

City of North Liberty Cafeteria Plan

Effective as of March 1, 2012

As Amended for the
Patient Protection and Affordable Care Act
and the
Health Care and Education Reconciliation Act

**SUMMARY OF MATERIAL MODIFICATIONS
TO
CITY OF NORTH LIBERTY
CAFETERIA PLAN**

The following changes have been made to the Plan which are effective for Plan Years beginning on or after January 1, 2013:

Your Employer has decided to implement the new IRS rule permitting a carry over of up to \$500.00 of unused Medical Flexible Spending Account balances to the next Plan Year. In the past, any amounts that were not used during the Plan Year were forfeited.

New \$500.00 Carry Over of Unused Health FSA Amounts

For Plan Years beginning on or after January 1, 2013, up to \$500.00 of any amounts remaining in your account will be carried over to increase the amount available to you for the following Plan Year. This carry over is automatic. You do not have to complete any forms or elections to have any unused Health FSA amounts carried over to the next Plan Year.

Employees Not Electing Health FSA Benefits Will Still Receive the Carry Over

If you are otherwise eligible for the Health FSA for a Plan Year but you do not make a Health FSA election, unused Health FSA amounts from the prior Plan Year will still be carried over.

Impact on Eligibility to make Contributions to a Health Savings Account

Under IRS rules, if you carry over any unused Health FSA amounts to the next Plan Year, you (and any other individual whose expenses can be reimbursed by your Health FSA) cannot contribute to a Health Savings Account (HSA) during that entire next Plan Year unless you file an election to limit Health FSA reimbursements to only dental and vision expenses. Please see your Employer for the proper forms on which to make this election.

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City of North Liberty Cafeteria Plan

As Adopted Effective March 1, 2012

ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

City of North Liberty (the "Employer") hereby establishes the City of North Liberty Cafeteria Plan (the "Plan") effective March 1, 2012 (the "Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay for his or her share of premiums under the Insurance Plan on a pre-tax Salary Reduction basis, and to contribute on a pre-tax Salary Reduction basis to an account for reimbursement of certain Medical Care Expenses and Dependent Care Expenses.

1.2 Legal Status

This Plan is intended to qualify as a "cafeteria plan" under Code § 125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

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

Although reprinted within this document, the Health FSA Component and the DCAP Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§ 105 and 129. The Health FSA Component is also a separate plan for purposes of applicable provisions of COBRA.

ARTICLE II. DEFINITIONS

2.1 Definitions

"**Account(s)**" means the Health FSA Accounts and the DCAP Accounts described in Sections 7.5 and 8.5, respectively.

"**Administrator**" means City of North Liberty.

"**Benefits**" means the Premium Payment Benefits, the Health FSA Benefits, the DCAP Benefits and the Health Savings Account deposit benefits offered under the Plan.

"**Benefit Package Option**" means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

"**Change in Status**" has the meaning described in Section 12.3.

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

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

"**Committee**" means the Benefits Committee appointed by City of North Liberty. If no Benefits Committee is appointed, "Committee" means the president, chief executive officer, proprietor or managing partner of City of North Liberty.

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

“DCAP” means dependent care assistance program.

“DCAP Account” means the account described in Section 8.5.

“DCAP Benefits” has the meaning described in Section 8.1.

“DCAP Component” means the Component of this Plan described in Article VIII.

“Dependent” means:

- (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component and for purposes of the Health FSA Component), (1) a dependent as defined in Code § 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof; and (2) any child (as defined in Code §152(f)(1)) of the Participant who as of end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Rev. Proc 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and
- (b) for purposes of the DCAP Component, a Qualifying Individual.

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

“Dependent Care Expenses” has the meaning described in Section 8.3.

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

“Effective Date” of this Plan has the meaning described in Section 1.1.

“Election Form/Salary Reduction Agreement” means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

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

“Employee” means an individual that the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll, but does not include the following: (a) any individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer’s W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any self-employed individual; (d) any partner in a partnership; and (e) any more-than-2% shareholder in a Subchapter S corporation. The term “Employee” does include “former Employees” for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer.

“Employer” means City of North Liberty, and any Related Employer that adopts this Plan with the approval of City of North Liberty. Related Employers that have adopted this Plan, if any, are listed in Appendix A to this Plan. However, for purposes of Article XIV and Section 15.3, “Employer” means only City of North Liberty.

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

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“FMLA” means the Family and Medical Leave Act of 1993, as amended.

“Health FSA” means health flexible spending arrangement.

