HUMAN RESOURCES COMMITTEE MEETING
LANSING BOARD OF WATER & LIGHT BOARD OF COMMISSIONERS
Tuesday, November 15, 2022 ◆ 4:00 P.M.
1201 S. Washington Ave., Lansing, MI 48910

AGENDA

Call to Order

Roll Call

Public Comments on Agenda Items

1. Human Resources Committee Meeting Minutes of June 21, 2022....................................... **TAB 1**

2. Lansing Board of Water & Light Amended and Restated Cafeteria Plan
   a. Summary Plan Description .... **TAB 2a**
   b. Adoption Agreement .... **TAB 2b**
   c. Basic Plan Document.. **TAB 2c**
   d. Proposed Resolution for Adoption of the Amended and Restated Cafeteria Plan .... **TAB 2d**

Other

Adjourn

HUMAN RESOURCES COMMITTEE
Meeting Minutes
June 21, 2022

Human Resources Committee: Tracy Thomas, Committee Chairperson; Commissioners: Dusty Horwitt, DeShon Leek, David Price; Sandra Zerkle (Alternate).

The Human Resources Committee of the Lansing Board of Water and Light (BWL) met at the BWL Headquarters-REO Town Depot located at 1201 S. Washington Ave., Lansing, MI, at 5:30 p.m. on Tuesday, June 21, 2022.

Human Resources (HR) Committee Chairperson Tracy Thomas called the meeting to order at 5:30 p.m. and asked the Corporate Secretary to call the roll. The following members were present: Commissioners Tracy Thomas, Dusty Horwitt, DeShon Leek, and David Price. Also present: Commissioners Sandra Zerkle (Alternate) and Tony Mullen; Commissioner Semone James attended the meeting via conference phone.

Absent: None.

Public Comments
None.

1. **Approval of Minutes**
   Motion by Commissioner David Price, **Seconded** by Commissioner DeShon Leek, to approve the Human Resources Committee meeting minutes of April 26, 2022.

   Action: Motion Carried.

2. **FY 2023 Board Appointee Performance Review – General Manager**
   HR Committee Chairperson Thomas opened the floor for the Board Appointee Performance Review.

   General Manager Richard Peffley requested a closed session for the purpose of receiving his contractual year-end performance evaluation as permitted by the Open Meetings Act exemption MCL 15.268(a).

   Motion by Commissioner David Price, **Seconded** by Commissioner DeShon Leek, to enter into closed session to discuss the contractual year-end performance evaluation of General Manager, Richard Peffley.

   Roll Call Vote:
   Yeas: Commissioners Tracy Thomas, Dusty Horwitt, DeShon Leek, and David Price.
   Nays: None.

   Action: Motion Carried.

   The Human Resources Committee went into closed session at 5:37 p.m.

Motion by Commissioner David Price, **Seconded** by Commissioner Dusty Horwitt, to reconvene into open session.

Roll Call Vote:
Yeas: Commissioners Tracy Thomas, Dusty Horwitt, DeShon Leek, and David Price.
Nays: None.

Action: Motion Carried.

The Human Resources Committee reconvened to open session at 6:10 p.m.

3. <u>General Manager Reappointment Resolution</u>

At the start of open session, the following motion was offered:

Motion by Commissioner David Price, **Seconded** by Commissioner Dusty Horwitt, to forward the resolution reappointing Richard (Dick) Peffley to the Charter position of General Manager for FY23 to the full Board for consideration at its July 2022 Meeting.

Action: Motion Carried.

The purpose of the revised contacts for the recently hired Internal Auditor and Corporate Secretary (Agenda Item 4) is:

- To align the contracts with the Board's Rules of Procedure for annual review and appointment of its three employees at the end each fiscal year ending June 30: "the Board at its first regular board meeting following July 1 of each year or as soon as practical thereafter, shall appoint a Director of Internal Audit and a Corporate Secretary."
- The original contract could not conform with this Procedure because the City Charter prohibits contracts in excess of 12 months and both new employees started their employment on May 9, 2022, creating a gap between May 9, 2023 and June 30, 2023.
- With the revised contracts a new term is established that conforms with the Board's own Procedure and the City Charter and eliminates the gap by appointing both employees for a new 12-month period commencing July 1, 2022 and ending June 30, 2023.

4. <u>Revised Employment Contract for Corporate Secretary and Internal Auditor</u>

Revised Employment Contract for Corporate Secretary

Motion by Commissioner David Price, Seconded by Commissioner DeShon Leek, to forward the resolution to revise the appointment of Corporate Secretary LaVella J. Todd from July 1, 2022 to June 30, 2023 to the full Board for consideration at its July 2022 Meeting.

Action: Motion Carried.

Revised Employment Contract for Internal Auditor

Motion by Commissioner David Price, **Seconded** by Commissioner DeShon Leek, to forward the resolution to revise the appointment of Internal Auditor Frank Macciocca from July 1, 2022 to June 30, 2023 to the full Board for consideration at its July 2022 Meeting.

Action: Motion Carried.

Other

There was no other business.

Adjourn

Human Resources (HR) Committee Chairperson Thomas adjourned the meeting at 6:16 p.m.

Respectfully Submitted,
Tracy Thomas, Chairperson
Human Resources Committee

FINAL

LANSING BOARD OF WATER AND LIGHT

CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

12/01/2022

FINAL

LANSING BOARD OF WATER AND LIGHT
CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

INTRODUCTION 1

ELIGIBILITY 1

ELECTION PROCEDURES 1

BENEFITS 3
- Premium Conversion Account 3
- Health Flexible Spending Account (Health FSA) 3
  - Health FSA Eligibility 4
  - Health FSA Contributions 4
  - Health FSA Eligible Expenses/Reimbursement 4
  - Termination of Employment 5
  - Qualified Reservist Distributions 5
- Dependent Care Assistance Plan Account (DCAP) 5
  - DCAP Contributions 6
  - DCAP Eligible Expenses/Reimbursement 6
  - Termination of Employment 7

CLAIMS PROCEDURES 8
- **Claims for Plan Benefits (except for Health FSAs)** 9
- **Claims for Health FSA Benefits** 9
- Debit/Credit Cards 10

COBRA CONTINUATION COVERAGE 11
- Qualifying Events 11
- Continuing Coverage 11
- Election Procedures and Deadlines 12
- Cost of COBRA Continuation Coverage 12
- When Continuation Coverage Ends 12

MISCELLANEOUS 13
- FMLA 13
- Unclaimed Reimbursements 13
- Excess Payments/Reimbursements 13
- Beneficiaries 14
- Qualified Medical Child Support Orders 14
- Loss of Benefit 14
- Non-Alienation of Benefits 14
- Amendment and Termination of the Plan 14
- Plan Administrator Discretion 14
- Taxation 14
- Governing Law 14

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

INTRODUCTION

Lansing Board of Water and Light (the "Employer") established the Lansing Board of Water and Light Cafeteria Plan (the "Plan") effective August 1, 1987. This summary describes the Plan as amended and restated effective December 1, 2022. The Plan is a cafeteria plan that provides an eligible employee with the opportunity to choose among benefits offered under the Plan.

This summary supersedes all previous summaries of the Plan. Although the purpose of this document is to summarize the more significant provisions of the Plan, it is only a summary - the terms of the Plan document ultimately govern the operation and administration of the Plan. The Employer and any employer who has adopted the Plan is referred to in this document as the "Employer."

ELIGIBILITY

You are generally an "Eligible Employee" if you are an employee of the Employer or any affiliate who has adopted the Plan on the first day of the calendar month coincident with or next following your hire date. An Eligible Employee shall become eligible to become a Participant in the Plan with respect to the Premium Conversion Account at the same date as he or she becomes eligible to participate in the underlying benefit plan. An Eligible Employee shall become eligible to become a Participant in the Plan with respect to the Health Flexible Spending Account and Dependent Care Assistance Plan Account effective on the date the Participant becomes eligible to participate in the major medical coverage sponsored by the Employer ("Major Medical Coverage").

However, you are not an "Eligible Employee" if you are any of the following:

- A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.
- A leased employee.
- A student worker or employee not classified as "full-time" by the Employer, as further defined in the Employer's policies and applicable collective bargaining agreements.

If you are eligible to participate in the Major Medical Coverage , then you are eligible to participate in the Health Flexible Spending Account, even if you do not elect to participate in the Major Medical Coverage.

Solely for purposes of Cash in Lieu of Major Medical Benefits, the term "Participant" includes, unless prohibited by law, a "retiree" (as defined in the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light) as further defined and set forth in Plan Administrator procedures.

ELECTION PROCEDURES

You may elect to participate in the Benefits under the Plan within 30 days after your eligibility date (or a shorter period if established by the Plan Administrator).

If you do not enroll in the Plan upon your initial eligibility, you may enroll during the enrollment period established by the Plan Administrator. Your election will be effective as of the first day of the Plan Year following the enrollment period.

You may also enroll in the Plan upon a change in status event as described below.

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

To enroll in the Plan, you may need to submit a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. If, as of the start of a Plan Year, you have not submitted a completed election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

If you fail to submit an election form, prior year elections will automatically apply to the Premium Conversion Account benefits. An election to participate in the Plan is generally irrevocable for the Plan Year. You may not change your election during a Plan Year unless you experience a change in status. Your change in election must be on account of and correspond with a change in status that affects your eligibility for coverage under the Plan.

Depending on the Benefit, a "change in status" includes:

- Change in your marital status.
- Change in the number of your dependents.
- Change in your employment status or the employment status of your spouse or dependents.
- Your dependent satisfies or ceases to satisfy eligibility requirements.
- Change in your place of residence.
- Commencement or termination of an adoption proceeding.
- Court judgment, decree, or order.
- Entitlement to Medicare or Medicaid by you, your spouse, or your dependent.
- Significant cost or other coverage changes.
- You change coverage under another cafeteria plan.
- You take leave under the FMLA.
- You lose coverage under the group health plan due to a reduction in hours.
- You are eligible to enroll in a qualified health plan through the Marketplace.

Pursuant to Internal Revenue Service Notice 2020-29, effective January 1, 2020, during the Plan Year beginning in 2020 only, a Participant is permitted to revoke an election, make a new election, or decrease or increase an existing election applicable to the Health Flexible Spending Account and/or DCAP Account on a prospective basis, subject to the following: (1) the election shall not violate any other statute or regulation applicable to the Plan; (2) no Participant is permitted to elect to revoke or decrease either the Health Flexible Spending Account or DCAP Account amounts below the amount already disbursed/reimbursed from the applicable account; and (3) a Participant is only permitted to change his or her election applicable to the Health Flexible Spending Account under this provision once during the Plan Year beginning in 2020.

Pursuant to Section 214 of Division EE of the Consolidated Appropriations Act, 2021 (the "CAA"), and IRS Notice 2021-15, effective January 1, 2021, during the Plan Year ending in 2021 only, a Participant may make an election to prospectively modify the amount (but not in excess of any applicable dollar limitation) of such Participant's contributions to the Health Flexible Spending Account and/or DCAP Account (without regard to any change in status) subject to the following: (1) the election shall not violate any other statute or regulation applicable to the Plan; (2) no Participant is permitted to elect to revoke or decrease either the Health Flexible Spending Account or DCAP Account amounts below the amount already disbursed/reimbursed from the applicable account; and (3) a Participant is only permitted to change his or her election applicable to the Health Flexible Spending Account under this provision once during the Plan Year beginning in 2021.

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

BENEFITS

Contributions pertaining to a Benefit will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes. Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

If you are a highly paid employee or an owner of your Employer, federal law may impose limits on your behalf to participate in the Plan and/or the benefits you may receive from the Plan. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify your election in order to assure compliance with such requirements or limitations.

1. Premium Conversion Account

The Plan will automatically establish a Premium Conversion Account in your name when you become an Employee for the payment of premiums under the Employer-sponsored benefits listed below unless you affirmatively elect to not establish or contribute to such account. Your Premium Conversion Account will be credited with amounts withheld from your compensation. The amount of the contribution to your Premium Conversion Account is equal to the amount of your portion of the premium due for the following benefits/contracts:

- Major Medical Coverage
- Employer Dental
- Employer Vision
- Employer Group Term Life
- Employer Accidental Death & Dismemberment

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts sponsored by the Employer as permitted by applicable law.

If you affirmatively elect not to participate in the Premium Conversion Account for a Plan Year, you will not be enrolled unless and until you elect to participate in the Premium Conversion Account as described in the "Election Procedures" above. Contributions to the Premium Conversion Account are not subject to federal income tax or social security taxes, except that contributions for the payment of premiums under Employer Group Term Life Insurance will be made on an after-tax basis to the extent that the premiums relate to coverage in excess of $50,000.

In the event of a conflict between the terms of this Plan and the terms of the applicable contract, the terms of the contract (or the benefit plan under which it is established) will control.

2. Health Flexible Spending Account ("Health FSA")

The following Health Flexible Spending Account is available under the Plan:

- General Purpose Health FSA

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

General Purpose Health FSAs may only be used to reimburse for Medical Expenses during the Plan Year. If you are eligible, you may elect to contribute to a Health FSA in accordance with the "Election Procedures" described above.

a. Health FSA Eligibility

Please be aware that there are some limitations on your eligibility to participate in Health FSAs. If you are an Eligible Employee, you are eligible to contribute to a Health FSA. However, if you are not eligible to participate in the Major Medical Coverage, then you are not eligible to participate in a Health FSA.

b. Health FSA Contributions

Your Health FSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your General Purpose Health FSA and/or HSA-Compatible Health FSA is the maximum amount permitted under the tax code ($2,850 for 2022). There is no minimum contribution for participation in your Health FSA. The Employer will not make additional contributions to your General Purpose Health FSA on your behalf.

c. Health FSA Eligible Expenses/Reimbursement

You will be entitled to receive reimbursement from your General Purpose Health FSA for Medical Expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone you may claim as a dependent on your federal tax return and also include a child until the last day of the calendar month in which they turn 26.

"Medical Expenses" means expenses incurred during the Plan Year by a Participant, or by the spouse or dependent of the Participant, for medical care as defined in Code §213(d) and only as allowed to be reimbursed under Code §125 and the regulations and guidance thereunder, but only to the extent that the Participant or other persons incurring the expense are not reimbursed for the expense through insurance or otherwise. If only a portion of the Medical Expense has been reimbursed elsewhere, the Plan may reimburse the remaining portion of the expense if it otherwise meets this definition. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code §7702B(c) or any premium payments for health care coverage. Medical Expenses are incurred at the time the services to which the expense relates are rendered, regardless of when the Participant is charged for the services. Effective for expenses incurred after December 31, 2019, pursuant to §3702 of the CARES Act, reimbursement of certain over-the-counter drugs and medicine are permitted without prescription and Medical Expenses shall include expenses incurred for menstrual care products (as defined in Code §223(d)(2)(D)). Effective for expenses incurred on or after January 1, 2021, pursuant to IRS Announcement 2021-7 reimbursement of certain COVID-19 personal protective equipment is permitted.

The entire annual amount you elect to contribute for the Plan Year to your Health FSA, less any reimbursements already distributed from your Health FSA, will be available for reimbursement throughout the Plan Year.

You may receive reimbursement for Medical Expenses incurred during the Plan Year when you are participating in your Health FSA. Health insurance premiums are not an eligible Medical Expense for the Health FSA.

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

You will not be reimbursed for any expenses that were (1) incurred before you are eligible to participate in the Health FSA; (2) incurred after you have become ineligible to participate in the Health FSA and are attributable to a tax deduction you took in a prior taxable year; or (3) covered, paid, or reimbursed from another source. Your claim for reimbursement must include substantiation that the Plan Administrator or Claims Administrator considers sufficient for determining that the claim constitutes an expense eligible for reimbursement under the Plan.

d. General Purpose FSA Grace Period

Any amounts remaining in your General Purpose Health FSA at the end of the Plan Year may be used for expenses that you incur during the Grace Period. The "Grace Period" is the 15th day of the 3rd month after the Plan Year. You must submit claims for reimbursement from your General Purpose Health FSA no later than 120 days after the end of the Grace Period. Any amounts remaining in your General Purpose Health FSA at the end of the Grace Period after all timely claims have been paid will be forfeited.

Pursuant to Internal Revenue Service Notice 2020-29, effective January 1, 2020, for unused amounts remaining in the Health Flexible Spending Account as of the end of the Grace Period ending in 2020, the Plan shall permit Employees to apply those unused amounts to pay or reimburse Medical Expenses incurred through December 31, 2020.

Pursuant to Section 214 of Division EE of the Consolidated Appropriations Act, 2021 (the "CAA") and IRS Notice 2021-15, effective January 1, 2021, the Plan shall permit Employees with unused amounts remaining in the Health Flexible Spending Account as of the end of the Grace Period ending in 2021, to apply those unused amounts to pay or reimburse Medical Expenses incurred through December 31, 2021.

e. Termination of Employment

If you terminate employment with the Employer for any reason during the Plan Year, your contributions to your FSA will end as of your date of termination. You may submit claims for reimbursement from your FSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your Health FSA no later than 90 days after the date your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted prior to this date have been processed.

f. Qualified Reservist Distributions

If you are a military reservist called to active duty for a period in excess of 179 days or for an indefinite period, you may elect to receive a distribution from your Health FSA up to an amount equal to the amount you have contributed to the applicable FSA for the Plan Year, minus reimbursements paid as of the date of the distribution request. You must make the distribution request during the period beginning on the date of your call-up and ending on the last date that reimbursements could otherwise be made for that Plan Year.

3. Dependent Care Assistance Plan Account ("DCAP")

A Dependent Care Assistance Plan Account may be used to reimburse expenses incurred for the care of a qualifying dependent. If you are eligible, you may elect to contribute to a DCAP Account in accordance with the "Election Procedures" described above.

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

a. DCAP Contributions

Your DCAP Account will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount that you may contribute each year to your DCAP Account is the maximum amount permitted under the tax code ($5,000 for 2022, $2,500 if you are married and filing separately.) There is no minimum contribution for participation in your DCAP Account.

The Employer will not make additional contributions to your DCAP Account on your behalf.

