participant's death for the remainder of the Plan Year. In addition, a Qualified Beneficiary may be eligible to elect COBRA continuation coverage in accordance with Section 3.07 and obtain reimbursement for their own health care expenses incurred after the Participant's death through the end of the Plan Year.

ARTICLE IV. BENEFITS

- 4.01 **Pre-tax Premium(s)**. The Pre-tax Premium(s) of a Participant for the Benefit Plan shall be paid by the Employer subject to the provisions of Section 5.01.
- 4.02 **Qualified Health Care Expenses**. The Plan Administrator or designated agent shall reimburse a Participant for Qualified Health Care Expenses incurred by the Participant or the Participant's Spouse or Dependent Child in accordance with the provisions of Section 5.02. Reimbursement for Qualified Health Care Expenses during a Plan Year is limited to the annualized amount directed by the Participant to the Qualified Health Care Expense account under a valid Salary Reduction Agreement. The annual amount elected by the Participant for a Qualified Health Care Expense account under a valid Salary Reduction Agreement shall be available at all times during the applicable period of coverage regardless of the actual amount credited to the Participant's Qualified Health Care Expense account. An Employee who is enrolled in a High Deductible Health Plan with contributions to a Health Savings Account cannot participate in the Qualified Health Care Expense account portion of this Plan.
- 4.03 **Qualified Dependent Care Expenses**. The Plan Administrator or designated agent shall reimburse a Participant for Qualified Dependent Care Expenses in accordance with the provisions of Section 5.03. Reimbursement for Qualified Dependent Care Expenses during a Plan Year is limited to the amount of expenses incurred, not to exceed the amount in the Participant's account at the time a claim is made.
- 4.04 **Determination of Noncompliance**. It is the intent of this Plan to provide a benefits plan that is nondiscriminatory and which provides benefits to a classification of Employees while not discriminating in favor of any group, as set forth in Code section 125. In the event that a determination is made that all or any part of the contributions to the Plan do not qualify as non-taxable contributions to a "cafeteria plan" or a "dependent care assistance program" under Code sections 125 and 129, the affected contributions made by any Participant shall be treated as salary and, to the extent not yet expended, returned to such Participant. The Participant shall pay:
- a. any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed thereon;
 - b. the Participant's share (as determined in good faith) of any applicable FICA contributions which would have been withheld from such amounts, had such amounts been treated as salary and not as Qualifying Dependent Care Expenses or Qualified Health Care Expenses; and
 - c. an amount (as determined in good faith) equal to the portion of any applicable penalties and interest payable as the result of the failure to withhold and pay such amounts to the appropriate payee allocable to the Participant.

ARTICLE V. FUNDING

5.01 Funding of Pre-tax Premium(s). In return for the Employer payment of a Participant's Pre-tax Premium(s) under Section 4.01, the Participant agrees to reduce the Participant's salary or wage each month by the amount of the Pre-tax Premium(s) under the Benefit Plan under a Salary Reduction Agreement. The premium amounts paid under the Salary Reduction Agreement will be adjusted during a Plan Year to reflect changes in the Pre-tax Premium(s).

5.02 Funding of Qualified Health Care Expense Account.

- a. Qualified Health Care Expenses shall be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year under a valid Salary Reduction Agreement.
- b. A Participant's salary or wage may be reduced under this Section 5.02 in an amount not to exceed \$2,500, as adjusted in accordance with Code section 125(i) to the extent such adjustment is approved by the Board.
 1. The salary reduction amount so elected shall be funded prorata over the number of consecutive pay periods in the Plan Year. The salary reduction amount for any single pay period may not exceed the amount of the Participant's salary or wage for that period. Salary reduction amounts for a pay period shall be reduced by the amount it exceeds the Participant's salary or wage for that period.
 2. For members of the Legislative Assembly, the salary reduction amount may vary per pay period however, the total amount of salary reduction must equal the annual election amount.
- c. The Plan Administrator or designated agent shall establish individual Qualified Health Care Expense accounts for each Participant and shall credit to each Participant's account salary reduction amounts elected under this Section 5.02. The Plan Administrator or designated agent shall reimburse Participants for Qualified Health Care Expenses in accordance with Article VII.