“Health FSA Account” means the account described in Section 7.5.

“Health FSA Benefits” has the meaning described in Section 7.1.

“Health FSA Component” means the Component of this Plan described in Article VII.

“Health Savings Account” means an account established by an Employee to which deposits may be made under Code §223.

“High Deductible Health Plan” means a health plan that satisfies the definition found in Code §233(c)(2).

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“HMO” means any health maintenance organization Benefit Package Option under the Insurance Plan.

“Insurance Benefits” means the Insurance Plan coverage for purposes of this Plan.

“Insurance Plan” means the plan or plans that the Employer maintains for its Employees (and for their Spouses and Dependents) that may be eligible under the terms of such plan, providing benefits through an insurance policy or policies or through a plan that is not insurance (such as a plan that is self-funded by the Employer) that provides benefits which have the characteristics of insurance. The Employer may substitute, add, subtract or revise at any time the menu of such plans and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

“Medical Care Expenses” has the meaning defined in Section 7.3.

“Open Enrollment Period” with respect to a Plan Year means the period immediately preceding the beginning of each Plan Year as established by the Administrator.

“Participant” means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include any Eligible Employee who elects to receive any Benefit, whether pre-tax or after-tax, except those Eligible Employees who elect instead to receive their full salary in cash.

“Period of Coverage” means the Plan Year and the 2½ month period following the end of the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1 plus the 2½ month period following the end of the Plan Year; (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.2 and (c) for purposes of determining benefits under Article VII (Health FSA Component) and Article VIII (DCAP Component) it shall mean the Plan Year only without taking into consideration any period of time following the end of the Plan Year.

“PHI” means Protected Health Information.

“Plan” means the City of North Liberty Cafeteria Plan as set forth herein and as amended from time to time.

“Plan Year” means the 12-month period commencing January 1 and ending on December 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

“PPO” means any preferred provider organization Benefit Package Option under the Insurance Plan.

“Premium” means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Sections 6.2, 7.2 and 8.2.

“Premium Payment Benefits” means the Premium Payment Benefits described in Section 6.1.

“Premium Payment Component” means the Component of this Plan described in Article VI.

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

“QMCSO” means a qualified medical child support order, as defined in ERISA § 609(a).

“Qualifying Dependent Care Services” has the meaning described in Section 8.3.

“Qualifying Individual” has the meaning described in Section 8.3.

“**Related Employer**” means any employer affiliated with City of North Liberty that, under Code § 414(b), (c), or (m), is treated as a single employer with City of North Liberty for purposes of Code § 125(g)(4).

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

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

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

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual: (a) is an Employee, (b) is regularly scheduled to work 35 hours or more per week, and (c) has satisfied the eligibility conditions for the Employer’s group medical plan, the provisions of which are specifically incorporated herein by reference. An Employee who has met the Plan’s eligibility requirements may elect coverage effective as of the date that the eligibility requirements are met, or for any subsequent Plan Year, in accordance with the procedures described in Article IV. For purposes of pre-taxing COBRA coverage, a former Employee receiving severance pay or other taxable compensation may continue eligibility for the remainder of the Plan Year in which the Employee ceased to be employed by the Employer, as described in Section 3.2.

3.2 Termination of Participation

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

- the expiration of the Period of Coverage for which the Employee has elected to participate (unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating);
- the termination of this Plan;
- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of: (a) pre-taxing COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis (but not beyond the end of the current Plan Year) under Section 6.4 or Section 7.8 or (b) incurring additional Dependent Care Expenses under Section 8.8; or
- the date the Participant revokes his or her election to participate under a circumstance when such change is permitted under the terms of this Plan.

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

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to

participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Insurance Plan is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction in hours, and then becomes an Eligible Employee again, the Employee will become a participant in the Plan immediately upon satisfying the eligibility requirements described in Section 3.1.

3.4 FMLA Leaves of Absence

(a) *Health Benefits*. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's health Insurance Benefits, Health Savings Account Benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Premium.

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

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

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Premium, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation upon the Participant's return on a pre-tax or after-tax basis).

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

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

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

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Premiums due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If a Participant goes on an unpaid leave that affects eligibility, the election change rules in Section 12.4 will apply.