In accordance with Section 9632 of the American Rescue Plan Act of 2021 (the "ARPA"), during the Plan Year ending in 2021 only, the amount of all contributions to a Participant's DCAP Account shall not exceed the maximum annual limit set forth in Code section 129(a)(2) as temporarily amended by the ARPA (i.e., $10,500 ($5,250 if a separate tax return is filed by a Participant who is marred as determined under the rules of paragraph (3) and (4) of Code §21(e))."

b. DCAP Eligible Expenses/Reimbursement

The entire annual amount you elect to contribute for the Plan Year to your DCAP Account, less any reimbursements already distributed from your DCAP Account will be available for reimbursement. You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your DCAP Account. Eligible expenses generally include those that you incur in order to be gainfully employed and for the care of (i) your dependent who is under age 13, or (ii) your spouse or dependent who lives with you and who is physically or mentally incapable of caring for themselves. Expenses incurred for overnight camp are not eligible for reimbursement. A dependent is generally someone who you may claim as a dependent on your federal tax return.

For purposes of Plan Years ending in 2020 and 2021, the DCAP of an "eligible employee" shall substitute age 14 for age 13 for purposes of determining the dependent care expenses that may be paid or reimbursed. An "eligible employee" means an employee who (1) enrolled in a DCAP for the last plan year with respect to which the end of the regular enrollment period for such Plan Year was on or before 01/31/2020; and (2) has one or more dependents (as defined in Code §152(a)(1)) who attains age 13 either (a) during that Plan Year or (b) in the case of an employee who has an unused balance in his or her DCAP Account for such Plan Year (determined as of the close of the last day on which, under the terms of the Plan, claims from reimbursement may be made with respect to such Plan Year) the subsequent Plan Year.

c. DCAP Grace Period

Any amounts remaining in your DCAP Account at the end of the Plan Year may be used for expenses that you incur during the Grace Period. The Grace Period is the 15th day of the 3rd month after the Plan Year. You must submit claims for reimbursement from your DCAP Account no later than 120 days after the end of the Grace Period. Any amounts remaining in your DCAP Account at the end of the Grace Period after all timely claims have been paid will be forfeited.

Pursuant to Internal Revenue Service Notice 2020-29, effective January 1, 2020, for unused amounts remaining in the DCAP Account as of the end of the Grace Period ending in 2020, the Plan shall permit Employees to apply those unused amounts to pay or reimburse dependent care expenses and incurred through December 31, 2020.

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

Pursuant to Section 214 of the CAA and IRS Notice 2021-15, effective January 1, 2021, the Plan shall permit Employees with unused amounts remaining in the DCAP Account as of the end of the Grace Period ending in 2021, to apply those unused amounts to pay or reimburse dependent care expenses incurred through December 31, 2021.

d. Termination of Employment

If you terminate employment with the Employer for any reason during the Plan Year, your contributions to your DCAP Account will end as of your date of termination. You may submit claims for reimbursement from your DCAP Account for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your DCAP Account no later than 90 days after the date your employment terminates. Any balance remaining in your DCAP Account will be forfeited after claims submitted prior to this date have been processed.

4. Cash in Lieu of Major Medical Benefits

a. Election to Waive Major Medical Coverage and Receive Cash

A Participant who is eligible to receive Major Medical Coverage may elect to receive additional cash compensation from the Employer in an amount periodically determined by the Employer and communicated to the Participant prior to the beginning of each Plan Year in lieu of Major Medical Coverage ("Cash-In-Lieu"), provided that the Participant meets the below requirements. In order to elect to waive Major Medical Coverage, the Participant must provide a written or electronic waiver on a form provided by the Plan Administrator. Unless otherwise agreed, the Cash-in Lieu payment shall be paid on a pro rata basis per pay period.

In order for Cash-In-Lieu to apply, a Participant must be eligible for Major Medical Coverage under a collective bargaining agreement, the health and prescription drug plans for active employees, or the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light.

b. Restrictions on Election to Waive Major Medical Coverage and Receive Cash-in-Lieu

In order to receive the Cash-in-Lieu payment when waiving Major Medical Coverage, a Participant must attest in writing (or electronically) at least one time each Plan Year that the Participant and each member of the Participant's "expected tax family" is (or will be) enrolled in "Alternative Minimum Essential Coverage" (i.e., an insurance plan that meets the Affordable Care Act requirement for having health coverage and is described in Code §5000A(f) (other than coverage in the individual market, whether or not obtained through the marketplace) for the Plan Year (or that portion of the Plan Year) to which the Cash-in-Lieu waiver applies. A Participant's "expected tax family" includes all individuals for whom the Participant reasonably expects to claim a personal exemption deduction under Code §151 for the taxable year or years that begin or end in or with the Plan Year to which the cash waiver applies.

Additionally, the Employer will not make the Cash-in-Lieu payment if it knows or has reason to know that the Participant, or any member of the Participant's expected tax family, does not (or will not) have Alternative Minimum Essential Coverage during the eligible Plan Year.

An Employee-Participant shall not be eligible to receive the Cash-in-Lieu payment when waiving Major Medical Coverage if he or she is covered by the Major Medical Coverage as a Dependent.

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

c. Revocation of Election Upon Loss of Other Alternative Minimum Essential Coverage

A Participant who elects to waive Major Medical Coverage and who (or whose family member) subsequently loses Alternative Minimum Essential Coverage: (a) must immediately notify the Employer, at which time the Cash-in-Lieu payment will cease; and (b) may be permitted to change an election pursuant to the Plan's change in election rules and, to the extent permitted under the Major Medical Coverage, to prospectively revoke his or her election by providing proof of the loss of Alternative Minimum Essential Coverage and occurrence of a change in election event to the Plan Administrator.

Elections made (or deemed made) under this section shall automatically terminate on the date on which the Participant no longer meets the requirements of this section, or on the date on which the Participant ceases to be a Participant in the Plan.

d. Election Procedure

Prior to the beginning of the Plan Year and upon meeting the eligibility requirements for newly eligible Employees, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement (which may be through the self-service HRIS system) to each Participant and to each other Employee who is expected to become a Participant. Each Participant who elects to waive Major Medical Coverage and receive a Cash-in-Lieu payment shall so specify on the Election Form/Salary Reduction Agreement. Each Election Form/Salary Reduction Agreement must be completed and returned to the Plan Administrator (which may be through the self-service HRIS system) on or before such date as the Plan Administrator shall specify, which date shall be no later than (1) the beginning of the Plan Year for purposes of open enrollment; and (2) the beginning of the first pay period for which the Participant's election will apply for newly eligible Employees. A Participant who fails to provide a completed Election Form/Salary Reduction Agreement to the Plan Administrator on or before the specified due date for each Plan Year shall not receive the Cash-in-Lieu payment.

e. Maximum Employer Contributions

The maximum amount of Employer contributions under this section for any Participant shall be equal to the Cash-in-Lieu payment elected by a Participant who waives Major Medical Coverage as provided in this section.

CLAIMS PROCEDURES

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to Claims Administrator at:

Address: As provided on Plan Administrator forms
Phone number: As provided on Plan Administrator forms

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

To the extent that the Plan Administrator approves a claim, the Employer may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

reimbursed without regard to the minimum payment amount.

1. Claims for Plan Benefits (except for Health FSAs)

You must file a claim for benefits under this Plan in accordance with the Plan Administrator's guidelines. If your claim does not include enough information to process the claim, you will be given an opportunity to provide the missing information. You may designate an authorized representative by providing written notice of the designation to the Plan Administrator.

You may apply for benefits under the Plan by completing and filing a claim with the Plan Administrator. Your claim must include all information and evidence that the Plan Administrator deems necessary to evaluate the merit of your claim and to make any necessary determinations on your claim. The Plan Administrator may request any additional information from you as necessary to evaluate the claim.

2. Claims for Health FSA Benefits

If you file a claim for benefits from your Health FSA and that claim is denied, the Plan Administrator will notify you within a reasonable period of time, but no later than 30 days after the Plan Administrator received the claim. The Plan Administrator may notify you, prior to the expiration of this 30-day period, of the need to extend the period by up to 15 days due to matters beyond its control. In such case the Plan Administrator will notify you of the circumstances requiring the extension of time and the date by which the Plan Administrator will notify you of its decision. If the extension is necessary because you did not submit information necessary to decide the claim, the notice of extension will describe the required information, and you will have at least 45 days from the day you receive the notice to provide the specified information.

If your claim is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for the denial, (B) the Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under applicable law after following the Plan's claims procedures. The notice will also include (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or (2) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

a. Appeal of Denied Claim.

If you wish to appeal the denial of a claim, you must file an appeal with the Plan Administrator on or before the 180th day after you receive the Plan Administrator's notice that the claim has been denied. You will lose the right to appeal if the appeal is not made within this 180-day period. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will be provided, upon request and free of charge, documents and other information relevant to your claim. Your appeal may also include any comments, statements or documents that you desire to provide. The Plan Administrator will consider the merits of your presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

will:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any denial that is based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the denial; and

(D) Provide that the health care professional engaged for purposes of a consultation under (B) above will be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify you of the Plan's benefit determination on review within 60 days after receipt by the Plan of your request for review of the denial.

b. Denial of Appeal.

If your appeal is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for such denial, (B) the Plan provisions on which the denial is based, (C) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (D) a statement describing your right to bring an action under applicable law after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

c. Exhaustion of Remedies; Limitations Period for Filing Suit.

Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

d. Benefits Provided under Contracts.

Please see the underlying contracts for any additional claims and reimbursement rules under those contracts.

3. Debit/Credit Cards

Lansing Board of Water and Light will provide you with a debit/credit and/or other stored-value card for purposes of making purchases that are eligible for reimbursement from your Health Flexible Spending Account and/or Dependent Care Assistance Plan Account. The Plan Administrator will provide you with more information about these cards as well as any limitations at the time you enroll in the Plan. You do not have to

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

use the cards and may request reimbursements as listed above.

COBRA CONTINUATION COVERAGE

If you are participating in the Health FSA and your Employer is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs fewer than 20 employees, but you should contact the Plan Administrator who can inform you if the Employer is a small employer not subject to COBRA and is not required to comply with these rules. Depending on your Health FSA balance at the time of the Qualifying Event (described below), you may not be eligible for COBRA continuation coverage.

1. Qualifying Events

You have the right to continue your coverage under the Health FSA if any of the following events results in your loss of coverage under the Health FSA:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Health FSA if any of the following events results in their loss of coverage under the Health FSA:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."

If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Health FSA for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice which explains your rights regarding COBRA continuation coverage.

2. Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

3. Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if they are not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of their COBRA continuation coverage rights.

4. Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

5. When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Health FSA;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides a Health FSA to any of its employees.

6. COBRA Subsidy During 2021 – Special Enrollment Rights

An Assistance Eligible Individual (AEI) may enroll in the same coverage that they were enrolled at the time of the qualifying event. The election must be made within 90 days of receipt of enrollment eligibility.

For purposes of this election and in accordance with IRS Notice 2021-31, an "Assistance Eligible Individual" (AEI) is any individual who is (1) a qualified beneficiary as the result of (A) the reduction of hours of a covered employee's employment or (B) the involuntary termination of a covered employee's employment (other than by reason of an employee's gross misconduct), (2) is eligible for COBRA continuation coverage for some or all of the period beginning on 04/01/2021 through 09/30/2021, and (3) elects the COBRA continuation coverage. This includes qualified beneficiaries who are the spouse or dependent child of the employee who had the reduction in hours or involuntary termination of employment resulting in a loss of coverage, as well as the employee, if that reduction in hours or involuntary termination of employment caused the qualified beneficiary to lose coverage and the other requirements are satisfied.

In order to be a qualified beneficiary who is eligible to become an AEI, an individual must (1) be covered under the group health plan on the day before the reduction in hours or involuntary termination of the covered employee's employment, and (2) lose eligibility for the coverage due to the reduction in hours or involuntary

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

termination of the covered employee's employment. An individual who loses group health coverage in connection with the termination of a covered employee's employment by reason of the employee's gross misconduct is not a qualified beneficiary and, thus, cannot be an AEI.

Enrollment in other group health plan coverage before electing COBRA continuation coverage does not end the period of eligibility for COBRA continuation coverage. If the individual is no longer covered by (or eligible to enroll in) the other group health plan coverage as of 04/01/2021, that prior coverage by a group health plan does not disqualify the individual from COBRA premium assistance. However, beginning on 04/01/2021, coverage by (or eligibility to enroll in) another group health plan would disqualify the individual from COBRA premium assistance, even though it does not end the period of eligibility for COBRA continuation coverage.

An individual who is a qualified beneficiary as the result of a reduction in hours or involuntary termination of employment but who is currently enrolled in individual health insurance coverage through a Health Insurance Exchange may be eligible to elect COBRA continuation coverage and for COBRA premium assistance. However, an individual is not eligible for a premium tax credit to help pay for the cost of Exchange coverage during any month that the individual is enrolled in COBRA continuation coverage. An individual who elects COBRA continuation coverage (with or without COBRA premium assistance) and who is enrolled in coverage through a Health Insurance Exchange with advance payments of the premium tax credit (APTC) may be required to repay the APTC for the overlap months.

COBRA premium assistance applies until the earliest of (1) the first date the AEI becomes eligible for other group health plan coverage (with certain exceptions) or Medicare coverage, (2) the date the individual ceases to be eligible for COBRA continuation coverage, or (3) the end of the last period of coverage beginning on or before 09/30/2021.

MISCELLANEOUS

1. FMLA

If you go on leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving certain Plan benefits. If you go on a non-FMLA leave of absence, entitlement to continue Plan coverage shall be determined by the Employer’s applicable policies and procedures. Contact the Plan Administrator for more information under the Plan.

2. Unclaimed Reimbursements

Payments from the Account that are not claimed on a timely basis (for example, checks issued from the Plan that are not timely cashed) will be forfeited and returned to the Plan. Please contact your Plan Administrator about what constitutes "timely" claims of payment from the Plan.

3. Excess Payments/Reimbursements

If you receive an excess benefit or payment under the Plan, you must immediately repay any such excess payments/reimbursements. You must also reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable to you under this Plan.

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

4. Beneficiaries

If you die, your beneficiaries or your estate may submit claims for eligible expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents, or a representative of your estate.

5. National Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a national medical child support order. You may obtain a copy of the national medical child support order procedures from the Plan Administrator, free of charge.

6. Loss of Benefit

You may lose all or part of your Account(s) under the Plan if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

Non-Alienation of Benefits

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary to receive benefits under the Plan in the event of your death.

Amendment and Termination of the Plan

The Employer may amend or terminate the Plan at any time.

Plan Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding on all persons and parties.

Taxation

The Employer intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Governing Law

The Plan is governed by the laws of Michigan to the extent not pre-empted by Federal law. The Plan and its component programs are not subject to and are not required to comply with ERISA.

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

FINAL

PLAN INFORMATION

1. The "Plan Sponsor" and "Plan Administrator" is Lansing Board of Water and Light.

2. The Plan Sponsor's and Plan Administrator's Address is 1110 S. Pennsylvania, Building E, Lansing, Michigan 48912

3. The Plan Sponsor's EIN is 38-6005774

4. The Plan Sponsor and Plan Administrator's phone number is 517-702-7011

5. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code. The Health FSA Benefit under the Plan is a welfare benefit plan.

6. The Plan number is 505.

7. The Plan's designated agent for service of legal process is the Plan Sponsor. Any legal papers should be delivered to the Plan Sponsor at the address listed above. However, service may also be made upon the Plan Administrator.

8. The Plan Year is the 12-consecutive month period ending on December 31.

9. Amount contributed by Plan Participants and the Employer to the Plan are general assets of the Employer. All payments of benefits under the Plan are made solely out of the general assets of the Employer. The Employer has no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. The Employer may, in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.

39542925.7/101173.00017

Copyright © 2002-2022
CCH Incorporated, DBA ftwilliam.com

FINAL

LANSING BOARD OF WATER AND LIGHT
CAFETERIA PLAN

TABLE OF CONTENTS

PLAN INFORMATION 1

A. GENERAL INFORMATION AND DEFINITIONS 1

B. ELIGIBILITY 2
- Eligible Employees 2
- Excluded Employees 3
- Leave of Absence under FMLA 3
- Non-FMLA 3
- Termination of Participation 3
- Reemployment 4

C. PARTICIPATION ELECTIONS 4
- Failure to Elect (Default Elections) 4
- Change in Status 4

D. PREMIUM CONVERSION ACCOUNT 4
- Contracts for Reimbursement 4
- Enrollment 5
- Contributions 5

E. FLEXIBLE SPENDING ACCOUNTS 5
- Employer Contributions 5
- Eligible Expenses 6
- Expenses Not Eligible for Reimbursement 7
- Reimbursement 7
- Grace Period 7
- Run Out Period 7
- Automatic Payment of Claims 7
- Carryover 8
- Termination of Employment 8
- Qualified Reservist Distributions 8
- Employer Contributions 8

G. FLEXIBLE BENEFIT CREDITS (Flex Credits) (Section 11.01) 9
- Health Flex Contribution 9
- Cash Outs 9

H. PURCHASE AND SALE OF PAID TIME OFF (PTO) (Section 11.02) 10
- Purchase of PTO 10
- Sale of PTO 10
- Carryover of PTO 10

I. MISCELLANEOUS 10
- Plan Administrator Information 10

J. EXECUTION PAGE 11

CUSTOM LANGUAGE ADDENDUM 12

Copyright © 2002-2022
Miller Canfield

FINAL

ADOPTION AGREEMENT
CAFETERIA PLAN

The undersigned adopting employer hereby adopts this Plan. The Plan is intended to qualify as a cafeteria plan under Code section 125. The Plan shall consist of this Adoption Agreement, its related Basic Plan Document and any related Appendix and Addendum to the Adoption Agreement. Unless otherwise indicated, all Section references are to Sections in the Basic Plan Document.