5.03 Funding of Qualified Dependent Care Expense Account.

- a. Qualified Dependent Care Expenses may be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year under a valid Salary Reduction Agreement, not to exceed the amount in the Participant's account at the time reimbursement is required.
- b. A Participant's salary or wage may be reduced under this Section 5.03 in an amount not to exceed \$5,000 (\$2,500 if the employee is married, but filing separately) for each Plan Year.
 1. The salary reduction amount so elected shall be funded prorata over the number of consecutive pay periods in the Plan Year. The salary reduction

amount for any single pay period may not exceed the amount of the Participant's salary or wage for the pay period. Salary reduction amounts for a pay period shall be reduced by the amount it exceeds the Participant's salary or wage for that period.

2. For members of the Legislative Assembly, the salary reduction amount may vary per pay period however, the total amount of salary reduction must equal the annual election amount.
- c. The Plan Administrator or designated agent shall establish individual Qualified Dependent Care Expense accounts for each Participant and shall credit to each Participant's account salary reduction amounts elected under this Section 5.03. The Plan Administrator or designated agent shall reimburse Participants for Qualified Dependent Care Expenses in accordance with Article VII.

5.04 Accounting. The Plan Administrator or designated agent shall maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of Qualified Health Care Expenses or Qualified Dependent Care Expenses on behalf of any Participant for six (6) years as required under ERISA and federal tax law.

ARTICLE VI. SALARY REDUCTION ELECTIONS

6.01 Election Period for Salary Reduction.

- a. In order to fund a Qualified Health Care Expense account or a Qualified Dependent Care Expense account for a Plan Year, a Participant must complete and submit to the Plan Administrator an appropriate Salary Reduction Agreement election form within the applicable election period.
- b. An Employee who is eligible to participate in the salary reduction for Pre-tax Premium(s) must complete and submit to the Plan Administrator an appropriate Salary Reduction Agreement form within the applicable election period.
- c. For the purpose of employee supplemental life insurance Pre-tax Premium benefits, an employee may elect not to participate by completing an appropriate Salary Reduction Agreement declination form within the applicable election period.

6.02 Termination, Revocation, or Amendment of Salary Reduction Elections.

- a. A Participant's Salary Reduction Agreement election for a Plan Year shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year. Failure to make such an election will result in waiving participation for a Qualified Health Care Expense account or a Qualified Dependent Care Expense account and any applicable Pre-tax Premium paid to the Employer on an after-tax basis.
- b. The employee supplemental life insurance Pre-tax benefits will be automatic unless an Employee declines this action.
- c. Termination, revocation or amendment of salary reduction elections may only be made by a Participant in accordance with Article III.

6.03 Limitations on Exclusion from Gross Income for Dependent Care Expense Account.

- a. Reimbursements under the Plan for Qualified Dependent Care Expenses shall be excluded from the gross income of a Participant during a Plan Year in accordance with Code section 129. An Employee's exclusion from gross income under the Plan in a calendar year shall not exceed:
 1. \$5,000 if the Employee is married and filing a joint return or if the Employee is a single parent (\$2,500 if the employee is married, but filing separately); or
 2. in the case of an Employee who is not married at the close of such Plan Year, the Earned Income of such Employee for such Plan Year; or

3. in the case of an Employee who is married at the close of such Plan Year, the lesser of the Earned Income of such Employee or the Earned Income of the Spouse of such Employee for such Plan Year.

To the extent reimbursements exceed the maximum amount excludable from a Participant's gross income, the reimbursements shall be treated as taxable income to the Participant.

- b. The amount excluded from the income of an Employee under the Plan for any Plan Year shall not include:
 1. payments made or incurred to an individual who can be claimed as a Dependent Child of the Employee or the Spouse of such Employee; or
 2. payments made or incurred to an individual who is a child, under the age of nineteen (19), of such Employee or the Spouse of such Employee.