ARTICLE IV. METHOD AND TIMING OF ELECTIONS

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may commence participation after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Administrator by the later of (a) the date on which participation will commence, and (b) 30 days following the date on which the Employee's employment commences. An Employee who does not elect to participate when first eligible will be subject to the provisions of Section 4.3. Eligibility for Premium Payment Benefits shall be subject to the additional requirements, if any, specified in the Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the Insurance Plan.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Administrator on or before the last day of the Open Enrollment Period. If an Eligible Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then, subject to any continuing election described under Section 4.3, the Employee may not elect to participate in this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 12.4.

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

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee shall be deemed to have affirmatively elected to participate in the Premium Payment and Health Savings Account Components of the Plan under the same elections that were made for the immediately prior Plan Year. If the Eligible Employee was not eligible for benefits in the immediately prior Plan Year, then the Employee shall be deemed to have affirmatively elected to pay for all Insurance Benefits under the Premium Payment Component and deposits to a Health Savings Account (if any) with pre-tax salary deferrals and shall be deemed to have affirmatively elected not to participate in the Health FSA Component or the DCAP Component. The Eligible Employee may not elect to participate in the Health FSA Component of the Plan or the DCAP Component of the Plan: (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Section 12.4.

4.4 Irrevocability of Elections

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

ARTICLE V. BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

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

- (a) Premium Payment Benefits, as described in Article VI;
- (b) Health FSA Benefits, as described in Article VII;
- (c) DCAP Benefits, as described in Article VIII; and
- (d) Deposits to a Health Savings Account, as described in Article X.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

5.2 Employer and Participant Contributions

- (a) *Employer Contributions.* For Participants who elect Insurance Benefits described in Article VI, the Employer may contribute a portion of the premium as provided in the open enrollment materials furnished to employees and/or on the Election Form/Salary Reduction Agreement. The Employer may from time to time elect, at the Employer's discretion and in amounts determined by the Employer, make deposits through this Plan to the Health FSA, DCAP and/or Insurance Reimbursement Accounts of Participants as communicated to Participants in the open enrollment materials furnished to employees and/or on the Election Form/Salary Reduction Agreement. The Employer may from time to time elect, at the Employer's discretion and in amounts determined by the Employer, to make deposits through this Plan to the Health Savings Accounts of Participants who are covered under a High Deductible Health Plan sponsored by the Employer. Such deposits, if any, shall be made in amounts and at such times that are in compliance with all applicable laws and regulations.
- (b) *Participant Contributions.* Participants who elect any of the Insurance Benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing an Election Form/Salary Reduction Agreement. Participants who elect Health FSA Benefits or DCAP Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement. Deposits to a Participant's Health Savings Account may be made on a pre-tax Salary Reduction basis, or with after-tax payroll deductions, by making the appropriate election on the Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

1. *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual premium for such Benefits (as described in Sections 6.2, 7.2 and 8.2, as applicable), divided by the number of pay periods in the Period of Coverage, (2) an amount otherwise agreed upon between the Employer and the Participant, or (3) an amount deemed appropriate by the Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld may fluctuate). If a Participant increases his or her election under the Health FSA Component or DCAP Component as permitted under Section 12.4, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 12.4, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change, (2) an amount otherwise agreed upon between the Employer and the Participant, or (3) an amount deemed appropriate by the Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld may fluctuate).
2. *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the premiums for the Premium Payment Benefits, the premiums for the Health FSA Benefits and the DCAP Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.
3. *After-Tax Contributions for Premium Payment Benefits.* For those Participants who elect to pay their share of the cost of any of the Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such premiums will be paid outside of this Plan.

4. *Annual Dollar Limitation on Salary Reduction Contributions to the Health FSA Component.* Notwithstanding any provision of this Plan to the contrary, the maximum Salary Reduction Contribution that can be made to the Plan to pay for benefits elected under the Health FSA Component shall be limited to \$2,500.00 (as indexed) for taxable years of the Employee beginning on or after January 1, 2013. If a Participant elects Health FSA Component benefits that would result in Employee pre-tax contributions for the Employee's tax year exceeding the applicable limit, the Plan Administrator shall reduce the Participant's Health FSA Component election amount to comply with this limit.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third party paying agent to make Benefit payments on its behalf. The maximum contributions that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits, as described in Section 6.2; and (b) as described under Sections 7.4(b) and 8.4(b) for Health FSA and DCAP Benefits.

ARTICLE VI. PREMIUM PAYMENT COMPONENT

6.1 Benefits

The Insurance Benefits that are offered under the Premium Payment Component are benefits under the Insurance Plan. The Insurance Benefits are subject to the terms and conditions of the Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the premiums for Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component, and to pay for his or her share of the premiums, if any, for Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 Benefit Premiums (a.k.a. Contributions for Cost of Coverage)

The annual premium for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier, if any.