COMPANY INFORMATION

1. Name of adopting employer (Plan Sponsor): Lansing Board of Water and Light

2. Address: 1110 S. Pennsylvania, Building E

3. City: Lansing

4. State: Michigan

5. Zip: 48912

6. Phone number: 517-702-7011

7. Fax number: _____

8. Plan Sponsor EIN: 38-6005774

9. Plan Sponsor fiscal year end: 06/30

10. Entity Type:

- **a.** Plan Sponsor entity type:
  - **i.** **[ ]** C Corporation
  - **ii.** **[ ]** S Corporation
  - **iii.** **[ ]** Non-Profit Organization
  - **iv.** **[ ]** Partnership
  - **v.** **[ ]** Limited Liability Company
  - **vi.** **[ ]** Limited Liability Partnership
  - **vii.** **[ ]** Sole Proprietorship
  - **viii.** **[ ]** Union
  - **ix.** **[X]** Government Agency
  - **x.** **[ ]** Other: _____
  - **xi.** If "Union"(10a.viii) is selected, enter name of the representative of the parties who established or maintain the Plan: _____

11. State of organization of Plan Sponsor: Michigan

12. Controlled Groups/Affiliated Service Groups

- **a.** **[ ]** The Plan Sponsor is a member of an affiliated service group. List all members of the group (other than the Plan Sponsor): _____

13. Controlled Groups

- **a.** **[ ]** The Plan Sponsor is a member of a controlled group. List all members of the group (other than the Plan Sponsor): _____

NOTE: *Affiliated service group members and controlled group members may adopt the Plan with the approval of the Plan Sponsor.*

NOTE: *Listing affiliated service group members and controlled group members is for information purposes only and is optional. Participating Employers in the Plan are listed in Addendum.*

PLAN INFORMATION

A. GENERAL INFORMATION AND DEFINITIONS

1. Plan Number: 505

2. Plan Name:

- **a.** Lansing Board of Water and Light
- **b.** Cafeteria Plan

3. Effective Date: 08/01/1987

- **a.** **[X]** Is this a restatement of a previously-adopted plan?

Copyright © 2002-2022
Miller Canfield

b. Effective date of Plan restatement: 12/01/2022 ("Restatement Date")

4. Plan Year:

a. Plan Years mean each 12-consecutive month period ending on 12/31 (e.g. December 31). If the Plan Year changes, any special provisions regarding a short Plan Year shall be placed in the Addendum to the Adoption Agreement.

b. **[ ]** The Plan has a short Plan Year. The short Plan Year begins _____ and ends on _____.

Plan Features

5. The following Benefits are available under the Plan:

a. **[X]** Premium Conversion Account
b. **[X]** Health Flexible Spending Account
c. **[ ]** Limited Purpose HSA-Compatible Health Flexible Spending Account
d. **[ ]** Post-Deductible HSA-Compatible Health Flexible Spending Account
e. **[X]** Dependent Care Assistance Plan Account
f. **[ ]** Adoption Assistance Flexible Spending Account
g. **[ ]** Health Savings Account
h. **[ ]** Flexible Benefits Credits
i. **[ ]** PTO Purchase/Sale

6. Simple Cafeteria Plan

a. **[ ]** The Plan is intended to qualify as a simple cafeteria plan under Code section 125(j).

b. The Employer shall make contributions to the Plan as follows:

i. **[ ]**______% (no less than 2%) of an Eligible Employee's Compensation for the Plan Year.

ii. **[ ]**______% (at least 200%) of an Eligible Employee's salary reduction contribution for the Plan Year, but no less than 6% of the Eligible Employee's Compensation for the Plan Year.

B. ELIGIBILITY

Eligible Employees - Employees must meet the following requirements:

1. Minimum age requirement for an Employee to become an Eligible Employee: None.
NOTE: *If the Plan is intended to be a simple cafeteria plan under Article 12, B.1 may not exceed "21."*

2a. An Employee must complete the following service requirements to become an Eligible Employee on the date set forth in B.2b:

i. **[X]** None
ii. **[ ]** Completion of _____ hours of service.
iii. **[ ]** Completion of _____ days of service.
iv. **[ ]** Completion of _____ months of service.
v. **[ ]** Completion of _____ years of service.

NOTE: *If the Plan is a simple cafeteria plan under Article 12, B.2 may not exceed 1,000 hours of service or one year of service.*

2b. Effective Date of Eligibility. An Employee will become an Eligible Employee on the date below upon completing the age and service requirements in B.1 and B.2a:

i. **[ ]** An Employee shall become an Eligible Employee immediately upon completing the age and service requirements in B.1 and B.2a.
ii. **[X]** first day of each calendar month.
iii. **[ ]** first day of each plan quarter.
iv. **[ ]** first day of the first month and seventh month of the Plan Year.
v. **[ ]** first day of the Plan Year.

2c. If eligibility is not immediate after meeting age and service requirements, an Employee shall become an Eligible Employee on the Eligibility Date in B.1 and B.2b that is:

i. **[X]** coincident with or next following the period in B.2b
ii. **[ ]** following the completion of the period in B.2b.

3. Describe any other modifications to the eligibility rules specified in B.1 and B.2: An Eligible Employee shall become eligible to become a Participant in the Plan with respect to the Premium Conversion Account effective on the same date that he or she becomes eligible to participate in the underlying benefit plan. An Eligible Employee shall become eligible to become a Participant in the Plan with respect to the Health Flexible Spending Account and Dependent Care Assistance Plan Account effective on the same date that he or she becomes eligible to

Copyright © 2002-2022
Miller Canfield

participate in the Employer's Major Medical Coverage.

Excluded Employees

4. The term "Eligible Employee" shall not include:

- **a.** **[ ] Union Employees.** Any Employee who is included in a unit of Employees covered by a collective bargaining agreement, if benefits were the subject of good faith bargaining between employee representatives and the Employer, and if the collective bargaining agreement does not provide for participation in this Plan.
- **b.** **[X] Leased Employees.**
- **c.** **[ ] Non-Resident Aliens.** Any Employee who is a non-resident alien described in Code section 410(b)(3)(C).
- **d.** **[ ] Part-time Employees.** Any Employee who is expected to work fewer than _____ hours per week.
- **e.** **[X] Other.** The term "Eligible Employee" shall not include student workers or employees not classified as "full-time" by the Employer, as further defined in the Employer's policies and procedures, and applicable collective bargaining agreements. (any exclusion must satisfy Code section 125(g) and the requirements under Article 13).

NOTE: *If the Plan is intended to be a simple cafeteria plan, B.4b, B.4d and B.4e may be selected only to the extent that the provisions do not violate the requirements on Code section 125(j).*

5. **[ ]** Describe any modifications to the definition of the term "Eligible Employee" for the specified Plan Benefit: _____________

Leave of Absence under FMLA

6. If a Participant takes an unpaid leave of absence under FMLA, the Participant may elect the following with respect to the health Benefits under the Plan (i.e., Premium Conversion Account, Health FSA, and Limited Purpose Health FSA) **(select at least one):**

- **a.** **[X]** Revoke coverage, which will be reinstated under the same terms upon the Participant's return from the FMLA leave of absence.
- **b.** **[X]** Continue coverage but discontinue payment of his or her contribution for the period of the FMLA leave of absence.

7. **[X]** If B.6b. is selected, the Employer may recover the Participant's suspended contributions when the Participant returns to work from the FMLA leave of absence.

8. A Participant on leave of absence under FMLA (select only one):

- **a.** **[X]** may continue coverage for all Benefits for which he is eligible when on FMLA leave, including non-health Benefits.
- **b.** **[ ]** may only continue coverage for Premium Conversion Accounts, Health FSA, and Limited Purpose Health FSA, as applicable.

9. A Participant who continues coverage for Benefits while on FMLA leave of absence may make contributions for such Benefits as follows (select at least one):

- **a.** **[X]** pre-pay on a pre-tax (to the extent permissible under Code section 125) or after-tax basis, prior to commencement of the FMLA leave of absence period, the contributions due for the FMLA leave of absence period
- **b.** **[X]** pay on an after-tax basis the same schedule as payments would have been made if the Participant were not on a leave of absence or if contributions were being made under COBRA
- **c.** **[X]** to the extent agreed in advance, the Participant will repay amounts advanced by the Employer to the Plan on behalf of the Participant upon the Participant's return from the FMLA leave of absence

NOTE: *B.9a may only be elected together with B.9.b or B.9c.*
NOTE: *B.9b must be elected if available for non-FMLA leaves of absence.*
NOTE: *B.9c may only be elected together with B.9a and/or B.9b unless it is the only option available to Participants on a non-FMLA leave of absence.*

Non-FMLA

10. **[X]** A Participant may elect to continue coverage of Benefits when on unpaid non-FMLA leave of absence.

Termination of Participation

11. If a Participant remains an Employee but is no longer an Eligible Employee, his or her participation in the Plan shall terminate:

- **a.** **[ ]** on the last day of employment during which the Participant ceases to be an Eligible Employee
- **b.** **[ ]** on the last day of the payroll period during which the Participant ceases to be an Eligible Employee
- **c.** **[X]** on the last day of the month during which the Participant ceases to be an Eligible Employee
- **d.** **[ ]** on the last day of the Plan Year during which the Participant ceases to be an Eligible Employee

Copyright © 2002-2022
Miller Canfield

e. **[ ]** Other _____

Reemployment

12. If an Eligible Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee within 30 days after Termination:
- **a.** **[X]** the Plan Administrator shall automatically reinstate the Benefit elections in effect at the time of Termination
- **b.** **[ ]** the Eligible Employee shall not resume or become a Participant until the first day of the subsequent Plan Year

13. If an Eligible Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee more than 30 days after Termination:
- **a.** **[ ]** the Plan Administrator shall automatically reinstate the Benefit elections in effect at the time of Termination
- **b.** **[ ]** the Eligible Employee shall not resume or become a Participant until the first day of the subsequent Plan Year
- **c.** **[X]** the Eligible Employee may elect to reinstate the Benefit election in effect at the time of Termination or make a new election under the Plan

C. <u>PARTICIPATION ELECTIONS</u>

Failure to Elect (Default Elections)

1. The election for the immediately preceding Plan Year relating to the following Benefits will apply to the applicable Plan Year:
- **a.** **[X]** Premium Conversion Account (Non-Employer-sponsored Contracts)
- **b.** **[ ]** Health Flexible Spending Account
- **c.** **[ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSAs)
- **d.** **[ ]** Dependent Care Assistance Plan Account
- **e.** **[ ]** Health Savings Account
- **f.** **[ ]** Adoption Assistance Flexible Spending Account

NOTE: *If a Benefit is not selected, an Eligible Employee who does not make an affirmative election under the Plan for a Plan Year will be deemed to have elected not to participate in that Benefit for the Plan Year.*

Change in Status

2. An Eligible Employee may change his or her election upon the following Change in Status events:
- **a.** **[ ]** None
- **b.** **[X]** Any event described in Treas. Reg. section 1.125-4 and other events permitted by IRS guidance
- **c.** **[ ]** Pursuant to written Plan Administrative Procedures, which are incorporated herein by reference
- **d.** **[ ]** Other: _____

D. <u>PREMIUM CONVERSION ACCOUNT</u>

Contracts for Reimbursement

NOTE: *If Premium Conversion Account is not a selected Benefit under A.5a, Section D is disregarded.*

1. If Premium Conversion Accounts are allowed under the Plan, select the types of Contracts with respect to which a Participant may contribute under Section 5.04:
- **a.** **[X]** Employer Health
- **b.** **[X]** Employer Dental
- **c.** **[X]** Employer Vision
- **d.** **[ ]** Employer Short-Term Disability
- **e.** **[ ]** Employer Long-Term Disability
- **f.** **[X]** Employer Group Term Life
- **g.** **[X]** Employer Accidental Death & Dismemberment
- **h.** **[ ]** Individually-Owned Dental
- **i.** **[ ]** Individually-Owned Vision

Copyright © 2002-2022
Miller Canfield

j. **[ ]** Individually-Owned Disability
k. **[ ]** COBRA continuation coverage under the Employer group health plan
l. **[ ]** Other: _____

Enrollment

2. **[X]** All Employees will automatically be enrolled in the Premium Conversion Account upon their date of hire and will be deemed to have elected to contribute the entire amount of any premiums payable by the Employee during the Plan Year for participation in Employer-sponsored Contract(s).
NOTE: *If D.2 is not selected, Eligible Employees may only elect to participate in the Premium Conversion Account pursuant to Section 4.02(b), 4.02(c) and Section 4.03 of the Plan.*

Contributions

3. **[X]** **Participant elections** will be automatically adjusted for changes in the cost of Employer-sponsored Contracts pursuant to the terms of Treas. Reg. 1.125-4(f)(2)(i).

E. <u>FLEXIBLE SPENDING ACCOUNTS</u>

NOTE: *If Flexible Spending Accounts are not a permitted Benefit under A.5b, Section E is disregarded.*

Employer Contributions

1. **[ ]** **Matching Contributions.** The Plan permits Employer matching contributions to the applicable Benefits as follows:
a. **Health FSA:**
i. **[ ]** None
ii. **[ ]** Discretionary
iii. **[ ]** _____% of the Participant's Health FSA contribution up to _____% of the Participant's Compensation
iv. **[ ]** _____% of the Participant's Health FSA contribution up to $_____
v. **[ ]** Other: _____
b. **Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA)**
i. **[ ]** None
ii. **[ ]** Discretionary
iii. **[ ]** _____% of the Participant's HSA-Compatible Health FSA contribution up to _____% of the Participant's Compensation
iv. **[ ]** _____% of the Participant's HSA-Compatible Health FSA contribution up to $_____
v. **[ ]** Other: _____
c. **Dependent Care Assistance Plan Account:**
i. **[ ]** None
ii. **[ ]** Discretionary
iii. **[ ]** _____% of the Participant's DCAP Account contribution up to _____% of the Participant's Compensation
iv. **[ ]** _____% of the Participant's DCAP Account contribution up to $_____
v. **[ ]** Other: _____
d. **Adoption Assistance Flexible Spending Account:**
i. **[ ]** None
ii. **[ ]** Discretionary
iii. **[ ]** _____% of the Participant's Adoption Assistance FSA contribution up to _____% of the Participant's Compensation
iv. **[ ]** _____% of the Participant's Adoption Assistance FSA contribution up to $_____
v. **[ ]** Other: _____
NOTE: *If there are no Employer matching contributions to the Plan, questions under E.1 are disregarded.*
NOTE: *Only one contribution formula is permitted for each applicable Benefit.*
NOTE: *If the Plan is intended to be a simple cafeteria plan, the matching contributions in this section will apply in addition to the contributions at A.6b.*

2. **[ ]** **Non-Elective Employer Contributions.** The Plan permits Employer contributions to the applicable Benefits as follows:
a. **Health Flexible Spending Account:**

Copyright © 2002-2022
Miller Canfield

i. [ ] None
ii. [ ] Discretionary
iii. [ ] _____% of the Participant's Compensation
iv. [ ] $_____ per Eligible Employee
v. [ ] Other: _____

b. Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA):
i. [ ] None
ii. [ ] Discretionary
iii. [ ] _____% of the Participant's Compensation
iv. [ ] $_____ per Eligible Employee
v. [ ] Other: _____

c. Dependent Care Assistance Plan Account:
i. [ ] None
ii. [ ] Discretionary
iii. [ ] _____% of the Participant's Compensation
iv. [ ] $_____ per Eligible Employee
v. [ ] Other: _____

d. Adoption Assistance Flexible Spending Account:
i. [ ] None
ii. [ ] Discretionary
iii. [ ] _____% of the Participant's Compensation
iv. [ ] $_____ per Eligible Employee
v. [ ] Other: _____

NOTE: *If there are no non-elective Employer contributions, questions under E.2 are disregarded.*
NOTE: *Employer matching and non-elective contributions shall not exceed the limits set forth in the BPD including: Health FSA, Section 6.04(b); HSA-Compatible FSA Section 7.04; Dependent Care Assistance Plan Account Section 8.04; and Adoption Assistance Flexible Spending Account, Section 10.04.*
NOTE: *If the Plan is intended to be a simple cafeteria plan, the Employer non-elective contributions in this section will apply in addition to the contributions at A.6b.*

3. Contribution Limits. Select the maximum allowable Participant contribution to the applicable FSA in any Plan Year:
a. [X] The maximum amount permitted under Code section 125(i), 129(a)(2) and/or 137(b)(1)
b. [ ] Other amounts
i. Health Flexible Spending Account: _____
ii. Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA): _____
iii. Dependent Care Assistance Plan Account: _____
iv. Adoption Assistance Flexible Spending Account: _____

NOTE: *Other amounts for Health Flexible Spending Account in E.3bi and Limited Purpose/Post-Deductible Health Flexible Spending Account in E.3ii cannot exceed the Code section 125(i) maximum. Other amounts in E.3b.iii for Dependent Care Assistance Plan Account cannot exceed Code 129(a)(2) amounts and E.3b(iv) cannot exceed Code section 137(b)(1) maximum.*

Eligible Expenses

4. Individual Expenses Eligible for Reimbursement. Participant may only be reimbursed from the applicable FSA for expenses that are incurred by:
a. [X] Participant, spouse and Dependents. The Participant, his or her spouse and all Dependents, and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday:
b. [ ] Persons covered under Employer-sponsored group health plan. The Participant, his or her spouse and all Dependents, and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday, but only if such persons are also covered under an Employer-sponsored health plan:
c. [ ] Participants only. No reimbursement for expenses incurred by the Participant's spouse or Dependents:
d. [ ] Other: _____ (may not include anyone other than the Participant, his or her spouse and all Dependents, and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday)

Copyright © 2002-2022
Miller Canfield

Expenses Not Eligible for Reimbursement

5. **Expenses Not Eligible for Reimbursement.** In addition to those listed in the Basic Plan Document, the following expenses are not eligible for reimbursement from a Participant's FSA:
   - **a.** **[ ]** Health Flexible Spending Account: _____
   - **b.** **[ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA): _____
   - **c.** **[ ]** Dependent Care Assistance Plan Account: _____
   - **d.** **[ ]** Adoption Assistance Flexible Spending Account: _____
6. **Adult Children Coverage.** Reimbursement for adult children may be paid from the applicable FSA for claims incurred:
   - **a.** **[X]** until the date the child attains age 26
   - **b.** **[ ]** until the last day of the calendar year in which the child attains age 26

Reimbursement

7. **[X] Amounts Available for Reimbursement.** The Plan Administrator may direct reimbursement of FSAs up to the entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the applicable FSA, less any reimbursements already disbursed from the applicable FSA for the following Benefits:
   - **a.** **[X]** Dependent Care Assistance Plan Account
   - **b.** **[ ]** Adoption Assistance Flexible Spending Account