6.04 Forfeiture of Salary Reduction Amounts.

- a. If a Participant fails to claim any amounts in the Qualified Health Care Expense account or Qualified Dependent Care Expense account by the time allowed in Section 7.04, d., and Section 7.05, d., such amounts shall not be carried over to reimburse the Participant for expenses incurred during a subsequent Plan Year and rights to such amounts shall be forfeited by the Participant.
- b. All forfeitures under this Plan shall be used first to offset any losses experienced by the Board during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the premiums paid by such Participant via salary reductions. Second, forfeitures shall be used to reduce the Board's cost of administering this Plan during the Plan Year.

6.05 Amendment of Salary Reduction Elections Due To Leave of Absence, Family and Medical Leave Act (FMLA) or Military Leave.

- a. Benefit Plan and Qualified Health Care Expense Account.
 1. *Leave with taxable compensation.* Pre-tax contributions during a leave may be made if taxable compensation is due to the Participant while on leave of absence, FMLA leave, or military leave.
 2. *Leave without taxable compensation.* An unpaid leave of absence will be considered a change in status, and the Participant may amend salary reduction elections to be consistent with the change in status.
 3. *FMLA.* A Participant commencing a qualifying leave under FMLA may, to the extent required by the FMLA, continue to maintain coverage under the Benefit Plan and Qualified Health Care Expense Account under the terms and conditions set forth hereafter. For leaves of absence and leaves under FMLA, if no coverage during leave is elected and the Participant returns to active work during the same Plan Year, and the salary reduction election

has not been amended, as provided in 6.05, a., 2., then the same election the Participant had before the leave must be maintained for the remainder of the Plan Year upon return from the leave.

- (a) *“Pre-pay option”*: A Participant may make pre-tax contributions by increasing his/her salary reduction contributions before taking the leave, but only for the portion of the leave that occurs during the Plan Year.
 - (b) *“Catch-up option”*: Employer will continue coverage during the leave. A Participant must make after-tax contributions after the leave to make up missed contributions.
4. A Participant may elect not to continue coverage during the leave. If the Participant does not make the salary reduction on a pre-tax basis or by after tax contributions described in paragraph 3. above, his/her participation will cease the last day of the month in which a contribution is received. The Participant may submit claims for eligible expenses incurred before participation ended, and will be reimbursed for Qualified Health Care Expenses as described in section 4.02 herein.
5. *USERRA*. If a Participant returns from a qualified military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and commences employment again, he/she may choose to become a Participant and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid or to amend the salary reduction election, as provided in paragraph 2. above, or to elect not to participate for the remainder of the Plan Year.
6. For the Qualified Health Care Expense account, if a Participant revokes coverage upon commencement of the leave and elects to be reinstated upon return from the leave, the Participant has a choice between two options:
- (a) *Full Coverage*: The Participant may maintain the same election the Participant had before the leave and reinstate the level of coverage in effect when the leave began, provided that the Participant makes contributions to reduce his/her salary or wage to fund the Qualified Health Care Expense account for the contributions that were missed during the leave.
 - (b) *Prorated Coverage*: The Participant may reinstate a level of coverage that is reduced by the amount of contributions to reduce his/her salary or wage to fund the Qualified Health Care Expense account that were missed during the leave.