6.3 Insurance Benefits Provided Under the Insurance Plan

Insurance Benefits will be provided by the Insurance Plan, not this Plan. The types and amounts of Insurance Benefits, the requirements for participating in the Insurance Plan, and the other terms and conditions of coverage and benefits of the Insurance Plan are set forth in the plan document or summary plan description for each plan that provides an Insurance Benefit. All claims to receive benefits under the Insurance Plan shall be subject to and governed by the terms and conditions of the Insurance Plan and the rules, regulations, policies and procedures from time to time adopted in accordance therewith, as may be amended from time to time.

6.4 Health Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Health Insurance Benefits because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Premium Payment Component the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA), with premiums for such coverage to be paid on a pre-tax basis unless determined otherwise by the Administrator on a uniform and consistent basis (but not beyond the current Plan Year).

ARTICLE VII. HEALTH FSA COMPONENT

7.1 Benefits

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

7.2 Benefit Premiums (aka Cost of Coverage)

The annual premium for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum \$2,400 annual benefit amount is elected, then the annual premium amount is also \$2,400).

7.3 Eligible Medical Care Expenses

Under Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.

- (a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed for, is charged for, or pays for the medical care.
- (b) *Medical Care Expenses.* "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213, but excluding expenses that are excluded under Appendix B to this Plan and also excluding any medicine or drug (except for insulin) that is purchased after January 1, 2011 that is not "prescribed" within the meaning of Code §106(f), but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Insurance Plan, other insurance, or any other accident or health plan other than a Health Savings Account. The Participant may elect to further limit the definition of Eligible Medical Care Expenses as provided in Section 7.3(c) and/or (d) below. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Insurance Plan imposes co-payment or deductible limitations), the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VII.
- (c) *Participant Limitations on Medical Care Expenses.* At the election of the Participant, "Medical Care Expenses" can be limited to mean only expenses incurred by a Participant or his or her Spouse or Dependents for dental or vision care.
- (d) *Employee-only Coverage.* At the election of the Participant, "Medical Care Expenses" can be limited to exclude expenses incurred by a Participant's spouse or by a Participant's spouse and dependents.

7.4 Maximum and Minimum Benefits

- (a) *Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been satisfied.
- (b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be \$2,500.00, subject to Section 5.3 (4) above and Section 7.5 (c) below. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be \$30.00. Reimbursements due for Medical Care

Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

- (c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year, or wishes to increase his or her election mid-year as permitted under Section 12.4, there will be no proration rule— i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.
- (d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII affecting annual contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions made by the Participant (if any) as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage.

7.5 Establishment of Account

The Administrator will establish and maintain a Health FSA Account with respect to each Participant who has elected to participate in the Health FSA Component, but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under *Section 7.6*.

- (a) *Crediting of Accounts.* A Participant's Health FSA Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account plus Employer contributions, if any.
- (b) *Debiting of Accounts.* A Participant's Health FSA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.
- (c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements during the Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Period of Coverage, but any such negative amount shall never exceed the maximum dollar amount of annual benefits elected by the Participant under this Plan.

7.6 Forfeiture of Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: (a) first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to any Participant in excess of the premiums paid by such Participant through Salary Reductions; (b) second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Administrator); and (c) third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Procedure

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

(b) *Claims Substantiation.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe, by the end of the third calendar month following the close of the Plan Year in which the Medical Care Expense was incurred, set forth:

- the person or persons on whose behalf Medical Care Expenses have incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator may request. Except for the final reimbursement claim for a Period of Coverage, claims for reimbursement of less than \$25 may be held until the aggregate claims for reimbursement are at least \$25.

(c) *Claims Paid by Electronic Payment Card.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may pay for Medical Care Expenses with an electronic payment (i.e.; debit or credit) card issued to the Participant for that purpose. Unless the Medical Care Expense is an expense which qualifies for automatic substantiation under the applicable regulations, the Participant must submit additional third-party information describing (1) the service or product, (2) the date of the service or sale, and (3) the amount of expense. The Administrator shall notify the Participant within a reasonable period of time after the payment of the expense which reimbursements do not qualify for automatic substantiation. If additional third-party information is not provided within a reasonable period of time, the Administrator shall seek reimbursement for the payment by (1) requesting reimbursement to the Plan by the Participant; (2) offsetting the amount against future claims of the Participant; or (3) requesting the Employer to withhold the amount from the Participant's Compensation. If these correction procedures do not succeed, the Employer shall reimburse the Plan for the amount and the Participant shall be indebted to the Employer for the payment amount, which shall be treated the same as any other business indebtedness of the Employer.