   NOTE: *If 7.a or 7.b is not selected, the Plan Administrator may direct reimbursement only up to the amount in the applicable FSA at the time the reimbursement request is received by the Plan Administrator.*

Grace Period

8. **[X]** The Plan will reimburse claims incurred during a Grace Period immediately following the end of the Plan Year for the following Benefits.
   - **a.** **[X]** Health Flexible Spending Account
   - **b.** **[ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA)
   - **c.** **[X]** Dependent Care Assistance Plan Account
   - **d.** **[ ]** Adoption Assistance Flexible Spending Account

   NOTE: *The Plan cannot reimburse claims incurred during a Grace Period if carryovers are permitted in Part E.12.*
9. **Last day of Grace Period:**
   - **a.** **[X]** Fifteenth day of the 3rd month following end of the Plan Year
   - **b.** **[ ]** Other _____

Run Out Period

10. If **no Grace Period** applies for the Plan Year, an active Participant must submit claims for the Plan Year for reimbursement from the applicable FSA no later than:
    - **a.** **[ ]** _____ days after the end of the Plan Year
    - **b.** **[ ]** _____ (insert date, e.g., March 31) immediately following such Plan Year
11. If a **Grace Period** applies for the Plan Year, an active Participant must submit claims for the Plan Year for reimbursement from the applicable FSA no later than:
    - **a.** **[ ]** 120 days after the end of the Grace Period
    - **b.** **[X]** 120th day (insert date, e.g., March 31st) immediately following such Plan Year

    NOTE: *The date in E.11b should be later than the last day of the Grace Period.*

Automatic Payment of Claims

12. Eligible expenses not covered under the Employer-sponsored health plan (e.g., co-payments, co-insurance, deductibles) automatically paid from the applicable FSA.
    - **a.** **[ ]** Health Flexible Spending Account

Copyright © 2002-2022
Miller Canfield

b. **[ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA)

Carryover

13. The Plan will carry over unused Health FSA balances at the end of the Plan Year for the following Benefits:
- **a.** **[ ]** Health Flexible Spending Account
  - **i.** **[ ]** Maximum amount, as indexed
  - **ii.** **[ ]** Other: _____
- **b.** **[ ]** Limited Purpose/Post-Deductible Health Flexible Spending Account (HSA-Compatible FSA)
  - **i.** **[ ]** Maximum amount, as indexed
  - **ii.** **[ ]** Other: _____

NOTE: *If carryover is selected (E.13a or E.13b is selected for the applicable FSA), the Plan may not provide for a Grace Period for the applicable FSA and the Plan may not provide for a Grace Period for the applicable FSA in the Plan Year to which the carryover amount is applied.*

Termination of Employment

14. In the event of a Termination of Employment the Participant may elect to continue to make contributions to FSAs under the Plan on an after-tax basis and reimbursements will be allowed for the remainder of the Plan Year.
- **a.** **[ ]** Yes
- **b.** **[ ]** Yes - subject to the following limitations: _____
- **c.** **[X]** No

NOTE: *If E.14c is selected, then contributions shall cease upon Termination and reimbursements will be allowed only for expenses incurred prior to Termination.*
NOTE: *If applicable, any COBRA elections shall supersede this section.*

15. In the event of a Termination of Employment, a Participant may submit claims for reimbursement from the applicable FSA no later than:
- **a.** **[X]** 90 days after a Termination of Employment.
- **b.** **[ ]** _____ days following the Plan Year in which the Termination occurs.

NOTE: *If E.14a or E.14b is selected, then E.15b must be selected.*

Qualified Reservist Distributions

16. **[X] Qualified Reservist Distributions are available for:**
- **a.** **[ ]** The entire amount elected for the applicable Health FSA for the Plan Year minus applicable Health FSA reimbursements received as of the date of the Qualified Reservist Distribution request.
- **b.** **[X]** The amount contributed to the applicable Health FSA as of the date of the Qualified Reservist Distribution request minus applicable FSA reimbursements received as of the date of the Qualified Reservist Distribution request.
- **c.** **[ ]** Other amount (not to exceed the entire amount elected for the applicable Plan Year minus reimbursements): _____

F. HEALTH SAVINGS ACCOUNT (HSA Account) (Article 9)

NOTE: *If HSA Account is not a permitted Benefit under A.5g, Section F is disregarded.*

Employer Contributions

1. **Matching Contributions.** The Plan permits Employer matching contributions to the HSA Account as follows (not to exceed the limits in Section 9.04):
- **a.** **[ ]** None
- **b.** **[ ]** Discretionary
- **c.** **[ ]** _____% of the Participant's elected HSA Account contribution up to _____% of the Participant's Compensation
- **d.** **[ ]** _____% of the Participant's elected HSA Account contribution up to $_____
- **e.** **[ ]** Other: _____

NOTE: *If the Plan is intended to be a simple cafeteria plan, the matching contributions in this section will apply in addition to the contributions at A.6b.*

2. **Employer Non-Elective Contributions.** The Plan permits Employer non-elective contributions to the HSA Account as follows (not to exceed

Copyright © 2002-2022
Miller Canfield

the limits in Section 9.04):

a. **[ ]** None

b. **[ ]** Discretionary

c. **[ ]** _____% of the Participant's Compensation

d. **[ ]** $_____ per Eligible Employee

e. **[ ]** Other: _____

NOTE: *If the Plan is intended to be a simple cafeteria plan, the Employer non-elective contributions in this section will apply in addition to the contributions at A.6b.*

3. **Contribution Limits.** Select the maximum allowable contribution to a Participant's HSA Account in any Plan Year:

a. **[ ]** The maximum amount permitted under Code section 223(b), reduced by any Employer contributions.

b. **[ ]** Other amount: _____ (not to exceed the Code section 223(b) maximum when combined with any Employer contributions).

G. FLEXIBLE BENEFIT CREDITS ("Flex Credits") (Section 11.01)

Health Flex Contribution

NOTE: *If Flexible Benefit Credits are not permitted Benefits in A.5h, Section G is disregarded.*

1. **[ ]** **Health Flex Contribution.** The Flex Credit is intended to qualify as a "health flex contribution" under Treas. Reg. section 1.5000A-3(e)(3)(ii)(E): The Participant may not opt to receive the Flex Credit as a cash or taxable benefit and the Participant may only use the Flex Credit for the payment of premiums applicable to health care and toward the Health FSA or HSA-Compatible Health FSA Benefits.

2. **Eligible Benefits.** Participants may elect to contribute the Flex Credits to the following benefits:

a. **[ ]** All Benefits offered under the Plan

b. **[ ]** All Benefits offered under the Plan except the following:_________.

c. **[ ]** Only the following Benefits: _____

d. **[ ]** Only the portion of the (i) Premium Conversion Account paid toward Employer-sponsored Health Contract premiums and/or (ii) Health FSA or HSA-Compatible Health FSA Benefits.

NOTE: *If G.1 is selected, G.2d must be selected.*

3. **Amount of Flex Credit.** The Employer will contribute a Flex Credit on behalf of each Eligible Employee as follows:

a. **[ ]** $_____ per Eligible Employee

b. **[ ]** A discretionary amount as determined by the Employer

c. **[ ]** Other: _____

d. **[ ]** The amount of the simple cafeteria plan contributions described in A.6b

4. **[ ]** **Contribution to 401(k) Plan.** An Eligible Employee may elect to contribute all or a portion of his or her Flex Credits to a Qualified Plan in accordance with the terms of the following Qualified Plan(s): _____

NOTE: *If G.4 is selected, then G.5 (cash out) must also be elected.*

Cash Outs

5. **Cash Out of Flex Credits.** A Participant may elect to receive all or a portion of his or Flex Credits in cash.

a. **[ ]** Yes

b. **[ ]** Yes, subject to the following limitations: _____

c. **[ ]** No

NOTE: *If G.5a or G.5b is selected, then Flex Credits a Participant elects to contribute to a Health FSA will count toward the Code section 125(i) contribution limitation.*

NOTE: *If G.1 is selected, G.5c must be selected.*

NOTE: *If G.5.c is selected, the maximum value of Flex Credits a Participant can contribute to a Health FSA for a Plan Year is $500.*

6. **Amount of Cash Out.** For each Flex Credit dollar that a Participant elects to receive in cash from the Plan, the Participant will receive: $ (insert dollar value of each Flex Credit; if no amount is provided, the cash out value of each Flex Credit is $1.00)

7. **Maximum Flex Credit Cash Out.** The amount of cash a Participant may receive in exchange for Flex Credits in Plan Year shall not exceed:

a. **[ ]** No limit

b. **[ ]** $_____ per calendar year

c. **[ ]** Other: _____

Copyright © 2002-2022
Miller Canfield

8. **Payment of Cash Out.** Amounts distributed in cash from the Plan pursuant to Section 11.03 shall be paid to the Participant in:
   a. **[ ]** Equal payroll installments
   b. **[ ]** A single lump sum at the beginning of the Plan Year
   c. **[ ]** A single lump sum at the end of the Plan Year
   d. **[ ]** Other: _____

H. PURCHASE AND SALE OF PAID TIME OFF (PTO) (Section 11.02)

Purchase of PTO

1. **Maximum PTO Purchase.** A Participant can elect to purchase no more than the following periods of PTO in a Plan Year:
   a. **[ ]** None
   b. **[ ]** _____ hours
   c. **[ ]** _____ days
   d. **[ ]** _____ weeks
   e. **[ ]** Other: _____
   NOTE: *If Purchase of PTO is not a permitted Benefit in A.5i, H.1 is disregarded.*

Sale of PTO

2. **Maximum PTO Sale.** A Participant can elect to sell no more than the following periods of PTO in a Plan Year:
   a. **[ ]** None
   b. **[ ]** _____ hours
   c. **[ ]** _____ days
   d. **[ ]** _____ weeks
   e. **[ ]** Other: _____
   NOTE: *If Sale of PTO is not a permitted Benefit in A.5i, H.2 is disregarded.*

Carryover of PTO

3. **[ ] No Carryover of Elective PTO.** Unused elective PTO (determined as of the last day of the Plan Year) shall be paid in cash on or prior to the last day of the Plan Year.
   NOTE: *If Sale and/or Purchase of PTO are not permitted Benefits in A.5i, H.3 is disregarded.*
   NOTE: *If H.3 is not selected, unused elective PTO will be forfeited as of the last day of the Plan Year.*

I. MISCELLANEOUS

Plan Administrator Information

1. **Plan Administrator.**
   a. **[X]** Plan Sponsor
   b. **[ ]** Committee appointed by Plan Sponsor
   c. **[ ]** Other: _____
2. **Indemnification.** Type of indemnification for the Plan Administrator:
   a. **[ ]** None - the Company will not indemnify the Plan Administrator.
   b. **[X]** Standard as provided in Section 14.02.
   c. **[ ]** Custom. (If I.2.c. (Custom) is selected, indemnification for the Plan Administrator is provided pursuant to an Addendum to the Adoption Agreement.)
3. **Governing Law.** The following state's law shall govern the terms of the Plan to the extent not pre-empted by Federal law: Michigan
4. **Participating Employers.** Additional participating employers may be specified in an addendum to the Adoption Agreement.
5. **State of Organization.** State of organization of Plan Sponsor: Michigan
   (If state law requires written document language regarding benefits herein, add language to Addendum.)

Copyright © 2002-2022
Miller Canfield

J. EXECUTION PAGE

Failure to properly fill out the Adoption Agreement may result in the failure of the Plan to achieve its intended tax consequences.

The Plan shall consist of this Adoption Agreement, its related Basic Plan Document #125 and any related Appendix and Addendum to the Adoption Agreement.

The undersigned agree to be bound by the terms of this Adoption Agreement and Basic Plan Document and acknowledge receipt of same. The Plan Sponsor caused this Plan to be executed this _______ day of ________________, 2022.

LANSING BOARD OF WATER AND LIGHT:

Signature:________________________________

Print Name: ______________________________

Title/Position:_____________________________

Copyright © 2002-2022
Miller Canfield

CUSTOM LANGUAGE ADDENDUM

ADOPTION AGREEMENT

Election A.5 of the Adoption Agreement is amended to read as follows:

5. The following Benefits are available under the Plan:
a. **[X]** Premium Conversion Account
b. **[X]** Health Flexible Spending Account
c. **[ ]** Limited Purpose HSA-Compatible Health Flexible Spending Account
d. **[ ]** Post-Deductible HSA-Compatible Health Flexible Spending Account
e. **[X]** Dependent Care Assistance Plan Account
f. **[ ]** Adoption Assistance Flexible Spending Account
g. **[ ]** Health Savings Account
h. **[ ]** Flexible Benefits Credits
i. **[ ]** PTO Purchase/Sale
j. [**X**] Cash in Lieu of Major Medical Benefits

Election E.6 of the Adoption Agreement is amended to read as follows:

6. Adult Children Coverage. Reimbursement for adult children may be paid from the applicable FSA for claims incurred:
a. **[ ]** until the date the child attains age 26
b. **[ ]** until the last day of the calendar year in which the child attains age 26
c. [**X**] until the last day of the calendar month in which the child attains age 26

BASIC PLAN DOCUMENT #125

1. The Plan and its component programs are not subject to and are not required to comply with ERISA. Any and all references to ERISA made in the Basic Plan Document are hereby deleted.

2. ARTICLE 2 of the Basic Plan Document is amended to add / amend the following definitions:

Alternative Minimum Essential Coverage means
an insurance plan that meets the Affordable Care Act requirement for having health coverage and is described in Code §5000A(f) (other than coverage in the individual market, whether or not obtained through the marketplace).

Major Medical Coverage means
major medical coverage sponsored by the Employer.

Medical Expenses means
expenses incurred during the Plan Year by a Participant, or by the Spouse or Dependent of the Participant, for medical care as defined in Code §213(d) and only as allowed to be reimbursed under Code §125 and the regulations and guidance thereunder, but only to the extent that the Participant or other persons incurring the expense are not reimbursed for the expense through insurance or otherwise. If only a portion of the Medical Expense has been reimbursed elsewhere, the Plan may reimburse the remaining portion of the expense if it otherwise meets this definition. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code §7702B(c) or any premium payments for health care coverage. Medical Expenses are incurred at the time the services to which the expense relates are rendered, regardless of when the Participant is charged for the services. Effective for expenses incurred after December 31, 2019, pursuant to §3702 of the CARES Act, reimbursement of certain over-the-counter drugs and medicine are permitted without prescription and Medical Expenses shall include expenses incurred for menstrual care products (as defined in Code §223(d)(2)(D)). Effective for expenses incurred on or after January 1, 2021, pursuant to IRS Announcement 2021-7 reimbursement of certain COVID-19 personal protective equipment is permitted.

Participant means

Copyright © 2002-2022
Miller Canfield

an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4. Solely for purposes of Cash in Lieu of Major Medical Benefits available under Article 19, the term "Participant" includes, unless prohibited by law, a "retiree" (as defined in the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light) as further defined and set forth in Plan Administrator procedures.

3. Section 4.01 of the Basic Plan Document is amended to add Cash in Lieu of Major Medical Benefits as a Benefit option.

4. Section 6.05(b) of the Basic Plan Document is amended in its entirety to read as follows:

(b) Eligible Expenses. Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her General Purpose Health FSA for Medical Expenses.

5. Section 7.05(b)(1) of the Basic Plan Document is amended to read as follows:

(b) *Eligible Expenses*.
(1) *Limited Purpose Health FSA*. Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Limited Purpose Health FSA for expenses that are: (i) incurred in the Plan Year (except as provided in Section 7.05(c)), (ii) incurred while the Participant participates in the Plan, (iii) excludable under Code section 105(b), (iv) incurred for dental or vision care or for preventive care (as defined under Code section 223(c)(2)(C); and (v) incurred for telehealth services as defined in Code section 223(c)(2)(E); provided that such expenses that are not covered, paid or reimbursed from any other source.

6. Section 7.05(c) of the Basic Plan Document is amended to read as follows:

(c) For purposes of determining whether an expense is excludable under Code section 105(b), the following applies:
(1) *Michelle's Law*. Unless otherwise provided in the Adoption Agreement, "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a Dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

(2) *Coverage of Adult Children*. Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.

7. ARTICLE 19 of the Basic Plan Document is added in its entirety to read to as follows:

ARTICLE 19. CASH IN LIEU OF MAJOR MEDICAL COVERAGE

Section 19.01 ELECTION TO WAIVE MAJOR MEDICAL COVERAGE AND RECEIVE CASH.

A Participant who is eligible to receive Major Medical Coverage may elect to receive additional cash compensation from the Employer in an amount periodically determined by the Employer and communicated to the Participant prior to the beginning of each Plan Year in lieu of Major Medical Coverage ("Cash-In-Lieu"), provided that the Participant meets the requirements of Section 19.02. In order to elect to waive Major Medical Coverage, the Participant must provide a written or electronic waiver on a form provided by the Plan Administrator. Unless otherwise agreed, the Cash-in Lieu payment shall be paid on a pro rata basis per pay period.

In order for Cash-In-Lieu to apply, a Participant must be eligible for Major Medical Coverage under a collective bargaining agreement, the health and prescription drug plans for active employees, or the Post-Retirement Benefit Plan for Eligible Employees of Lansing Board of Water and Light.

Section 19.02 RESTRICTIONS ON ELECTION TO WAIVE MAJOR MEDICAL COVERAGE AND RECEIVE CASH-IN-LIEU

In order to receive the Cash-in-Lieu payment when waiving Major Medical Coverage, a Participant must attest in writing (or electronically) at least one time each Plan Year that the Participant and each member of the Participant's "expected tax family" is (or

Copyright © 2002-2022
Miller Canfield

will be) enrolled in Alternative Minimum Essential Coverage for the Plan Year (or that portion of the Plan Year) to which the Cash-in-Lieu waiver applies. A Participant's "expected tax family" includes all individuals for whom the Participant reasonably expects to claim a personal exemption deduction under Code §151 for the taxable year or years that begin or end in or with the Plan Year to which the cash waiver applies.

Additionally, the Employer will not make the Cash-in-Lieu payment if it knows or has reason to know that the Participant, or any member of the Participant's expected tax family, does not (or will not) have Alternative Minimum Essential Coverage during the eligible Plan Year.