- b. Qualified Dependent Care Expense Account.
1. *Leave with taxable compensation.* Pre-tax contributions during a leave may be made if taxable compensation is due to the Participant while on leave of absence, FMLA leave, or military leave.
 2. *Leave without taxable compensation.* An unpaid leave of absence will be considered a change in status, and the Participant may amend salary reduction elections to be consistent with the change in status.
 3. *FMLA.* A Participant commencing a qualifying leave under FMLA may, to the extent required by FMLA, continue to maintain coverage under the Qualified Dependent Care Expense Account under the terms and conditions set forth hereafter. For leaves of absence and leaves under FMLA, if no coverage during leave is elected and the Participant returns to active work during the same Plan Year, and the salary reduction election has not been amended, as provided in paragraph 2. above, then the same election the Participant had before the leave must be maintained for the remainder of the calendar year upon return from the leave.
 - (a) *"Pre-pay option"*: A Participant may make pre-tax contributions by increasing his/her salary reduction contributions before taking the leave, but only for the portion of the leave that occurs during the Plan Year.
 - (b) *"Catch-up option"*: Employer will continue coverage during the leave. A Participant must make after-tax contributions after the leave to make up missed contributions.
 4. A Participant may elect not to continue coverage during the leave. If the Participant does not make the salary reduction on a pre-tax basis or by after tax contributions described in paragraph 3. above, his/her participation will cease the last day of the month in which a contribution is received. The Participant may submit claims for eligible expenses incurred before participation ended, and will be reimbursed as described in section 4.03 herein. Eligible expenses are only those expenses that enable the Employee or the Employee and the Employee's Spouse to be gainfully employed. Any other expenses would not be reimbursable during the leave of absence period.
 5. *USERRA.* If a Participant returns from a qualified military leave under USERRA and commences employment again, he/she may choose to become a Participant and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid or to amend the salary reduction election, as provided in paragraph 2. above, or to elect not to participate for the remainder of the Plan Year.

ARTICLE VII. PAYMENT OF CLAIMS

- 7.01 **Determination of Status of Eligible Expenses.** After receiving an appropriately submitted claim and the information required under Section 7.04 or Section 7.05, the Plan Administrator shall determine whether such expenses are Qualified Health Care Expenses or Qualified Dependent Care Expenses. The Plan Administrator may delegate the authority to administer claims under the Plan to a designated agent.
- 7.02 **Payment of Claims.** The Plan Administrator will authorize payment of properly submitted claims for reimbursement at such intervals, as it may consider appropriate.
- 7.03 **Expenses.** All administrative expenses incurred prior to the termination of the Plan that arise in connection with the administration of the Plan shall be paid as authorized by the Plan Administrator.
- 7.04 **Claims Reimbursement for Qualified Health Care Expenses.**
- a. The Participant must submit a properly completed claim form to the Plan Administrator or the designated agent along with written evidence from an independent third party describing the Health Care Expense that has been incurred, the person on whose behalf such Health Care Expense has been incurred, the date such expense was incurred, the amount of such expense, and such other information as the Plan Administrator may find necessary.
 - b. The Participant must submit with other required documents a signed statement in such form as determined by the Plan Administrator certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Health Care Expenses.
 - c. The Plan Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Health Care Expenses.
 - d. All claims for reimbursement must be submitted no later than April 30 following the end of the Plan Year in which the expense was incurred.
 - e. Claims reimbursement for Qualified Health Care Expenses using a debit card shall be made in accordance with the terms of the debit card agreement and Proposed Treasury Regulations section 1.125-6 and other applicable IRS rulings.
- 7.05 **Claims Reimbursement for Qualified Dependent Care Expenses.**
- a. To make a claim for reimbursement of Qualified Dependent Care Expenses, the Participant shall submit a statement to the Plan Administrator or the designated agent on an appropriate form adopted by the Plan Administrator which may contain the following information:
 1. the Qualifying Individual(s) for whom the Qualified Dependent Care Expenses were incurred;

2. a statement to substantiate that the dependent or dependents are Qualifying Individuals, such as the age of the dependent or a statement as to the physical or mental capacity of the dependent;
3. the nature of the services which will generate the Qualified Dependent Care Expenses;
4. written evidence from an independent third party stating the expenses have been incurred, the amount of such expense, the date of such expense, and such other information as the Plan Administrator in its sole discretion may request;
5. the name of the person, organization or entity to who the expense was paid, including the taxpayer identification number, and the relationship, if any, of the person performing the services to the Participant;
6. a statement as to where the services were performed;
7. if the services are to be performed in a Dependent Care Center, a statement verifying that each of the requirements for a Dependent Care Center specified in Section 2.05 of the Plan are met;
8. a statement indicating whether the services are necessary to enable the Participant to be gainfully employed;
9. if the Participant is married, a statement:
 - (a) that the Spouse is employed; or
 - (b) if the Spouse is not employed, a statement that he/she is incapacitated or that he/she is a Student within the meaning of Section 2.25 of the Plan.