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

7.8 Reimbursements After Termination; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant (or the Participant's estate) files a claim no later than the end of the third calendar month following the close of the Plan Year in which the Medical Care Expenses arose.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA or, if the Employer is not subject to COBRA, to the extent required by COBRA as if the Employer were subject

to COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA), with premiums for such coverage to be paid on an after-tax basis unless permitted otherwise by the Administrator on a uniform and consistent basis (but not beyond the current Plan Year). Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

7.9 Overlapping Coverage Periods

Medical Care Expenses incurred during a period of overlapping coverage and approved for reimbursement in accordance with Section 7.7 will be reimbursed first from any amount remaining for reimbursement from the most recently completed Plan Year and then from any amounts that are available for reimbursement from the current Plan Year, except that if the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Medical Care Expenses incurred during an overlapping coverage period may need to be submitted manually in order to be reimbursed from amounts remaining for reimbursement from a prior Plan Year if the card is unavailable for such reimbursement.

7.10 Named Fiduciary for Health FSA

City of North Liberty is the named fiduciary for the Health FSA Component.

7.11 HIPAA Provisions

- (a) *Provision of Protected Health Information to Employer.* If members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Health FSA, such information is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The Employer shall have access to PHI from the Health FSA only as permitted under this Section 7.11 or as otherwise required or permitted by HIPAA.
- (b) *Permitted Disclosure of Enrollment/Disenrollment Information.* The Health FSA may disclose to the Employer information on whether the individual is participating in the Plan.
- (c) *Permitted Uses and Disclosure of Summary Health Information.* The Health FSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health FSA. "Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.
- (a) *Permitted and Required uses and Disclosure of PHI for Plan Administration Purposes.* Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 7.11(e) and obtaining written certification pursuant to Section 7.11(g), the Health FSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Health FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR§164.504(f).

(a) *Conditions of Disclosure for Plan Administration Purposes.* The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer shall:

- not use or further disclose Protected Health Information other than as permitted or required by this Plan document or as required by law;
- ensure that any agents or subcontractors to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer;
- not use or disclose Protected Health Information for employment related actions or in connection with any other employee benefit plan;
- report to the Employer's Privacy Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures;
- make Protected Health Information available to Plan participants, consider their amendments and, upon request, provide them with an accounting of Protected Health Information disclosures;
- make the Employer's internal practices and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services upon request; and
- if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between the Health FSA and the Employer (i.e., the "firewall"), required in 45 CFR §504(f)(2)(iii), is satisfied.

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

(a) *Adequate Separation Between Plan and Employer.* The Employer shall allow access to PHI to any employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Health FSA. No other persons shall have access to PHI. These employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Health FSA. In the event that any of these employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures. The Employer will ensure that the provisions of this Section 7.11(f) are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

(a) *Certification of Plan Sponsor.* The Health FSA shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Employer agrees to the conditions of disclosure set forth in Section 7.11(e).

ARTICLE VIII. DCAP COMPONENT

8.1 Benefits

An Eligible Employee can elect to participate in the DCAP Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses, and to pay the premium for such

benefits on a pre-tax Salary Reduction basis (DCAP Benefits). Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 Benefit Premiums (a.k.a. Contributions for Cost of Coverage)

The annual premium for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum \$5,000 annual benefit amount is elected, the annual premium amount is also \$5,000).

8.3 Eligible Dependent Care Expenses

Under the DCAP Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

- (a) *Incurred.* A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).
- (b) *Dependent Care Expenses.* "Dependent Care Expenses" means expenses that are considered to be employment-related expenses under Code § 21 (b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any), and expenses for incidental household services, if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (e.g. because the Spouse's DCAP imposes maximum benefit limitations), the DCAP can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.
- (c) *Qualifying Individual.* "Qualifying Individual" means:
 - a tax dependent of the Participant as defined in Code §152 who is under the age of thirteen (13) and who is the Participant's qualifying child as defined in Code §152(a)(1);
 - a tax dependent of the Participant as defined in §152 who is mentally or physically incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
 - a Participant's Spouse who is mentally or physically incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year.
- (h) *Qualifying Dependent Care Services.* "Qualifying Dependent Care Services" means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed:
 - in the Participant's home; or
 - outside the Participant's home for (1) the care of a Participant's Dependent who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services), then the center must comply with all applicable state and local laws and regulations.
- (h) *Exclusion.* Dependent Care Expenses do not include amounts paid to:
 - an individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;
 - a Participant's Spouse; or
 - a Participant's child who is under 19 years of age at the end of the year in which the expenses were incurred.