An Employee-Participant shall not be eligible to receive the Cash-in-Lieu payment when waiving Major Medical Coverage if he or she is covered by the Major Medical Coverage as a Dependent.

Section 19.03 REVOCATION OF ELECTION UPON LOSS OF OTHER ALTERNATIVE MINIMUM ESSENTIAL COVERAGE.

A Participant who elects to waive Major Medical Coverage and who (or whose family member) subsequently loses Alternative Minimum Essential Coverage: (a) must immediately notify the Employer, at which time the Cash-in-Lieu payment will cease; and (b) may be permitted to change an election pursuant to Section 4.03 and, to the extent permitted under the Major Medical Coverage, to prospectively revoke his or her election by providing proof of the loss of Alternative Minimum Essential Coverage and occurrence of a change in election event to the Plan Administrator.

Elections made (or deemed made) under this Article 19 shall automatically terminate on the date on which the Participant no longer meets the requirements of Section 19.02, or on the date on which the Participant ceases to be a Participant in the Plan.

Section 19.04 ELECTION PROCEDURE.

Prior to the beginning of the Plan Year and upon meeting the eligibility requirements for newly eligible Employees, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement (which may be through the self-service HRIS system) to each Participant and to each other Employee who is expected to become a Participant. Each Participant who elects to waive Major Medical Coverage and receive a Cash-in-Lieu payment shall so specify on the Election Form/Salary Reduction Agreement. Each Election Form/Salary Reduction Agreement must be completed and returned to the Plan Administrator (which may be through the self-service HRIS system) on or before such date as the Plan Administrator shall specify, which date shall be no later than (1) the beginning of the Plan Year for purposes of Open Enrollment; and (2) the beginning of the first pay period for which the Participant's election will apply for newly eligible Employees. A Participant who fails to provide a completed Election Form/Salary Reduction Agreement to the Plan Administrator on or before the specified due date for each Plan Year shall not receive the Cash-in-Lieu payment.

Section 19.05 MAXIMUM EMPLOYER CONTRIBUTIONS

The maximum amount of Employer contributions under this Article 19 for any Participant shall be equal to the Cash-in-Lieu payment elected by a Participant who waives Major Medical Coverage as provided in this Article 19.

TEMPORARY AMENDMENTS RELATED TO CHANGES IN THE LAW

Temporary Provisions Related to 2020 Plan Year under IRS Notice 2020-29. Internal Revenue Service Notice 2020-29 grants employers the ability to provide relief for participants of Code §125 cafeteria plans. That notice is designed to provide temporary flexibility for employers and employees and assist with the national response to the 2019 novel coronavirus outbreak (COVID-19). In accordance with that notice, effective January 1, 2020:

- *Temporary Mid-Year Election Rights*. During the Plan Year beginning in 2020 only, Section 4.03 of the Basic Plan Document is modified so as to permit a Participant to revoke an election, make a new election, or decrease or increase an existing election applicable to the Health Flexible Spending Account and/or DCAP Account on a prospective basis, subject to the following: (1) the election shall not violate any other statute or regulation applicable to the Plan; (2) no Participant is permitted to elect to revoke or decrease either the Health Flexible Spending Account or DCAP Account amounts below the amount already disbursed/reimbursed from the applicable account; and (3) a Participant is only

Copyright © 2002-2022
Miller Canfield

permitted to change his or her election applicable to the Health Flexible Spending Account under this provision once during the Plan Year beginning in 2020.

- *Continuation of the Grace Period Through December 31, 2020*. For unused amounts remaining in the Health Flexible Spending Account and/or DCAP Account as of the end of the Grace Period ending in 2020, the Plan shall permit Employees to apply those unused amounts to pay or reimburse Dependent Care Expenses and Medical Expenses (as applicable) incurred through December 31, 2020.

Temporary Provisions Related to 2021 Plan Year under CCA and IRS Notice 2021-15. Section 214 of Division EE of the Consolidated Appropriations Act, 2021 (the "CAA") grant employers the ability to provide relief for participants of Code §125 cafeteria plans. Section 214 of the CAA is designed to provide temporary flexibility for employers and employees and assist with the national response to the 2019 novel coronavirus outbreak (COVID-19). In accordance with Section 214 of the CAA and IRS Notice 2021-15, effective January 1, 2021:

- *Temporary Mid-Year Election Rights*, During the Plan Year ending in 2021 only, a Participant may make an election to prospectively modify the amount (but not in excess of any applicable dollar limitation) of such Participant's contributions to the Health Flexible Spending Account and/or DCAP Account (without regard to any change in status) subject to the following: (1) the election shall not violate any other statute or regulation applicable to the Plan; (2) no Participant is permitted to elect to revoke or decrease either the Health Flexible Spending Account or DCAP Account amounts below the amount already disbursed/reimbursed from the applicable account; and (3) a Participant is only permitted to change his or her election applicable to the Health Flexible Spending Account under this provision once during the Plan Year beginning in 2021.

- *Continuation of the Grace Period through December 31, 2021***. T**he Plan shall permit Employees with unused amounts remaining in the Health Flexible Spending Account and/or DCAP Account as of the end of the Grace Period ending in 2021, to apply those unused amounts to pay or reimburse Dependent Care Expenses and Medical Expenses (as applicable) incurred through December 31, 2021.

- *Temporary Increase in Age for Dependent Care Expenses*. For purposes of Plan Years ending in 2020 and 2021, the DCAP of an "eligible employee" shall substitute age 14 for age 13 for purposes of determining the Dependent Care Expenses that may be paid or reimbursed. An "eligible employee" means an employee who (1) enrolled in a DCAP for the last plan year with respect to which the end of the regular enrollment period for such Plan Year was on or before 01/31/2020; and (2) has one or more dependents (as defined in Code §152(a)(1)) who attains age 13 either (a) during that Plan Year or (b) in the case of an employee who has an unused balance in his or her DCAP Account for such Plan Year (determined as of the close of the last day on which, under the terms of the Plan, claims from reimbursement may be made with respect to such Plan Year) the subsequent Plan Year.

DCAP Increased Limitation for 2021 Plan Year under ARPA. Section 9632 of the American Rescue Plan Act of 2021 (the "ARPA") grants employers the ability to provide relief for participants of Code §125 cafeteria plans. Section 9632 of the ARPA is designed to further assist employees affected by the 2019 novel coronavirus outbreak (COVID-19) and the associated economic downturn. In accordance with Section 9632 of the ARPA, during the Plan Year ending in 2021 only, Section 8.04 shall be amended to read: "The amount of all contributions to a Participant's DCAP Account shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 129(a)(2) as temporarily amended by the ARPA (i.e., $10,500 ($5,250 if a separate tax return is filed by a Participant who is marred as determined under the rules of paragraph (3) and (4) of Code §21(e))."

COBRA Subsidy - Special Enrollment Election

[X] An Assistance Eligible Individual (AEI) may:

1. **[X]** Enroll in the same coverage that they were enrolled at the time of the qualifying event
2. **[ ]** Change coverage to a less expensive option than the coverage enrolled in at the time of the qualifying event

The election must be made within 90 days of receipt of enrollment eligibility.

For purposes of this election and in accordance with IRS Notice 2021-31, an Assistance Eligible Individual (AEI) is any individual who is (1) a qualified beneficiary as the result of (A) the reduction of hours of a covered employee's employment or (B) the

Copyright © 2002-2022
Miller Canfield

involuntary termination of a covered employee's employment (other than by reason of an employee's gross misconduct), (2) is eligible for COBRA continuation coverage for some or all of the period beginning on 04/01/2021, through 09/30/2021, and (3) elects the COBRA continuation coverage. This includes qualified beneficiaries who are the spouse or dependent child of the employee who had the reduction in hours or involuntary termination of employment resulting in a loss of coverage, as well as the employee, if that reduction in hours or involuntary termination of employment caused the qualified beneficiary to lose coverage and the other requirements are satisfied.

In order to be a qualified beneficiary who is eligible to become an AEI, an individual must (1) be covered under the group health plan on the day before the reduction in hours or involuntary termination of the covered employee's employment, and (2) lose eligibility for the coverage due to the reduction in hours or involuntary termination of the covered employee's employment. An individual who loses group health coverage in connection with the termination of a covered employee's employment by reason of the employee's gross misconduct is not a qualified beneficiary and, thus, cannot be an AEI.

Enrollment in other group health plan coverage before electing COBRA continuation coverage does not end the period of eligibility for COBRA continuation coverage. If the individual is no longer covered by (or eligible to enroll in) the other group health plan coverage as of 04/01/2021, that prior coverage by a group health plan does not disqualify the individual from COBRA premium assistance. However, beginning on 04/01/2021, coverage by (or eligibility to enroll in) another group health plan would disqualify the individual from COBRA premium assistance, even though it does not end the period of eligibility for COBRA continuation coverage.

An individual who is a qualified beneficiary as the result of a reduction in hours or involuntary termination of employment but who is currently enrolled in individual health insurance coverage through a Health Insurance Exchange may be eligible to elect COBRA continuation coverage and for COBRA premium assistance. However, an individual is not eligible for a premium tax credit to help pay for the cost of Exchange coverage during any month that the individual is enrolled in COBRA continuation coverage. An individual who elects COBRA continuation coverage (with or without COBRA premium assistance) and who is enrolled in coverage through a Health Insurance Exchange with advance payments of the premium tax credit (APTC) may be required to repay the APTC for the overlap months.

COBRA premium assistance applies until the earliest of (1) the first date the AEI becomes eligible for other group health plan coverage (with certain exceptions) or Medicare coverage, (2) the date the individual ceases to be eligible for COBRA continuation coverage, or (3) the end of the last period of coverage beginning on or before 09/30/2021.

39538507.5/101173.00017

Copyright © 2002-2022
Miller Canfield

FINAL

BASIC PLAN DOCUMENT #125
FOR LANSING BOARD OF WATER AND LIGHT CAFETERIA PLAN

Copyright © 2005-2022
Miller Canfield
All Rights Reserved.

LANSING BOARD OF WATER AND LIGHT CAFETERIA PLAN

TABLE OF CONTENTS

ARTICLE 1. INTRODUCTION 1
Section 1.01 Plan 1
Section 1.02 Application of Plan 1

ARTICLE 3. ELIGIBILITY 4
Section 3.02 Ineligible Employees 4
Section 3.03 Leave of Absence 4
Section 3.04 Termination of Participation 5
Section 3.05 Termination of Employment 5
Section 3.06 Reemployment 5
Section 4.01 Benefit Options 5
Section 4.02 Election to Participate 5
Section 4.03 Mid-Year Election Changes 6

ARTICLE 5. PREMIUM CONVERSION ACCOUNT 8
Section 5.01 In General 8
Section 5.02 Eligible Employees 8
Section 5.03 Enrollment 8
Section 5.04 Eligible Expenses 9
Section 5.05 Termination of Employment 9

ARTICLE 6. HEALTH FLEXIBLE SPENDING ACCOUNT 9
Section 6.01 In General 9
Section 6.02 Eligible Employees 9
Section 6.03 Enrollment 9
Section 6.04 Limits 9
Section 6.05 Eligible Expenses 10
Section 6.06 Reimbursement 10
Section 6.07 Forfeitures 11
Section 6.08 Carryover to an HSA-Compatible Health FSA 11
Section 6.09 Termination of Employment 11
Section 6.10 Qualified Reservist Distributions 11
Section 6.11 Separate Plan 11

ARTICLE 7. HSA-COMPATIBLE HEALTH FLEXIBLE SPENDING ACCOUNT 12
Section 7.01 In General 12
Section 7.02 Eligible Employees 12
Section 7.03 Enrollment 12
Section 7.04 Limits 12
Section 7.05 Eligible Expenses 12
Section 7.06 Reimbursement 13
Section 7.07 Forfeitures 13
Section 7.08 Termination of Employment 14
Section 7.09 Qualified Reservist Distributions 14
Section 7.10 Separate Plan 14

ARTICLE 8. DEPENDENT CARE ASSISTANCE PLAN ACCOUNT 14
Section 8.01 In General 14
Section 8.02 Eligible Employees 14
Section 8.03 Enrollment 14
Section 8.04 Limits 15
Section 8.05 Eligible Expenses 15
Section 8.06 Reimbursement 15
Section 8.07 Forfeitures 15
Section 8.08 Termination of Employment 16
Section 8.09 Separate Plan 16

ARTICLE 9. HEALTH SAVINGS ACCOUNT 16
Section 9.01 In General 16
Section 9.02 Eligible Employees 16
Section 9.03 Enrollment 16

Copyright © 2002-2022
Miller Canfield

Section 9.04 Limits 16
Section 9.05 Administration 16
Section 9.06 Termination of Employment 17
Section 10.01 In General 17
Section 10.02 Eligible Employees 17
Section 10.03 Enrollment 17
Section 10.04 Limits 17
Section 10.05 Eligible Expenses 17
Section 10.06 Reimbursement 18
Section 10.07 Forfeitures 18
Section 10.08 Termination of Employment 18
Section 10.09 Separate Plan 18

ARTICLE 11. OTHER BENEFITS 18
Section 11.01 Flex Credits 18
Section 11.02 Purchase/Sale of PTO 18
Section 11.03 Cash Out 19

ARTICLE 12. SIMPLE CAFETERIA PLAN 19
Section 12.01 In General 19
Section 12.02 Eligible Employers 19
Section 12.03 Employer Contributions 19
Section 12.04 Eligible Employees 20

ARTICLE 13. NONDISCRIMINATION 20
Section 13.01 Nondiscrimination Requirements 20
Section 13.02 Adjustments 20

ARTICLE 14. PLAN ADMINISTRATION 20
Section 14.01 Plan Administrator 20
Section 14.02 Indemnification 21
Section 15.01 Amendment 21
Section 15.02 Termination 21

ARTICLE 16. CLAIMS PROCEDURES 21
Section 16.01 Contract Benefit and HSA Claims 21
Section 16.02 Claims Procedures for Plan Accounts (Other Than Contract Benefits and HSA) 22
Section 16.03 Refunds/Indemnification 23
Section 17.01 Nonalienation of Benefits 24
Section 17.02 No Right to Employment 24
Section 17.03 No Funding Required 24
Section 17.04 Medical Child Support Orders 24
Section 17.05 Governing Law 24
Section 17.06 Tax Effect 24
Section 17.07 Severability of Provisions 24
Section 17.08 Headings and Captions 24
Section 17.09 Gender and Number 25
Section 17.10 Transfers 25
Section 17.11 COBRA 25
Section 17.12 Conflicts 25
Section 17.13 Death 25

ARTICLE 18. HIPAA PRIVACY AND SECURITY COMPLIANCE 25
Section 18.01 Definitions 25
Section 18.02 HIPAA Privacy Compliance 26
Section 18.03 HIPAA Security Compliance 27

Copyright © 2002-2022
Miller Canfield

ARTICLE 1. INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to qualify as a cafeteria plan within the meaning of Code section 125. To the extent provided in the Adoption Agreement, the Plan provides for the pre-tax payment of premiums and contributions to spending accounts that are excludable from gross income under Code section 125, reimbursement of certain medical expenses that are excludable from gross income under Code section 105(b), reimbursement of certain dependent care expenses that are excludable from gross income under Code section 129, reimbursement of certain adoption expenses that are excludable from gross income under Code section 137, and/or for such other benefits as set forth herein.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Employer on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Employer whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2. DEFINITIONS

Account means
 the bookkeeping balance of an account established for each Participant as of the applicable date. "Account" or "Accounts" shall include, to the extent provided in the Adoption Agreement, a Premium Conversion Account, a General Purpose Health Flexible Spending Account, an HSA-Compatible Health Flexible Spending Account, a Dependent Care Assistance Plan Account, an Adoption Assistance Flexible Spending Account and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

Adoption Agreement means
 the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

Adoption Assistance Flexible Spending Account or Adoption Assistance FSA means
 the Account established with respect to the Participant's election to have Adoption Expenses reimbursed by the Plan pursuant to Article 10.

Adoption Expenses means
 the expenses described in Section 10.05(b)(2).

Affiliate means
 the Plan Sponsor or any other employer required to be aggregated with the Plan Sponsor under Code sections 414(b), (c), (m) or (o); provided, however, that "Affiliate" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

Benefits means
 the benefit options available to Eligible Employees under the Plan.

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

Code means
 the Internal Revenue Code of 1986, as amended from time to time.

Compensation means
 the cash wages or salary paid to a Participant. If the Adoption Agreement indicates that the Plan is a simple cafeteria plan as defined in Code section 125(j), "Compensation" shall mean Section 414(s) Compensation (defined below).

Contract means

Copyright © 2002-2022
Miller Canfield

an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. "Contract" shall not include any product which is advertised, marketed, or offered as long-term care insurance. "Contract" shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

Dependent means

an individual who qualifies as a dependent of a Participant under Code section 152 (as modified by Code section 105(b)). For purposes of the Premium Conversion Account, "Dependent" does not include any individual who is not a dependent under the underlying Contract. A child who is determined to be a Participant's alternate recipient under a qualified medical child support order under ERISA section 609 shall be considered a Dependent under this Plan, as applicable.

Dependent Care Assistance Plan Account or DCAP Account means

the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan pursuant to Article 8.

Effective Date shall have the meaning

set forth in Part A of the Adoption Agreement, provided that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.

Eligible Employee means

any Employee employed by an Employer, subject to the modifications and exclusions described in the Adoption Agreement. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Employer is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Employer in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

An individual who becomes employed by an Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the other entity shall not become eligible to participate in the Plan until the Employer or Plan Sponsor specifically authorizes such participation.

Employee means

any individual who is a common-law employee of an Employer, a leased employee as described in Code section 414(n), or full-time life insurance salesman as defined in Code section 7701(a)(20). The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock or combined voting power of an S corporation.

Employer means

the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

ERISA means

the Employee Retirement Income Security Act of 1974, as amended from time to time.

Flex Credits means

the Employer contributions described in Section 11.01 of the Plan.

FMLA means

the Family and Medical Leave Act of 1993 as amended from time to time.

Grace Period means

the designated period following a Plan Year during which a Participant who has unused benefits or contributions relating to a Benefit (for example, a Health FSA or DCAP Account) from the immediately preceding Plan Year and who incurs expenses for that same Benefit during the period, may be paid or reimbursed for those expenses as if the expenses had been incurred in the immediately preceding Plan Year.