If an Employee's Spouse is not employed, not incapacitated, nor a Student as defined in Section 2.25, such Employee is not eligible to participate in this Plan; and

10. a statement that the Qualified Dependent Care Expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.
- b. The Participant must submit with other required documents a signed statement in such form as determined by the Plan Administrator or designated agent certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Dependent Care Expenses.
 - c. The Plan Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Dependent Care Expenses.

- d. All claims for reimbursement must be submitted not later than April 30 following the end of the Plan Year in which the expense was incurred.

7.06 Grace Period for Qualified Health Care Expenses. Amounts remaining in a Participant's Qualified Health Care Expense account at the end of a Plan Year can be used to reimburse the Participant for Qualified Health Care Expenses that are incurred during the period that begins immediately following the close of that Plan Year and ends on the day that is two (2) months plus fifteen (15) days following the close of that Plan Year (the "Grace Period") under the following conditions:

- a. Applicability. In order for an individual to be reimbursed for Qualified Health Care Expenses incurred during a Grace Period from amounts remaining in his or her Qualified Health Care Expense account at the end of the Plan Year to which that Grace Period relates, he or she must be either (1) a Participant with Health Care Expense account 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 Care Expense account component on the last day of that Plan Year.
- b. No Cash-Out or Conversion. Prior Plan Year Qualified Health Care Expense accounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, a prior Plan Year Health Care Expense account may not be used to reimburse Qualified Dependent Care Expenses.
- c. Reimbursement of Grace Period Expenses. Qualified Health Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Qualified Health Care Expense account component will be reimbursed and charged first from any available prior Plan Year Qualified Health Care Expense account. If a current Plan Year Qualified Health Care Expense should subsequently be submitted, the claims for reimbursement under the Qualified Health Care Expense account component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or period of coverage.
- d. Run-Out Period and Forfeitures. Claims for reimbursement of Qualified Health Care Expenses incurred during a Plan Year or its related Grace Period must be submitted no later than the April 30 following the close of the Plan Year in order to be reimbursed from prior Plan Year Qualified Health Care Expense account amounts. Any prior Plan Year Qualified Health Care Expense account amounts that remain after all reimbursement have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends.

The Participant will forfeit all rights with respect to such balance, which will be subject to the Plan's provisions regarding forfeitures in section 6.04 of the Plan.

- e. Qualified Health Care Expense Account Balance, Grace Period and Health Savings Accounts. This Plan's Qualified Health Care Expense account operates with a Grace Period. Under IRS rules regarding a Qualified Health Care Expense Account's Grace Period, if a Participant's Qualified Health Care Expense Account is in effect with any balance in that account on the last day of a Plan Year, the Participant (and their Spouse, if married), nor an Employer on behalf of the Participant, can contribute to a Health Savings Account during the first three (3) months following the close of the Plan Year.
- f. Employee Participation in a Qualified Health Care Expenses Account Prevents Spouse or Dependent Child from Contributing to an HSA. Since this Plan's Qualified Health Care Expenses account is a general purpose account that permits reimbursement of qualifying medical expenses of Employees, Spouses and Dependent Children, under IRS rules, if the Spouse (or Dependent Child) of the Employee is enrolled in a High Deductible Health Plan with Health Savings Account, the Spouse (and Dependent Child) cannot contribute to an HSA while the Employee is enrolled in a general purpose Qualified Health Care Expenses account.

7.07 Grace Period for Qualified Dependent Care Expenses. Amounts remaining in a Participant's Qualified Dependent Care Expense account at the end of a Plan Year can be used to reimburse the Participant for Qualified Dependent Care Expenses that are incurred during the period that begins immediately following the close of that Plan Year and ends on the day that is two (2) months plus fifteen (15) days following the close of that Plan Year (the "Grace Period") under the following conditions:

- a. Applicability. In order for an individual to be reimbursed for Qualified Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her Qualified Dependent Care Expense Account at the end of the Plan Year to which that Grace Period relates, he or she must be a Participant with Qualified Dependent Care Expense account coverage that is in effect on the last day of that Plan Year.
- b. No Cash-Out or Conversion. Prior Plan Year Qualified Dependent Care Expense accounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, a Prior Plan Year Qualified Dependent Care Expense account may not be used to reimburse Qualified Health Care Expenses.
- c. Reimbursement of Grace Period Expenses. Qualified Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Qualified Dependent Care Expense account will be reimbursed and charged first from any available prior Plan Year Qualified Dependent Care Expense account. If a current Plan Year Qualified Dependent Care Expense should subsequently be submitted, the claims for reimbursement under the Qualified Dependent Care Expense account will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or period of coverage.
- d. Run-Out Period and Forfeitures. Claims for reimbursement of Qualified Dependent Care Expenses incurred during a Plan Year or its related Grace Period

must be submitted no later than the April 30 following the close of the Plan Year in order to be reimbursed from a prior Plan Year Qualified Dependent Care Expense account balance. Any prior Plan Year Qualified Dependent Care Expense account balance 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 after the Grace Period ends.

The Participant will forfeit all rights with respect to such balance, which will be subject to the Plan's provisions regarding forfeitures in Section 6.04 of the Plan.

- e. Grace Period Effect on Dependent Care Expense Account Exclusions. Grace Periods may have an adverse effect on the exclusions that individuals report on their personal income taxes. There may be taxable income to an individual if the Qualified Dependent Care Expense account reimbursements exceed IRS permitted Qualified Dependent Care Expense Account exclusion amounts as a result of the Grace Period. For example, if as a result of the Grace Period, a participant receives Qualified Dependent Care Expense account reimbursements for services incurred in a year that exceed his or her maximum Qualified Dependent Care Expense account exclusion, the excess will be included in the Participant's taxable income period. Individuals should be guided by the advice of their tax professional(s).

ARTICLE VIII. ADMINISTRATION

- 8.01 **Board Powers and Duties.** The Board shall interpret the Plan and decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Board with respect to any matter under the Plan shall be conclusive and binding on all persons. The Board shall:
- a. Make and enforce administrative rules or policies.
 - b. Decide questions concerning the Plan.
 - c. Provide a review to any Participant whose claim for benefits has been denied in whole or in part.
- 8.02 **Plan Administrator Duties.** The Plan Administrator or designated agent shall manage and administer the Plan. The Plan Administrator shall:
- a. Require any person to furnish such information as it may request for the purpose of the proper administration of the Plan and as a condition to receiving any benefits under the Plan.
 - b. Prescribe the use of administrative policies and procedures as it considers necessary for the efficient administration of the Plan.
 - c. Determine the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan.
 - d. Determine the amount of benefits which are payable to any person in accordance with the provisions of the Plan.
- 8.03 **Additional Operating Rules.** A Participant's salary reduction amount will not be subject to federal income tax withholding or to applicable Social Security (FICA or FUTA) tax withholding. Salary reduction amounts will not be subject to any state income tax withholding unless otherwise prohibited by applicable state law.
- Salary reduction amounts under this Plan shall not reduce salary or wage amounts for purposes of any other Employee benefit programs unless the provisions of those programs otherwise provide.
- 8.04 **Use and Disclosure of Protected Health Information.** The Plan will use protected health information (PHI) only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Plan rarely, if ever, uses or discloses PHI for treatment purposes. In addition, the Plan does not use or disclose PHI that is genetic information (as defined in 45 CFR 160.103) for underwriting purposes, as set forth in 45 CFR 164.502(a)(5)(1)).

With an authorization, the Plan will disclose PHI to a Benefit Plan for purposes related to administration of these plans.

The Plan will disclose PHI to the Employer only upon receipt of a certification from the Employer that the Employer, as Plan sponsor agrees to:

- a. not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- b. ensure that any agents to whom the Plan sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan sponsor with respect to such PHI;
- c. not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- d. not use or discloses PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- e. report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosure provided for of which it becomes aware;
- f. make PHI available to an individual in accordance with HIPAA's access requirements;
- g. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- h. make available the information required to provide an accounting of disclosures;
- i. make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- j. if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- k. if a breach of unsecured protected health information (PHI) occurs, the Plan will notify affected individuals in accordance with applicable federal law and regulations.