8.4 Maximum Benefits

- (a) *Maximum Reimbursement Available; Statutory Limitations.* The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCAP Account pursuant to Section 8.5. (No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant's Account (that is, the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements). Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been satisfied. Notwithstanding the foregoing, no reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the applicable statutory limit. The applicable statutory limit for a Participant is the smallest of the following amounts:
- the Participant's Earned Income for the calendar year;
 - the Earned Income of the Participant's Spouse for the calendar year (a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense, and (2) is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of \$200 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of \$400 per month); or
 - Either \$5,000 or \$2,500 for the calendar year, as applicable:
 - (1) \$5,000 for the calendar year if one of the following applies:
 - (A) the Participant is married and files a joint return;
 - (B) the Participant is married, but (1) furnishes more than one-half the cost of maintaining the Dependent for whom the Participant is eligible to receive reimbursements under the DCAP; (2) the Participant's Spouse maintains a separate residence for the last six months of the calendar year; and (3) the Participant files a separate tax return; or
 - (C) the Participant is single or is the head of the household for tax purposes; or
 - (2) \$2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.
- (b) *Maximum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be \$5,000 (subject to the other limitations described above, and subject to Section 8.4 (c)).
- (c) *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCAP Component mid-year, or wishes to increase his or her election mid-year as permitted under Section 12.4, there will be no proration rule— i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.
- (h) *Effect of Maximum Benefits If Election Change Permitted.* Any change in an election under Article XII affecting annual contributions to the DCAP Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Section 8.4(a). Such maximum reimbursement benefits for the balance for the Period of Coverage shall be calculated by adding (1) the contributions made by the Participant (if any) as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCAP Account, reduced by (3) reimbursements during the Period of Coverage.

8.5 Establishment of Account

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

- (a) *Crediting of Accounts.* A Participant's DCAP Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.
- (b) *Debiting of Accounts.* A Participant's DCAP Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.
- (c) *Available Amount Is Based on Credited Amount.* As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCAP Account, less any prior reimbursements; i.e., it is based on the amount credited to the DCAP Account at a particular point in time. Thus, a Participant's DCAP Account may not have a negative balance during a Period of Coverage.

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

If any balance remains in the Participant's DCAP Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to reduce the cost of administering this Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Administrator); and second, to provide increased benefits or compensation to Participants in subsequent years in any fashion the Administrator deems appropriate, consistent with applicable regulations. In addition, any DCAP Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

8.7 Reimbursement Procedure

- (a) *Timing.* Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.
- (b) *Claims Substantiation.* A Participant who has elected to receive DCAP Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe, by no later than the end of the third calendar month following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:
 - the person or persons on whose behalf Dependent Care Expenses have been incurred;
 - the nature and date of the Expenses so incurred;
 - the amount of the requested reimbursement;
 - the name of the person, organization or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if an individual); and
 - a statement that such Expenses have not otherwise been paid and are not expected to be paid through any other service.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator may request. Except for the final reimbursement claim for a Period of

Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least \$25.

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

8.8 Reimbursements After Termination

When a Participant ceases to be a Participant as defined under Section 3.2, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements, subject to the following: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to termination, including expenses incurred through the end of the calendar month following the calendar month in which termination occurs (but only if such calendar month is in the current Plan Year), provided that the Participant (or the Participant's estate) files a claim no later than the end of the third calendar month following the close of the Plan Year in which the Dependent Care Expense arose.

8.9 Report to Participants

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

ARTICLE IX. [RESERVED]

ARTICLE X. HEALTH SAVINGS ACCOUNT BENEFIT

10.1 Benefits

An Eligible Employee can elect to have deposits made by the Employer, as provided by Section 5.2(b), to a Health Savings Account established by the Participant. The amount will be contributed to the Employee's Health Savings Account each pay period in an amount equal to (1) the amount elected divided by (2) the number of pay periods in the Period of Coverage; or as otherwise agreed upon by the Employer and the Participant.

All deposits, whether by Employee Salary Reduction or by Employer contribution, made to a Health Savings Account established by a Participant shall be deemed to have been made through this Cafeteria Plan for purposes of the exception to the Comparability Rules contained in Treas. Reg. Section 54.4980G-5.