Copyright © 2002-2022
Miller Canfield

General Purpose Health Flexible Spending Account or General Purpose Health FSA means
the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Article 6.

Health Flexible Spending Account or Health FSA means
the General Purpose Health FSA and/or HSA-Compatible Health FSA established with respect to the Participant's election to have medical expenses reimbursed by the Plan pursuant to Article 6 and Article 7.

Health Savings Account or HSA means
a health savings account established pursuant to Article 9.

Highly Compensated Employee means
an Employee described in Code section 414(q).

Highly Compensated Individual means
an individual within the meaning of Code section 105(h)(5).

HIPAA means
the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

HRA means
a health reimbursement arrangement subject to Code section 105.

HSA-Compatible Health Flexible Spending Account or HSA-Compatible Health FSA means
a Limited Purpose Health Flexible Spending Account and/or a Post-Deductible Health Flexible Spending Account.

Key Employee means
an Employee described in Code section 416(i).

Leased Employee means
an Employee described in Code section 414(n)(2).

Limited Purpose Health Flexible Spending Account or Limited Purpose Health FSA means
the Account established with respect to the Participant's election to have medical expenses, as described in Section 7.05(b)(1), reimbursed by the Plan pursuant to Article 7.

Qualified Plan means
the retirement plan sponsored by an Employer and identified in the Adoption Agreement.

Participant means
an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

Plan means
the plan as identified in Part A.2 of the Adoption Agreement and as described in this Basic Plan Document and Adoption Agreement.

Plan Administrator means
the person(s) designated pursuant to the Adoption Agreement and Section 14.01.

Plan Sponsor means
the entity described in the Adoption Agreement that maintains the Plan.

Plan Year means
the 12-consecutive month period described in Part A of the Adoption Agreement.

Post-Deductible Health Flexible Spending Account or Post-Deductible Health FSA means

Copyright © 2002-2022
Miller Canfield

the Account established with respect to the Participant's election to have medical expenses, as described in Section 7.05(b)(2), reimbursed by the Plan pursuant to Article 7.

Premium Conversion Account means
the Account established with respect to the Participant's election to have premiums reimbursed by the Plan pursuant to Article 5.

PTO means
elective paid time off that must be used or forfeited by the last day of the Plan Year in which it was awarded.

Salary Reduction Agreement means
the agreement pursuant to which an Eligible Employee elects to reduce his or her Compensation and instead receive a Benefit provided under the Plan.

Section 414(s) Compensation means
compensation as defined in Code section 414(s) and Treas. Reg. section 1.414(s)-1. The period used to determine an Employee's compensation for a Plan Year must be either the Plan Year or the calendar year ending within the Plan Year. Whichever period is selected by the Plan Administrator must be applied uniformly to determine the compensation of every Eligible Employee under the Plan for that Plan Year. The Plan Administrator may, however, limit the period taken into account under either method to that portion of the Plan Year or calendar year in which the Employee was an Eligible Employee, provided that this limit is applied uniformly to all Eligible Employees.

Termination and Termination of Employment means
any absence from service that ends the employment of an Employee with the Employer.

ARTICLE 3. ELIGIBILITY

An Eligible Employee is an Employee who meets the age and service requirements set forth in the Adoption Agreement and who is not excluded pursuant to (a) Section 3.02, (b) the provisions governing the applicable Benefit below, or (c) the Adoption Agreement. An Eligible Employee may elect to participate in the Plan in accordance with Article 4.

Eligible Employees who were eligible to participate in the Plan immediately prior to the Effective Date shall be eligible to participate in the Plan on the Effective Date. Notwithstanding the foregoing, an Eligible Employee shall be eligible to make elections only for the Accounts as are specifically authorized in the Adoption Agreement.

Section 3.02 INELIGIBLE EMPLOYEES

Notwithstanding anything herein to the contrary, the Employees identified in the Adoption Agreement as such are not Eligible Employees and may not participate in any Benefit under the Plan.

Section 3.03 LEAVE OF ABSENCE

(a) FMLA Leave of Absence.

(1) *Health Benefits.* If a Participant takes a leave of absence under FMLA, the Participant shall be entitled to continue to participate in those Benefits under the Plan that provide health care, including the Premium Conversion Account for payment of premiums applicable to health care, the Health FSA, and Flex Credits. A Participant may also elect to revoke coverage during an unpaid FMLA leave of absence or continue coverage but discontinue contributions for the period of the FMLA leave of absence, as set forth in the Adoption Agreement. If a Participant elects to revoke coverage during the unpaid FMLA leave of absence, the coverage will be reinstated under the same terms upon the Participant's return from the FMLA leave of absence.

(2) *Non-Health Benefits.* A Participant shall not be entitled to continue to participate in Benefits under the Plan that do not provide health care except to the extent provided in the Adoption Agreement or in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave. Participant contributions for Benefits during a leave of absence under FMLA shall be determined by the Plan Administrator in accordance with Code section 125.

(3) *Non-FMLA Leave of Absence.* If a Participant takes an unpaid leave of absence other than under FMLA, the Participant shall not be entitled to continue to participate in Benefits under the Plan except to the extent provided in the Adoption Agreement or in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave.

Copyright © 2002-2022
Miller Canfield

(4) *USERRA.* If a Participant is on a leave of absence in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the Participant shall be entitled to elect to continue participation in the Premium Conversion Account and Health FSA for the lesser of (i) 24 months, beginning on the date the Participant's absence began and (ii) the date the Participant fails to apply for or return to employment with the Employer, as determined under USERRA.

(5) *Applicable State Law.* The Plan Administrator shall permit a Participant to continue Benefits under the Plan as required under any applicable state law to the extent that such law is not pre-empted by federal law.

(6) *Paid Leave of Absence.* A Participant shall not be entitled to revoke participation in any Benefits during a paid leave of absence except in accordance with Article 4.

Section 3.04 TERMINATION OF PARTICIPATION

If a Participant remains an Employee but is no longer an Eligible Employee (e.g., due to a change in job classification), his or her participation in the Plan shall terminate on the date on which the Participant ceases to be an Eligible Employee, unless provided otherwise herein or in the Adoption Agreement. Should such Employee again qualify as an Eligible Employee, he or she shall be eligible to participate in the Plan as of the first day of the subsequent Plan Year, unless earlier participation is required by applicable law or permitted pursuant to Section 4.03.

Section 3.05 TERMINATION OF EMPLOYMENT

If a Participant has a Termination of Employment, his or her participation in the Plan shall be governed in accordance with the terms of the applicable Benefit as provided herein.

Section 3.06 REEMPLOYMENT

(a) Except as otherwise provided in the Adoption Agreement, the Plan Administrator shall automatically reinstate Benefit elections for Eligible Employees who are rehired by an Employer within 30 days of a Termination. If an Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee more than 30 days following the date of Termination, the Plan Administrator may allow the Eligible Employee to elect to reinstate the Benefit election in effect at the time of Termination or to make a new election under the Plan, unless otherwise provided herein or in the Adoption Agreement.

(b) *Ineligible Employees.* An Employee who has a Termination of Employment and who is subsequently reemployed by the Employer but is not an Eligible Employee shall be eligible to participate on the date the individual becomes an Eligible Employee and, at that time, may elect to participate in the Plan in accordance with Article 4.

ARTICLE 4. BENEFITS AND PARTICIPATION

Section 4.01 BENEFIT OPTIONS

Each Participant may elect to participate in the following Benefits to the extent selected in the Adoption Agreement, pursuant to the applicable Article herein:

(a) Premium Conversion Account
(b) General Purpose Health Flexible Spending Account
(c) HSA-Compatible Health Flexible Spending Account
(d) Dependent Care Assistance Plan Account
(e) Adoption Assistance Flexible Spending Account
(f) Health Savings Account
(g) PTO Purchase/Sale
(h) 401(k) Plan Contributions
(i) Flexible Benefit Credits

Section 4.02 ELECTION TO PARTICIPATE

(a) *Elections to Participate.* The Plan Administrator shall prescribe such forms and may require such data from an Eligible Employee as are reasonably required and permitted under applicable law to enroll the Eligible Employee in the Plan or to effectuate any elections made pursuant to this Article 4. The Plan Administrator may adopt procedures governing the elections described in this Article 4, including, without limitation, a minimum annual and per pay-period contribution amount, a maximum contribution per pay-period amount consistent

Copyright © 2002-2022
Miller Canfield

with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

(b) *New Employees.* An Eligible Employee may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 30 days after the date the Eligible Employee becomes an Employee. The election will be effective as of the Employee's hire date; provided, however, that amounts used to pay for such election must be made from Compensation not yet currently available on the date of the election.

(c) *Newly Eligible Employees.* An Employee who becomes an Eligible Employee (for example, after satisfying the Plan's age and/or service requirements, if any) may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 31 days after the date the Employee becomes an Eligible Employee. The election will be effective on a prospective basis.

(d) *Continuing Eligible Employees.* An Eligible Employee may elect to enroll in the Plan or to modify or revoke his or her election during the period established by the Plan Administrator that precedes the Plan Year for which the election will be effective, except as provided in Article 9 and Article 10.

(e) *Failure to Elect.* If an Eligible Employee does not make an election in accordance with the required enrollment procedures with respect to any or all Benefits under the Plan, the Eligible Employee will be deemed to have elected not to participate in such Benefit for the applicable Plan Year, except as otherwise provided herein or specified in the Adoption Agreement.

Section 4.03 MID-YEAR ELECTION CHANGES

An Eligible Employee's election to participate in a Benefit, other than an HSA, hereunder is irrevocable during the Plan Year, except that an Eligible Employee may change his or her election during the Plan Year no later than the end of the 31-day period beginning on the date of a Change in Status, unless provided otherwise in the Adoption Agreement. The election change must be on account of and correspond with a Change in Status that affects eligibility for coverage under the Plan.

A "Change in Status" means events described in Treasury Regulation section 1.125-4. Change in Status includes, but is not limited to, the following, to the extent provided in the Adoption Agreement:

(a) *Legal Marital Status.* Events that change an Eligible Employee's legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.

(b) *Number of Dependents.* Events that change an Eligible Employee'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 Eligible Employee, the Eligible Employee's spouse, or the Eligible Employee's Dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer of the Eligible Employee or the Eligible Employee's Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the applicable plan, then that change constitutes a change in employment under this paragraph (c).

(d) *Dependent satisfies or ceases to satisfy eligibility requirements.* Events that cause an Eligible Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(e) *Residence.* A change in the place of residence of the Eligible Employee or the Eligible Employee's spouse or Dependent.

(f) *Adoption Assistance.* For purposes of adoption assistance provided through the Plan, the commencement or termination of an adoption proceeding.

(g) *COBRA.* If the Eligible Employee or the Eligible Employee's spouse or Dependent becomes eligible for continuation coverage under an Employer's group health plan as provided in Code section 4980B or any similar state law, the Eligible Employee may elect to increase contributions to his or her Premium Conversion Account under the Plan in order to pay for the continuation coverage.

(h) *Court Order.* A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for an Eligible Employee's child or for a foster child who is a Dependent of the employee. The Eligible Employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the Eligible Employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

(i) *Entitlement to Medicare or Medicaid.* If an Eligible Employee or an Eligible Employee's spouse or Dependent who is enrolled in an Employer's accident or health plan becomes enrolled 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), the Eligible Employee may make a prospective election change to cancel or reduce coverage of that Employee, spouse, or Dependent under the Employer-sponsored accident or health plan. In addition, if an Eligible

Copyright © 2002-2022
Miller Canfield

Employee or an Eligible Employee's spouse or Dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the Eligible Employee may make a prospective election to commence or increase his or her coverage or the coverage of his or her spouse or Dependent, as applicable, under the Employer-sponsored accident or health plan.

(j) *Significant Cost or Coverage Changes.*

(1) *Automatic Changes.* If the cost of an Employer-sponsored Contract premium increases (or decreases) during a period of coverage and, under the terms of the Contract, Eligible Employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Eligible Employees' elective contributions for the Plan.

(2) *Significant Cost Changes.* If the cost charged to an Eligible Employee for a Contract benefit package option significantly increases or significantly decreases during a period of coverage, the Plan may permit the Eligible Employee to make a corresponding change in an election under the Plan. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available. For example, if the cost of an indemnity option under an accident or health plan significantly increases during a period of coverage, Eligible Employees who are covered by the indemnity option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the indemnity option and, in lieu thereof, elect coverage under another benefit package option including an HMO option (or drop coverage under the accident or health plan if no other benefit package option is offered).

A cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the Plan, whether that increase or decrease results from an action taken by the Eligible Employee (such as switching between full-time and part-time status) or from an action taken by an Employer (such as reducing the amount of Employer contributions for a class of Eligible Employees).

This paragraph (j) applies in the case of the Dependent Care Assistance Plan Account only if the cost change is imposed by a Dependent care provider who is not a relative of the Eligible Employee as described in Code section 152(a)(1) through (8), incorporating the rules of Code section 152(b)(1) and (2). This paragraph (j) does not apply to Health FSAs.

(k) *Significant Curtailment Without Loss of Coverage.* If an Eligible Employee or an Eligible Employee's spouse and/or Dependent has a significant curtailment of coverage under a Contract during a period of coverage that is not a loss of coverage as described in paragraph (l) of this section (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under the Contract), the Eligible Employee may revoke his or her election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing similar coverage. This paragraph (k) does not apply to Health FSAs.

(l) *Significant Curtailment With Loss of Coverage.* If an Eligible Employee (or an Eligible Employee's spouse or Dependent) has a significant curtailment that is a loss of coverage, the Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. For purposes of this paragraph (l), a loss of coverage means:

(1) a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation);

(2) a substantial decrease in the medical care providers available under the Contract (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(3) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Eligible Employee or the Eligible Employee's spouse or Dependent is currently in a course of treatment; or

(4) any other similar fundamental loss of coverage as determined by the Plan Administrator's in its sole discretion.

This paragraph (l) does not apply to Health FSAs.

(m) *Addition or Improvement of a Benefit Package Option.* If the Plan or a Contract adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a period of coverage, an Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved benefit package option. This paragraph (m) does not apply to Health FSAs.

(n) *Change in Coverage Under Another Employer Plan.* An Eligible Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including another plan of the Employer or of another employer) if -

(1) The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under paragraphs (a) through (o) of this section (disregarding this paragraph (n)(1)); or

(2) This Plan permits Eligible Employees to make an election for a Plan Year that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

Copyright © 2002-2022
Miller Canfield

This paragraph (n) does not apply to Health FSAs.

(o) *FMLA.* If a Participant contributes to the cost of such Benefit, he or she may revoke coverage or continue coverage but discontinue payment of his or her share of the cost of a Benefit that provides group health plan coverage (including a Health FSA) during the period of a leave of absence under FMLA. An Eligible Employee who revokes coverage shall be entitled to reinstate coverage upon returning from a leave of absence under FMLA.

(p) *Loss of Coverage Under Other Group Health Coverage.* An Eligible Employee may make an election on a prospective basis to add coverage under the Plan for the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent if the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including a State's 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 section 7701(a)(40)), the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a Foreign government group health plan. This paragraph (p) does not apply to Health FSAs.

(q) *Revocation due to Reduction in Hours of Service.* A Participant may prospectively elect to cancel contribution for and payment of the Employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Employer-sponsored group health plan and (2) the revocation of the election of coverage under the Employer-sponsored group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(r) *Enrollment in a Qualified Health Plan.* A Participant may prospectively elect to cancel contribution for and payment of the employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant is eligible for a special enrollment period to enroll in a "qualified health plan" through a competitive marketplace established under Section 1311 of the Patient Protection and Affordable Care Act ("Marketplace") or the Employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.

The Plan Administrator reserves the right to determine whether an Eligible Employee has experienced a Change in Status and whether the Eligible Employee's requested election is consistent with such Change in Status.

ARTICLE 5. PREMIUM CONVERSION ACCOUNT

Section 5.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Premium Conversion Accounts, an Employee may elect to have a portion of his or her Compensation applied by the Employer toward the Premium Conversion Account. The Account established under this Article 5 is intended to qualify under Code sections 79 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 5.02 ELIGIBLE EMPLOYEES

All Employees are eligible to participate in the Premium Conversion Account, except as otherwise specified in the Adoption Agreement.

Section 5.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the Premium Conversion Account in accordance with Article 4. Except as otherwise provided in the Adoption Agreement, all Employees will automatically be enrolled in the Premium Conversion Account and will be deemed to have elected to contribute the entire amount of any premiums payable by the Employee for participation in Employer-sponsored Contract(s) unless he or she affirmatively elects otherwise in accordance with Section 4.02.

(b) *Contributions.* A Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation. The amount of a Participant's contribution to the Premium Conversion Account shall be equal to the amount of the Participant's portion of the premium on the applicable Contract. Except as elected in the Adoption Agreement, if the amount of the Participant's portion of the applicable premium on the Contract increases or decreases, the Participant's contribution to the Premium Conversion Account will automatically be adjusted to reflect the increase or decrease.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation

Copyright © 2002-2022
Miller Canfield

contributed to a Premium Conversion Account for the Plan Year with respect to non-Employer sponsored Contracts, regardless of the election he or she had in effect for the prior Plan Year. In addition, an Eligible Employee who affirmatively elected not to participate in the Premium Conversion Account for the Plan Year with respect to Employer-sponsored Contracts will not be enrolled in the Premium Conversion Account for any Plan Year until he or she affirmatively elects to participate in the Premium Conversion Account with respect to Employer-sponsored Contracts in accordance with Article 4.

Section 5.04 ELIGIBLE EXPENSES

A Participant's Premium Conversion Account will be debited for amounts applied to the Employee-paid portion of the applicable Contract premiums. The Plan Administrator will not direct the Employer to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

Contributions to the Premium Conversion Account for Code section 79 coverage (group term life insurance) shall be made on an after-tax basis to the extent that the premiums relate to coverage in excess of the limit described in Code section 79(a).