In accordance with HIPAA, only the Executive Director of the Public Employees Retirement System and staff designated by the Executive Director may be given access to PHI. Such persons may only have access to and use and disclose PHI for Plan administration functions that the Plan sponsor performs for the Plan. If such persons do not comply with this Section 8.04, the Plan sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

ARTICLE IX. APPEALS PROCEDURE

- 9.01 **Notice to Employee.** Any person who claims he/she has been denied a benefit under the Plan shall be entitled, upon written request to the Plan Administrator to receive, within sixty (60) days of receipt of such request, a written notice of such action, together with a full and clear statement of the specific reasons therefore, citing pertinent provisions of the Plan and a statement of the procedure to be followed in requesting a review of his/her claim.
- 9.02 **Late Claim Appeal.** Claims for the reimbursement of Qualified Health Care Expenses incurred in a Plan Year shall be paid as soon after a claim has been filed as is administratively practicable. If a Participant fails to submit a claim within the three (3) month period immediately following end of the Plan Year, those Health Care Expense claims shall not be considered for reimbursement by the Plan Administrator or designated agent; provided however, after three (3) months from the close of the Plan Year and before the end of three hundred sixty (360) days following the close of the Plan Year, a Participant may request the Board to authorize reimbursement of a Qualifying Health Care Expense incurred during the Plan Year by the Participant. The Participant must submit a written request to the Board specifying the request and the reason(s) why the Qualifying Health Care Expense was not submitted on or before the end of the 3rd month following the close of the Plan Year. The Board may authorize payment for any reason constituting good cause not involving fault on the part of the Participant if such payment would be permitted under the Plan. Upon authorization of the Board, the Plan Administrator or designated agent shall reimburse the Participant for the amount not to exceed the Qualified Health Care Expense account balance for that Plan Year. The decision of the Board shall be final.
- 9.03 **Appeal of Denial of Benefit.** If the claimant wishes further consideration of his/her claim, he/she may request a review. The Plan Administrator shall schedule a review by the Board on the issue within sixty (60) days following receipt of the claimant's request for such review. The decision following such review shall be communicated in writing to the claimant and, if the claim is denied, shall set forth the specific reasons for such denial, citing the pertinent provisions of the Plan. The decision of the Board as to all claims shall be final.

ARTICLE X. AMENDMENT OR TERMINATION OF THE PLAN

The Board reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Code) to modify or amend, in whole or in part, any or all of the provisions of the Plan provided, however, that no such modifications or amendment shall divest a Participant of a right to a benefit to which he becomes entitled in accordance with the Plan. The Board reserves the power to discontinue or terminate the Plan at any time. Any such amendment, discontinuance or termination shall be effective as of such date as the Board shall determine.

ARTICLE XI. GENERAL PROVISIONS

- 11.01 **No Right to be Retained in Employment.** Nothing contained in the Plan shall give any Employee the right to be retained in the employment of any Employer or affect the right of the Employer to dismiss any Employee.
- 11.02 **Alienation of Benefits.** No benefit under the Plan is subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so is void.
- 11.03 **Use of Form Required.** All communications in connection with the Plan made by a Participant are effective only when submitted to the Plan Administrator or designated agent.
- 11.04 **Applicable Law.** The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State of North Dakota.
- 11.05 **Statement of Benefits.** On or before January 31 of each year, the Board or a designated agent will furnish each Participant who received benefits under the Plan a written statement on appropriate forms required by the federal Internal Revenue Service, showing the amounts paid or incurred by the Plan in providing reimbursement under the Plan for Qualified Dependent Care Expenses with respect to the Participant for the prior Plan Year.
- 11.06 **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 a Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan shall, to the extent it deems administratively possible and otherwise permissible under Code section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he/she is properly entitled under the Plan. Such actions by the Plan may include withholding any amounts due to the Plan or the Employer from compensation paid by the Employer.

Dated: 2-3-16

By: J. Spaul Callers

Title: Executive Director

5388143v1/01640.010