10.2 Benefits Provided Under the Health Savings Account Agreement

Amounts deposited to the Participant's Health Savings Account pursuant to this Article X shall be held in the Health Savings Account subject to the rights and conditions as specified in the Health Savings Account agreement. All claims to receive benefits under the Health Savings Account shall be subject to the terms and conditions of the Health Savings Account agreement and the rules, regulations, policies and procedures established by the custodian or trustee of the Health Savings Account.

10.3 Repayment of Pre-funded Employer Contributions

The Employer may, at the Employer's election, pre-fund at the beginning of the Plan Year or at various times during the Plan Year, any or all amounts that are elected by the Participant as HSA deposits. Should pre-funded contributions deposited by the Employer to the Health Savings Account of a Participant who later terminates participation be greater than the amounts that were withheld from the Participant's Compensation or that would have been deposited pro rata by the Employer, such excess pre-funded amounts shall be paid back by the Participant to the Employer by the end of the Plan Year through: (1) direct repayment by the Participant by personal check or otherwise to the Employer; or 2) after-tax withholding from the Participant's remaining Compensation upon the consent of the Participant. In no event may such pre-funded amounts be repaid from the former Participant's Health Savings Account.

10.4 Selection of Initial HSA Trustee/Custodian

Contributions made to the Health Savings Accounts of Participants under this Plan shall only be made to the Trustee(s) and/ or Custodian(s) selected by the Employer. (Participants have the right to transfer amounts so deposited to a different Trustee/Custodian of their choice as permitted by the Code and

as permitted by the rules and procedures established by the Trustee/Custodian.) The Employer may, in the Employer's sole discretion, permit Participants to select the Trustee and/or Custodian for that Participant's Health Savings Account subject to the approval of the Employer.

ARTICLE XI. [RESERVED]

ARTICLE XII. IRREVOCABILITY OF ELECTIONS; EXCEPTIONS

12.1 Irrevocability of Elections

Except as described in this Article XII, a Participant's election under the Plan, other than an election relating to amounts to be deposited to a Health Savings Account, is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan;
- Salary Reduction amounts; or
- Election of particular Benefit Package Options.

12.2 Procedure for Making New Election If Exception to Irrevocability Applies

- (a) *Timing for When New Election Must Be Made.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 12.4 (other than an event described in Section 12.4(g) for which a new election must be made within 60 days of the occurrence), as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event, and the election is made within any specified time period.
- (b) *Effective Date of New Election.* Elections made pursuant to this Section 12.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 12.4 (e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Administrator, election changes may become effective later to the extent the coverage in the applicable Benefit Package Option commences later).
- (c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP Components, see Sections 7.4 and 8.4 respectively.

12.3 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 12.4, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- (a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;
- (b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;
- (c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefit plan of the Participant or his or her Spouse or Dependents depend on the

employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefit plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

- (d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and
- (e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

12.4 Events Permitting Exception to Irrevocability Rule

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

- (a) *Open Enrollment Period (Applies to Premium Payment, Health FSA and DCAP Benefits).* A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.
- (b) *Termination of Employment (Applies to Premium Payment, Health FSA and DCAP Benefits).* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.
- (c) *Leaves of Absence (Applies to Premium Payment, Health FSA and DCAP Benefits).* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.
- (d) *Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits as Limited Below, and DCAP Benefits as Limited Below).* A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 12.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage on account of attaining a certain age, etc. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

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

- law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment or legal separation).
- (2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Administrator has reason to believe that the Participant's certification is incorrect.
- (3) *Special Consistency Rule for DCAP Benefits.* With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129.
- (e) *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, but Not to Health FSA or DCAP Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code § 9801 (f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:
- (1) A Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or
 - (2) A new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).
- (f) *Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits).* If a judgment, decree, or order (an "order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may (1) change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.
- (g) *Medicare and Medicaid and State Children's Health Insurance Program (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines) or a

State Children's Health Insurance Program, the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid or State Children's Health Insurance Program coverage and/or the Participant's Health FSA coverage may be canceled (but not reduced). Further, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid or a State Children's Health Insurance Program loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility or eligibility under a State Children's Health Insurance Program and/or the Participant's Health FSA coverage may commence or increase.

- (h) *Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits).*

For purposes of this Section 12.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA, (2) the HMO and the PPO are considered to be similar coverage, and (3) coverage by another employer, such as a Spouse's or Dependent's employer, is treated as similar coverage.