Section 5.05 TERMINATION OF EMPLOYMENT

Upon a Participant's Termination of Employment, the Participant's contributions to the Premium Conversion Account will cease, except with respect to contributions for COBRA continuation coverage under the Employer-sponsored Contract, if applicable. Coverage under the applicable Contract may continue in accordance with the terms of the Contract for the remainder of the period of coverage with respect to which the required Contract premium has been paid.

ARTICLE 6. HEALTH FLEXIBLE SPENDING ACCOUNT

Section 6.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Health Flexible Spending Accounts, an Eligible Employee may elect to participate in a General Purpose Health Flexible Spending Account in accordance with this Article 6. The Account established under this Article 6 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 6.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the General Purpose Health Flexible Spending Account, except as otherwise specified in the Adoption Agreement. An Employee who is not eligible to participate in an Employer-sponsored group health plan is not eligible to participate in the General Purpose Health Flexible Savings Account. An Eligible Employee who has elected to participate in the HSA Benefit and/or the HSA-Compatible Health FSA Benefit is not eligible to participate in the General Purpose Health FSA Benefit under this Article 6.

Section 6.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the General Purpose Health FSA and elect to have a portion of his or her Compensation contributed to a General Purpose Health FSA in accordance with Article 4. A Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03.

(b) *Contributions.* A Participant's General Purpose Health FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a General Purpose Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 6.04 LIMITS

(a) The amount of an Eligible Employee's contribution to a Health Flexible Spending Account shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 125(i), as adjusted. The Code section 125(i) limit is reduced by the amount of Flex Credits, if any, that a Participant may elect to receive in cash as set forth in the Adoption Agreement or as a taxable benefit.

Copyright © 2002-2022
Miller Canfield

(b) Employer contributions to a Participant's Health FSA will not exceed the greater of (a) two times the amount elected in the Participant's Salary Reduction Agreement to be contributed to the Health FSA for the Plan Year, including Flex Credits the Participant elects to contribute to the Health FSA, if applicable or, (b) $500 plus the amount elected in the Participant's Salary Reduction Agreement and any Flex Credits contributed to the Health FSA. If the Plan provides for Flex Credits but does not allow the cash out of the Flex Credits, the maximum amount of Flex Credits that a Participant can elect contribute to the Health FSA shall be treated as an Employer contribution for purposes of this Section 6.04(b).

Section 6.05 ELIGIBLE EXPENSES

(a) *Debits from the Health FSA.* A Participant's Health FSA will be debited for expenses described in this Section 6.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the Health FSA, less any reimbursements already disbursed from the General Purpose Health FSA, shall be available to the Participant at any time during the Plan Year without regard to the balance in the General Purpose Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.

(b) *Eligible Expenses.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her General Purpose Health FSA for expenses that are: (i) incurred in the Plan Year (or Grace Period, if applicable), (ii) incurred while he or she is a Participant in the Plan, and (iii) excludable under Code section 105(b); provided that such expenses are not covered, paid or reimbursed from any other source. For purposes of determining whether an expense is excludable under Code section 105(b), the following applies:

  (1) *Michelle's Law.* "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

  (2) *Coverage of Adult Children.* Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.

Section 6.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's General Purpose Health FSA for eligible expenses incurred during the Plan Year. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's General Purpose Health FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a Grace Period beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with Prop. Treas. Reg. section 1.125-1(e), as amended or superseded. No claims incurred during a Grace Period shall be reimbursed from a General Purpose Health FSA if the Plan permits carry over of General Purpose Health FSA balances under Section 6.07(b).

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her General Purpose Health FSA during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant or, (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from General Purpose Health FSA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. Notwithstanding the foregoing payment schedule, the Plan Administrator may provide that payments/reimbursements from the General Purpose Health FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(d) *Coordination with HRA.* A Participant who is also eligible to participate in an HRA sponsored by the Employer shall not be entitled to payment/reimbursement under the General Purpose Health FSA for expenses that are reimbursable under both the General Purpose Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the General Purpose Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the General Purpose Health FSA have been paid.

(e) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who elects to receive coverage under a Contract that is offered in conjunction with an Employer-sponsored benefit plan may elect that any eligible expenses that are not covered under the applicable Contract, such as co-payments, co-insurance or deductibles, be automatically paid through his or her General Purpose Health FSA.

(f) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of

Copyright © 2002-2022
Miller Canfield

eligible General Purpose Health FSA expenses.

Section 6.07 FORFEITURES

(a) *Forfeitures.* Any balance remaining in a Participant's General Purpose Health FSA at the end of any Plan Year subject to the carryover amount limit in subsection (b) below, if applicable (or after the Grace Period described in Section 6.06(a), if applicable), shall be forfeited and shall be used to (1) pay administrative expenses, (2) offset losses to the Health FSA due to reimbursements exceeding contributions for the Plan Year, (3) reduce the required salary reduction amounts for the next Plan Year, (4) reduce the required employer contributions for the next Plan Year, (4) reallocate to participants on a uniform basis, and/or (5) any other use allowed under all applicable laws and regulations. If the General Purpose Health FSA is not subject to ERISA, the forfeited amount can be returned to the Employer.

(b) *Carryovers.* Notwithstanding subsection (a), and to the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year up to $500 (as indexed) of any amount remaining unused as of the end of the Plan Year in a Participant's General Purpose Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the General Purpose Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the Plan Year to which it is carried over. Any unused amount remaining in the General Purpose Health FSA in excess of $500 as indexed (or a lower amount specified in the Adoption Agreement) will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the rollover in the following Plan Year, provided that any such procedure is non-discriminatory.

Section 6.08 CARRYOVER TO AN HSA-COMPATIBLE HEALTH FSA

If a Participant who has elected a General Purpose Health FSA for a given Plan Year establishes a Health Savings Account under the Plan or otherwise for the subsequent Plan Year, he or she may elect (or may be deemed by the Plan Administrator to have elected) as of the last day of the Plan Year (the "Conversion Date") to carryover the balance in his or her General Purpose Health FSA to an available HSA-Compatible Health FSA for the subsequent Plan Year if so elected in the Adoption Agreement. An HSA-Compatible Health FSA cannot be converted into a General Purpose Health FSA.

Section 6.09 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 6.10 QUALIFIED RESERVIST DISTRIBUTIONS

(a) If the Adoption Agreement provides for Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his General Purpose Health FSA specified in the Adoption Agreement. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(b) A Participant may submit General Purpose Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 6.11 SEPARATE PLAN

Although described within this document, the General Purpose Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The General Purpose Health FSA is also a separate plan for purposes of ERISA,

Copyright © 2002-2022
Miller Canfield

HIPAA, and COBRA, if applicable.

ARTICLE 7. HSA-COMPATIBLE HEALTH FLEXIBLE SPENDING ACCOUNT

Section 7.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Limited Purpose Health Flexible Spending Accounts and/or Post-Deductible Health Flexible Spending Accounts (collectively, "HSA-Compatible Health FSAs"), an Eligible Employee may elect to have a portion of his or her Compensation contributed to an HSA-Compatible Health FSA. The Account established under this Article 7 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 7.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the HSA-Compatible Health FSA Benefit except as specified in the Adoption Agreement. An Employee who is not eligible to participate in Employer-sponsored group health plan is not eligible to participate in the HSA-Compatible Health FSA. A Participant who has elected the Health FSA under Article 6 is not eligible to elect an HSA-Compatible Health FSA except as otherwise provided in Section 6.08.

Section 7.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in an HSA-Compatible Health FSA in accordance with Article 4. An HSA-Compatible Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03.

(b) *Contributions.* A Participant's HSA-Compatible Health FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an HSA-Compatible Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 7.04 LIMITS

The amount of contribution to a Participant's HSA-Compatible Health FSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 125(i), as adjusted.

Section 7.05 ELIGIBLE EXPENSES

(a) *Debits from the HSA-Compatible Health FSA.* A Participant's HSA-Compatible Health FSA will be debited for expenses described in this Section 7.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the HSA-Compatible Health FSA, less any reimbursements already disbursed for the Plan, shall be available to the Participant at any time during the Plan Year without regard to the balance in the HSA-Compatible Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.

(b) *Eligible Expenses.*

   (1) *Limited Purpose Health FSA.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Limited Purpose Health FSA for expenses that are: (i) incurred in the Plan Year (except as provided in Section 7.05(c)), (ii) incurred while the Participant participates in the Plan, (iii) excludable under Code section 105(b), (iv) incurred for dental or vision care or for preventive care (as defined under Code section 223(c)(2)(C), and (v) incurred for telehealth services as defined in Code section 223(c)(2)(E); provided that such expenses that are not covered, paid or reimbursed from any other source.

   (2) *Post-Deductible Health FSA.* Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Post-Deductible Health FSA for expenses that are: (i) incurred in the Plan Year (except as provided in Section 7.05(c)), (ii) incurred while the Participant participates in the Plan, (iii) excludable under Code section 105(b), and (iv) incurred after the Participant has satisfied the minimum annual deductible under Code section 223(c)(2)(A)(i), provided that such expenses that are not covered, paid or reimbursed from any other source.

(c) For purposes of determining whether an expense is excludable under Code section 105(b), the following applies:

   (1) *Michelle's Law.* Unless otherwise provided in the Adoption Agreement, "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a Dependent due to a

Copyright © 2002-2022
Miller Canfield

medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

(2) *Coverage of Adult Children.* Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday or, if provided for in the Adoption Agreement, until the end of the calendar year in which the child turns age 26.

Section 7.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's HSA-Compatible Health FSA for eligible expenses incurred during the Plan Year or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in an HSA-Compatible Health FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a "Grace Period" beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with Prop. Treas. Reg. section 1.125-1(e), as amended or superseded.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her HSA-Compatible Health FSA during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Substantiation of Claims.* A Participant's claim for reimbursement from a Post-Deductible Health FSA must include information from an independent third party that the deductible for his or her high-deductible health plan has been satisfied. A Participant's claims for reimbursement from a Limited-Purpose Health FSA must include information from an independent third-party that the medical expenses to be reimbursed are for vision care, dental care or preventive care.

(d) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the HSA-Compatible Health FSA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements from the HSA-Compatible Health FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(e) *Coordination with HRA.* A Participant who is also eligible to participate in ("an HRA") sponsored by the Employer shall not be entitled to payment/reimbursement under the HSA-Compatible Health FSA for expenses that are reimbursable under both the HSA-Compatible Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the HSA-Compatible Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the HSA-Compatible Health FSA have been paid.

(f) *Automatic Payment.* If the Adoption Agreement so provides, a Participant who elects to receive coverage under a Contract that is offered in conjunction with an Employer-sponsored benefit plan may elect that any eligible expenses that are not covered under the applicable Contract, such as co-payments, co-insurance or deductibles, be automatically paid through his or her HSA-Compatible Health FSA.

(g) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible HSA-Compatible Health FSA expenses.

Section 7.07 FORFEITURES

(a) *Forfeitures.* Any balance remaining in a Participant's HSA-Compatible Health FSA at the end of any Plan Year, subject to the carryover amount limit in subsection (b) below, if applicable (or after the Grace Period described in Section 6.06(a), if applicable), shall be forfeited and shall be used to (1) pay administrative expenses, (2) offset losses to the Health FSA due to reimbursements exceeding contributions for the Plan Year, (3) reduce the required salary reduction amounts for the next Plan Year, (4) reduce the required employer contributions for the next Plan Year, (4) reallocate to participants on a uniform basis, and/or (5) any other use allowed under all applicable laws and regulations. If the HSA-Compatible Health FSA is not subject to ERISA, the forfeited amount can be returned to the Employer. Subject to Section 7.06(a) allowing for reimbursement of eligible expenses incurred during the Grace Period and subject to subsection (b) below, unused contributions to an HSA-Compatible Health FSA remaining at the end of a Plan Year may not be cashed-out or converted to any other taxable or nontaxable benefit.

(b) *Carryovers.* Notwithstanding subsection (a) and to the extent selected in the Adoption Agreement, the Plan will carry over to the immediately following Plan Year up to $500 (as indexed) of any amount remaining unused as of the end of the Plan Year in a Participant's HSA-Compatible Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the HSA-Compatible Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be

Copyright © 2002-2022
Miller Canfield

used to pay or reimburse eligible expenses incurred during the entire Plan Year to which it is carried over. Any unused amount remaining in the HSA-Compatible Health FSA in excess of $500 as indexed (or a lower amount specified in the Adoption Agreement) will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the carryover in the following Plan Year, provided that any such procedure is non-discriminatory.

Section 7.08 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's HSA-Compatible Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's HSA-Compatible Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 7.09 QUALIFIED RESERVIST DISTRIBUTIONS

(a) If the Adoption Agreement provides for Qualified Reservist Distributions, a Participant may receive a distribution of the portion of his HSA-Compatible Health FSA specified in the Adoption Agreement. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.

(b) A Participant may submit HSA-Compatible Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.

(c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 7.10 SEPARATE PLAN

Although described within this document, the HSA-Compatible Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The Health FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 8. DEPENDENT CARE ASSISTANCE PLAN ACCOUNT

Section 8.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Dependent Care Assistance Plan Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to a DCAP Account. The Account established under this Article 8 is intended to qualify as a dependent care assistance program under Code section 129 and shall be interpreted in a manner consistent with such Code section.

Section 8.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the Dependent Care Assistance Plan Account, except as specified in the Adoption Agreement.

Section 8.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the DCAP Account in accordance with Article 4.

(b) *Contributions.* A Participant's DCAP Account will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation

Copyright © 2002-2022
Miller Canfield

contributed to a DCAP Account for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 8.04 LIMITS

The amount of all contributions to a Participant's DCAP Account shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 129(a)(2), as adjusted.

Section 8.05 ELIGIBLE EXPENSES

(a) *Debits from the DCAP Account.* A Participant's DCAP Account will be debited for expenses described in this Section 8.05. However, the Plan Administrator will not direct the Employer to reimburse such expenses to the extent the reimbursement exceeds the balance of the Participant's DCAP Account, except as otherwise provided in the Adoption Agreement.

(b) *Eligible Expenses.*

(1) Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her DCAP Account for Dependent Care Expenses that are: (i) incurred in the Plan Year, (ii) are incurred while the Participant participates in the Plan, and (iii) qualify as eligible Dependent Care Expenses (as defined in Section 8.05(b)(2) below), provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the such expenses.

(2) "Dependent Care Expenses" are expenses incurred for the care of a Qualifying Individual, as defined in Code section 21(b)(1) and generally includes either: (i) a Dependent who is under age 13, or (ii) the Participant's spouse or Dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are Dependent Care Expenses only if they allow the Participant to be gainfully employed. Dependent Care Expenses include expenses for household services and expenses for the care of a Qualifying Individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the Qualifying Individual stays overnight. Expenses described in this subsection (2) that are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or Dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least eight hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

Section 8.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's DCAP Account for eligible expenses incurred during the Plan Year or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's DCAP Account at the end of a Plan Year may be used to reimburse expenses that are incurred during a Grace Period beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with IRS Notice 2005-42, as amended or superseded. If the Adoption Agreement so provides, an individual who ceases to be a Participant in the Plan (due to Termination or any other reason) may spend down his or her unused DCAP Account expenses, and such individuals may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of Participation occurs (or end of the Grace Period if applicable) to the extent the claims do not exceed the balance of the DCAP Account.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her DCAP Account during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from DCAP Account. The Plan Administrator may provide that payments/reimbursements from the DCAP Account of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

(d) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible DCAP Account expenses.

Section 8.07 FORFEITURES

Copyright © 2002-2022
Miller Canfield

Any balance remaining in a Participant's DCAP Account at the end of any Plan Year (or after the Grace Period described in Section 8.06(a), if applicable) shall be forfeited and shall remain the property of the Employer. Unused contributions to a DCAP Account may not be cashed-out or converted to any other taxable or nontaxable benefit.

Section 8.08 TERMINATION OF EMPLOYMENT

Except as provided in the Adoption Agreement, contributions to a Participant's DCAP Account shall cease upon Termination of Employment. Any balance remaining in a Participant's DCAP Account on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 8.09 SEPARATE PLAN

Although described within this document, the DCAP Account is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 129. The DCAP Account is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 9. HEALTH SAVINGS ACCOUNT

Section 9.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Health Savings Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to a Health Savings Account. The Account established under this Article 9 is intended to qualify as a health savings account under Code section 223 and shall be interpreted in a manner consistent with such Code section.

Section 9.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 who, as of the first day of the month, are enrolled in a high deductible health plan as defined in Code section 223(c)(2) are eligible to participate in the Health Savings Account for the month, except as specified in the Adoption Agreement. An Eligible Employee who has elected to participate in a General Purpose Health FSA is not eligible to participate in the HSA Benefit under this Article 9. A Participant who has elected the General Purpose Health FSA Benefit that is in effect on the last day of a Plan Year cannot elect the HSA Benefit under this Article 9 for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's General Purpose Health FSA is $0 as of the last day of such Plan Year. An Eligible Employee who is not enrolled in a high deductible health plan as defined in Code section 223(c)(2) is not eligible to elect the HSA Benefit.

Section 9.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the HSA in accordance with Article 4. An HSA election may be modified as determined by the Plan Administrator, but no less frequently than monthly, provided, however, that any modification of an election during the Plan Year shall apply on a prospective basis only. A participant who becomes ineligible to make HSA contributions may prospectively revoke his or her HSA contribution election.

(b) *Contributions.* A Participant's HSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.

(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an HSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 9.04 LIMITS

The amount of contributions to a Participant's HSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 223(b), as adjusted.

Section 9.05 ADMINISTRATION

Copyright © 2002-2022
Miller Canfield

The HSA Benefit is not an employer-sponsored employee benefit plan - it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the Employer does not establish or maintain the HSA. The Plan Administrator will maintain records to keep track of HSA contributions by the Employer and by the Participant, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

Section 9.06 TERMINATION OF EMPLOYMENT

Except as expressly provided herein, all contributions to a Participant's HSA will terminate upon a Termination of Employment. The Participant will continue to be eligible to receive a distribution from his or her HSA in accordance with the terms of the documents governing the HSA.

ARTICLE 10. ADOPTION ASSISTANCE FLEXIBLE SPENDING ACCOUNT

Section 10.01 IN GENERAL

To the extent that the Adoption Agreement authorizes Adoption Assistance Flexible Spending Accounts, an Eligible Employee may elect to have a portion of his or her Compensation contributed to an Adoption Assistance FSA. The Account established under this Article 10 is intended to qualify as an adoption assistance program under Code section 137 and shall be interpreted in a manner consistent with such Code section.