- (1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for the Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.
- (2) *Significant Cost Increases.* If the Administrator determines that the cost charge to an Employee of a Participant's Benefit Package Option(s) (such as the PPO) significantly increases during a Period of Coverage, the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option offered by the Employer that provides similar coverage (such as the HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.
- (3) *Significant Cost Decreases.* If the Administrator determines that the cost of any Benefit Package Option (such as the PPO) significantly decreases during a Period of Coverage, the Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option (such as the HMO, but not the Health FSA) other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO); and (b) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.
- (4) *Limitation on Change in Cost Provisions for DCAP Benefits.* The above "Change in Cost" provisions (Sections 12.4 (h)(1)-(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152 (a)(1) through (8), incorporating the rules of Code §§ 152(b)(1) and (2).

- (i) *Change in Coverage (Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits).*

The definition of "similar coverage" under Section 12.4(h) applies also to this Section 12.4(i).

- (1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined in subsection (I) below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth in subsection (ii) below, if the coverage curtailment results in a "Loss of Coverage" (as defined in subsection (iii) below), Participants may drop coverage if no similar coverage is offered by the Employer. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.
- (i) *Significant Curtailment Without Loss of Coverage.* If the Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.
- (ii) *Significant Curtailment With a Loss of Coverage.* If the Administrator determines that a Participant's Benefit Package Option (such as the PPO) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA), or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.
- (iii) *Definition of Loss of Coverage.* For purposes of this Section 12.4(I)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, the HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Administrator in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:
- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO or the HMO);
 - a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
 - any other similar fundamental loss of coverage
- (2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage, the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Administrator may permit the following election changes: (1) Participants who are enrolled in a Benefit Package Option other than the newly-added or significantly improved Benefit Package Option may change their election on a prospective basis to elect the newly-added or significantly improved Benefit Package

Option; and (2) Employees who are otherwise eligible under Section 3.1 may elect the subject to the terms and limitations of the Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

- (3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701 (a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).
- (12) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.
- (13) *DCAP Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

A Participant entitled to change an election as described in this Section 12.4 must do so in accordance with the procedures described in Section 12.2.

12.5 Election Modifications Required by Administrator

The Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE XIII. APPEALS PROCEDURE

13.1 Procedure If Benefits Are Denied Under This Plan

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

13.2 Claims Procedures for Insurance Benefits and Distributions from Health Savings Accounts

Claims and reimbursements for Insurance Benefits shall be administered in accordance with the claims procedures for the applicable Insurance Plan, as set forth in the policy, plan document and/or summary plan description for that Insurance Plan. Requests for distributions from a Health Savings Account shall be made to the Health Savings Account custodian or trustee in accordance with the policies and procedures of the Health Savings Account custodian or trustee.

ARTICLE XIV. RECORDKEEPING AND ADMINISTRATION

14.1 Administrator

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

14.2 Powers of the Administrator

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

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 14.1);
- (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- (c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- (e) to furnish each Employee and Participant with such reports and with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;
- (f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;
- (g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
- (h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- (i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- (j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

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

14.4 Provision for Third-Party Plan Service Providers

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

14.5 Fiduciary Liability

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

14.6 Compensation of Plan Administrator

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

14.7 Bonding

The Administrator shall be bonded to the extent required.

14.8 Insurance Contracts

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

14.9 Inability to Locate Payee

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

14.10 Effect of Mistake

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

ARTICLE XV. GENERAL PROVISIONS

15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 and 8.6. Any expenses remaining shall, at the option of the Employer, be paid by the Employer or be charged against the accounts of Participants. If any expenses are charged against the accounts of Participants, such expenses shall be considered to be paid through the Plan with pre-tax deferrals.

15.2 No Contract of Employment

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

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason and the Employer hereby grants limited authority to R. D. Drenkow & Co., Inc. to make amendments to the Plan that are clarifying in nature or advisable to comply with applicable law. Any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

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

15.5 Code Compliance

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

15.6 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

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

15.8 Non-Assignability of Rights

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

15.9 Headings

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

15.10 Plan Provisions Controlling

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

15.11 Severability

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

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the City of North Liberty Cafeteria Plan, City of North Liberty has caused this Plan to be executed in its name and on its behalf on this _____ day of _____, 201____.

City of North Liberty

By: _____

Appendix A
Related Employers That Have Adopted This Plan,
With the Approval of City of North Liberty

None

Appendix B

Exclusions --- Medical Expenses That Are Not Reimbursable

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code §213:

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- Any item or procedure that is not reimbursable under any applicable federal or state regulation.