Section 10.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the Adoption Assistance FSA, except as specified in the Adoption Agreement.

Section 10.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the Adoption Assistance FSA in accordance with Article 4.
(b) *Contributions.* A Participant's Adoption Assistance FSA will be credited with amounts withheld from the Participant's Compensation and any amounts contributed by the Employer pursuant to the Adoption Agreement.
(c) *Failure to Elect.* Except as provided in the Adoption Agreement, an Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an Adoption Assistance FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 10.04 LIMITS

The amount of contributions to a Participant's Adoption Assistance FSA shall not exceed the maximum annual limit described in the Adoption Agreement, and in no event shall exceed the limitations set forth in Code section 137(b)(1).

Section 10.05 ELIGIBLE EXPENSES

(a) *Debits from the Adoption Assistance FSA.* A Participant's Adoption Assistance FSA will be debited for expenses described in this Section 10.05. However, the Plan Administrator will not direct the Employer to reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Adoption Assistance FSA, except as otherwise provided in the Adoption Agreement.
(b) *Eligible Expenses.*
    (1) Except as otherwise provided in the Adoption Agreement, a Participant may be reimbursed from his or her Adoption Assistance FSA for expenses that: (i) are incurred in the Plan Year, (ii) are incurred while the Participant participates in the Plan, and (iii) qualify as eligible Adoption Expenses, (as defined in Section 10.05(b)(2) below) provided that such expenses are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the such expenses.
    (2) "Adoption Expenses" are the reasonable and necessary adoption fees, court costs, attorney fees and other expenses that are (i) directly related to the legal adoption of an Eligible Child by the Participant and (ii) not incurred in violation of state or federal law or in carrying out any surrogate parenting arrangement. For purposes of this paragraph, an "Eligible Child" is a child under age 18 or a child who is physically or mentally incapable of caring for himself/herself. An Eligible Child does not include a child of the Participant's spouse. In the case of an adoption of a child who is not a citizen or resident of the United States, any Adoption Expense with respect to such adoption is not reimbursable until such adoption becomes final.

Copyright © 2002-2022
Miller Canfield

Section 10.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's Adoption Assistance FSA for eligible expenses incurred during the Plan Year or as otherwise provided in the Adoption Agreement. If the Adoption Agreement so provides, the unused contributions that remain in a Participant's Adoption Assistance FSA at the end of a Plan Year may be used to reimburse expenses that are incurred during a "Grace Period" beginning on the first day of the subsequent Plan Year and ending no later than the fifteenth day of the third calendar month of such Plan Year, in accordance with Prop. Treas. Reg. section 1.125-1(e), as amended or superseded.

(b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her Adoption Assistance FSA during the Plan Year and no later than the date specified in the Adoption Agreement. The claim must be made in the manner required by the Plan Administrator.

(c) *Substantiation of Claims.* A Participant's claim for reimbursement from an Adoption Assistance FSA must include reasonable substantiation that the claim constitutes an Adoption Expense eligible for reimbursement under the Plan.

(d) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall reimburse the Participant. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements from the Adoption Assistance FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year (or Grace Period, if applicable) shall be reimbursed without regard to the minimum payment amount.

Section 10.07 FORFEITURES

Any balance remaining in a Participant's Adoption Assistance FSA at the end of any Plan Year (or after the Grace Period described in Section 10.06(a), if applicable), shall be forfeited and shall remain the property of the Employer.

Section 10.08 TERMINATION OF EMPLOYMENT

Except as expressly provided herein, any balance remaining in a Participant's Adoption Assistance FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days following Termination of Employment, unless a different period for submitting claims following Termination of Employment is indicated in the Adoption Agreement.

Section 10.09 SEPARATE PLAN

Although described within this document, the Adoption Assistance FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 137. The Adoption Assistance FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA, if applicable.

ARTICLE 11. OTHER BENEFITS

Section 11.01 FLEX CREDITS

(a) *In General.* To the extent the Adoption Agreement authorizes Flex Credits, an Employer may make a non-elective contribution to the Plan that may be used at each Participant's election for one or more Benefits under the Plan.

(b) *401(k) Contributions.* To the extent provided in the Adoption Agreement, an Eligible Employee may elect to contribute all or a portion of his or her Flex Credits to a Qualified Plan in accordance with the terms of the Qualified Plan, the applicable provisions of which are incorporated herein by reference. All claims for benefits that are provided under the Qualified Plan shall be governed by the terms of the Qualified Plan.

Section 11.02 PURCHASE/SALE OF PTO

(a) *In General.* To the extent that the Adoption Agreement authorizes the purchase and/or sale of PTO, an Eligible Employee may elect to purchase PTO days and/or sell PTO days.

(b) *Eligible Employees.* The Employees identified in Article 3 are eligible to purchase/sell PTO days, except as specified in the Adoption

Copyright © 2002-2022
Miller Canfield

Agreement.

(c) *Enrollment.* An Eligible Employee may elect to purchase PTO days at such time as an Eligible Employee may enroll in the Plan in accordance with Article 4 and to the extent the Adoption Agreement provides. A Participant's PTO Account will be credited with amounts withheld from the Participant's Compensation in accordance with the Participant's Salary Reduction Agreement and any amounts contributed by the Employer pursuant to the Adoption Agreement. The Participant may use these amounts to purchase PTO days.

(d) *Failure to Elect.* An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a PTO Account for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

(e) *Forfeiture.* A Participant must use PTO during the Plan Year in which it was purchased. Any unused elective PTO (determined as of the last day of the Plan Year) shall either be paid in cash or be forfeited as of the end of the Plan Year, pursuant to the Adoption Agreement. The Participant must receive the cash on or before the last day of the Plan Year to which the amounts contributed and used to purchase the unused PTO relate.

(f) *Ordering of Elective and Non-elective PTO.* Participants are deemed to use PTO in the following order:

(1) Non-elective PTO (that is, paid time off with respect to which the employee has no election to buy/sell) is used first; then

(2) Elective PTO is used after all non-elective PTO is used.

(g) *Sale of PTO.* An Eligible Employee may elect to sell PTO days at such time as an Eligible Employee may enroll in the Plan in accordance with Article 4 and to the extent the Adoption Agreement provides. A Participant's PTO Account will be credited with the value of the PTO sold in accordance with the Eligible Employee's election. The Participant may use the amounts in the PTO Account to purchase other Benefits under the Plan or may cash out the amounts in the PTO Account in accordance with Section 11.03.

(h) *Carryover of Unused PTO.* To the extend provided in the Adoption Agreement, unused elective PTO (determined as of the last day of the Plan Year) may be carried over to a subsequent Plan Year at the Participant's election, subject to the Employer's PTO policies.

Section 11.03 CASH OUT

(a) *In General.* To the extent provided in the Adoption Agreement, a Participant may elect to receive a cash distribution of Flex Credits and PTO from the Plan.

(b) *Eligible Employees.* The Employees identified in Article 3 are eligible to receive a cash distribution from the Plan under this Section 11.03.

ARTICLE 12. SIMPLE CAFETERIA PLAN

Section 12.01 IN GENERAL

If the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the nondiscrimination requirements of Code sections 125(b), 79(d), 105(h) and 129(d)(2), (3), (4), and (8) shall be treated as met during such year.

Section 12.02 ELIGIBLE EMPLOYERS

(a) The Plan shall not be a simple cafeteria plan if the Employer employed more than 100 Employees on business days during either of the two years preceding the date of the election. If the Employer was not in existence throughout the preceding year, the number of Employees shall be based on the average number of Employees that it is reasonably expect to employ on business days in the current year.

(b) If an Employer maintains the Plan as a simple cafeteria plan for its Employees then, if the Employer fails to meet the requirements of subparagraph (a) for any subsequent year, the Plan will continue to be a simple cafeteria plan for such subsequent year with respect to its Employees, unless and until the Employer employs an average of 200 or more Employees on business days during any year preceding any such subsequent year.

Section 12.03 EMPLOYER CONTRIBUTIONS

(a) *Required Employer Contributions.* The Employer shall make a contribution to provide Qualified Benefits under the Plan on behalf of each Eligible Employee who is not a Highly Compensated Employee or Key Employee (without regard to whether the Eligible Employee makes any salary reduction contribution) in an amount equal to:

(1) a uniform percentage (not less than two percent) of the Employee's Compensation for the Plan Year, or

(2) an amount which is not less than the lesser of:

Copyright © 2002-2022
Miller Canfield

(A) six percent of the Employee's Compensation for the Plan Year, or

(B) twice the amount of the salary reduction contributions of each Eligible Employee who is not a Highly Compensated Employee or Key Employee.

(b) *Additional Employer Contributions.* An Employer may elect to make additional contributions to the Plan, subject to the terms set forth herein; provided, however, that the rate of contributions with respect to any Participant contribution by a Highly Compensated Employee or Key Employee at any rate of contribution is not greater than the rate of contributions with respect to an employee who is not a Highly Compensated Employee or Key Employee.

Section 12.04 ELIGIBLE EMPLOYEES

To the extent that the Plan is intended to qualify as a simple cafeteria plan under Code section 125, all Employees who had at least 1,000 hours of service for the immediately preceding Plan Year are eligible to participate in the Plan, and each Employee eligible to participate in the Plan may, subject to terms and conditions applicable to all Participants, elect any Benefit available under the Plan.

ARTICLE 13. NONDISCRIMINATION

Section 13.01 NONDISCRIMINATION REQUIREMENTS

Unless the Adoption Agreement indicates this Plan is intended to be a simple cafeteria plan and the requirements of Code section 125(j) are met for any year, the following nondiscrimination requirements shall apply:

(a) *Cafeteria Plan.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate.

(b) *Group Term Life.* The Plan may not discriminate in favor of Key Employees as to benefits provided or eligibility to participate with respect to any group term life insurance offered pursuant to Section 4.01.

(c) *Health Flexible Spending Account.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate with respect to the Health FSA.

(d) *Dependent Care Assistance Plan Accounts.* The Plan may not discriminate in favor of Highly Compensated Employees as to benefits provided or eligibility to participate with respect to DCAP Accounts.

(e) *Adoption Assistance FSAs.* The Plan may not discriminate in favor of Highly Compensated Employees as to benefits provided or eligibility to participate with respect to Adoption Assistance FSAs.

Section 13.02 ADJUSTMENTS

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Section 13.02 shall be carried out in a uniform and non-discriminatory manner.

ARTICLE 14. PLAN ADMINISTRATION

Section 14.01 PLAN ADMINISTRATOR

(a) *Designation.* The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor. The Committee shall elect a chair and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents on its behalf. The Plan Administrator shall also be the Plan "administrator" as such term is defined in section 3(16) of ERISA and the "named fiduciary" of the Plan (only to the extent that the Plan is subject to ERISA).

(b) *Authority and Responsibility of the Plan Administrator.* The Plan Administration shall have total and complete discretionary power and authority:

(1) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(2) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for

Copyright © 2002-2022
Miller Canfield

38974593.5/101173.00017

benefits under the Plan;
(3) to determine the amount and manner of any allocations hereunder;
(4) to maintain and preserve records relating to the Plan;
(5) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;
(6) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;
(7) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;
(8) to determine all questions of the eligibility and of the status of rights of Participants;
(9) to adjust Accounts in order to correct errors or omissions;
(10) to determine the validity of any judicial order;
(11) to retain records on elections and waivers by Participants;
(12) to supply such information to any person as may be required; and
(13) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) *Procedures.* The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) *Allocation of Duties and Responsibilities.* The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) *Compensation.* The Plan Administrator shall serve without compensation for its services.

(f) *Expenses.* All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Plan Sponsor.

Section 14.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Plan Sponsor shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegates) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA to the extent that the Plan is subject to ERISA.

ARTICLE 15. AMENDMENT AND TERMINATION

Section 15.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor or its delegate.

Section 15.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will continue indefinitely; however, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) A participating Employer may terminate its participation in this Plan upon (i) written notice to the Plan Sponsor of its intent to terminate participation in the Plan, (ii) the closing of a merger in which the participating Employer is not the surviving entity and the surviving entity is not an affiliate of the Plan Sponsor, or (iii) the sale of all or substantially all of the participating Employer's assets to an entity that is not an affiliate of the Plan Sponsor.

ARTICLE 16. CLAIMS PROCEDURES

Section 16.01 CONTRACT BENEFIT AND HSA CLAIMS

(a) *Benefits Provided by Contracts.* Claims and reimbursement for benefits provided under any Contract shall be administered in accordance with the claims procedures for the applicable Contract, as set forth in the Contract's plan documents, summary plan description, and/or

Copyright © 2002-2022
Miller Canfield

similar documentation.

(b) *HSA Claims.* Claims relating to the HSA shall be administered by the HSA trustee/custodian in accordance with the HSA trust or custodial document between the Participant and such trustee/custodian.

Section 16.02 CLAIMS PROCEDURES FOR PLAN ACCOUNTS (OTHER THAN CONTRACT BENEFITS AND HSA)

(a) *Claims.* A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) *Documentation.* A Participant or any other person requesting benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(c) *Health Flexible Spending Account Claims.* This Section 16.02(c) shall apply for any claim for benefits under the Health Flexible Spending Account.

(1) *Timing of Notice of Denied Claim.* The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA after following the Plan's claims procedures, and (E): (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The Claimant shall lose the right to appeal if the appeal is not timely made. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental,

Copyright © 2002-2022
Miller Canfield

investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

(4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (D) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Before a suit can be filed in federal court, claims must exhaust internal remedies. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Health Flexible Spending Account must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

(d) *Other Plan Account Claims.* This Section 16.02(d) shall apply for any claim for benefits under Accounts other than the Health Flexible Spending Account.

(1) Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, ordinarily within 90 days after receipt of the claim, unless the Plan Administrator determines additional time is required to make a determination.

(2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying the reason or reasons for such denial and an explanation of the steps that the Claimant must take if he wishes to appeal the denial.

(3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall rule on an appeal within a reasonable period of time, ordinarily within 60 days of receipt of the appeal, unless the Plan Administrator determines additional time is required to make a determination.

(4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying the reason or reasons for such denial. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Unless otherwise prohibited under the Plan or pursuant to applicable law, before a suit can be filed in court, Claimants must exhaust the Plan's claim procedures. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Section 16.03 REFUNDS/INDEMNIFICATION

If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (a) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (b) offset other benefits payable hereunder.

Copyright © 2002-2022
Miller Canfield

ARTICLE 17. MISCELLANEOUS

Section 17.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he or she may expect to receive, contingently or otherwise, under the Plan.

Section 17.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and the Participant, or as a right of any Employee to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

Section 17.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made solely out of the general assets of the Employer.
(b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.
(c) No person shall have any rights to, or interest in, any Benefit or account other than as expressly authorized in the Plan.

Section 17.04 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

To the extent the Plan is not subject to ERISA, any applicable law related to qualified medical child support orders or National Medical Support Notices shall apply and the Plan Administrator shall follow any required procedures under such law.

Section 17.05 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth identified in the Adoption Agreement, to the extent not preempted by Federal law.
(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 17.06 TAX EFFECT

The Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan.

Section 17.07 SEVERABILITY OF PROVISIONS

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

Section 17.08 HEADINGS AND CAPTIONS

Copyright © 2002-2022
Miller Canfield

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 17.09 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Section 17.10 TRANSFERS

Except as explicitly set forth herein, amounts may not be transferred between Accounts.

Section 17.11 COBRA

If the Plan or Benefit is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan or Benefit is subject to COBRA, a Participant shall be entitled to continuation coverage as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

Section 17.12 CONFLICTS

In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions that must be satisfied to become covered, if any, the benefits Participants are entitled to receive and the circumstances under which coverage terminates.

Section 17.13 DEATH

If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her Dependents or a representative of the Participant's estate. Such payment shall fully discharge the Plan Administrator and the Employer from further liability on account thereof.

ARTICLE 18. HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article 18 shall only apply in the event that the Health FSA(s) under the Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy and security rules. The Plan will comply with HIPAA as set forth below.

Section 18.01 DEFINITIONS

For purposes of this Article 18, the following terms have the following meanings:

(a) Business Associate means
any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) Group Health Benefits means
the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

(c) Individual means
the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.

(d) Notice of Privacy Practices means
a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) Plan Administration Functions means
the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions

Copyright © 2002-2022
Miller Canfield

performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) Protected Health Information ("PHI") means

information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan or the Plan Sponsor;

(2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and

(3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) Summary Health Information means

information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

(1) names;

(2) any geographic information which is more specific than a five digit zip code;

(3) all elements of dates relating to a covered Individual (*e.g.*, birth date) or any medical treatment (*e.g.*, admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) facial photographs or biometric identifiers (*e.g.*, finger prints); and

(6) any other unique identifying number, characteristic, or code.

Section 18.02 HIPAA PRIVACY COMPLIANCE The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;

(B) for auditing claims payments made by the Plan;

(C) to request proposals for services to be provided to or on behalf of the Plan; and

(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.

(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

(3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.

(3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.

(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under

Copyright © 2002-2022
Miller Canfield

the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

Section 18.03 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware.

Copyright © 2002-2022
Miller Canfield

Proposed Resolution

Adoption of the Amended and Restated Cafeteria Plan

WHEREAS, the Lansing Board of Water and Light ("BWL") maintains the Lansing Board of Water and Light Cafeteria Plan ("Cafeteria Plan") for the benefit of certain employees and retirees; and

WHEREAS, the BWL desires to amend and restate the Cafeteria Plan for certain technical regulatory changes and for certain plan design changes for consistency with Plan operations and administration.

NOW, THEREFORE, BE IT RESOLVED, that the amended and restated Cafeteria Plan effective as of December 1, 2022 is hereby approved and adopted; and

FURTHER RESOLVED, that the officers of the BWL, and their designee(s), are hereby authorized and directed to take such actions and to implement and execute such documents and instruments (including the amendment referenced above as well as ancillary documentation) as necessary or desirable to effectuate the intent of this resolution.

Motion by Commissioner ________, Seconded by Commissioner _____________ to approve and adopt the amended and restated Cafeteria Plan at a Board meeting held on __________, 2022.

Action: Motion Carried