MONTANA UNIVERSITY SYSTEM

PLAN DOCUMENT

for the

FLEXIBLE SPENDING ACCOUNT BENEFITS PLAN

Plan Group #49699

EFFECTIVE DATE: JULY 1, 2025

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MONTANA UNIVERSITY SYSTEM
FLEXIBLE SPENDING ACCOUNT BENEFITS PLAN

INTRODUCTION

The Employer has amended this Plan effective July 1, 2025, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different benefits based on their own goals and needs. This Plan is a restatement of a Plan which was originally effective on July 1, 2020. The Plan shall be known as the Montana University System Flexible Spending Account Benefits Plan (the "Plan").

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

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer which is a member of a controlled group (as defined in Code Section 414(b)) which includes the Employer; any organization which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **"Code"** means the Internal Revenue Code of 1986, as amended, or replaced, at any time.

1.6 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **"Dependent"** means any individual who qualifies as a dependent under the self-funded plan for purposes of that plan or under Code Section 152 (as modified by Code Section 105(b)).

"Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes their natural child, stepchild, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of twenty-six (26), regardless of student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the month in which the child turns age twenty-six (26).

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, regardless if the adoption has become final, who has not attained the age of eighteen (18) as of the date of placement for adoption. The term "placed" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have commenced.

1.8 **"Effective Date"** means the date on which a Participant’s coverage begins.

1.9 **"Annual Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Plan Administrator, which is applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if the individual is not reported on the payroll records of the Employer as a common law employee. It is intended that individuals not treated as common law employees by the Employer on their payroll records are not "Eligible Employees" and are excluded from Plan participation.

1.11 **"Employee"** means any person who is employed by the Employer.

1.12 **"Employer"** means the Montana University System, which shall maintain this Plan.

1.13 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.14 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits, the Employer.

1.15 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.16 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate in the Plan.

1.17 **"Plan"** means this benefits coverage, including all amendments thereto.

1.18 **"Plan Year"** means the 12-month period beginning July 1 and ending June 30. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. If a Participant commences participation during a Plan Year, the initial coverage period shall be that portion of the Plan Year commencing on the Participant's date of hire, with the effective date for Flexible Spending Accounts being on the first of the month following the Participant's date of hire and ending on the last day of the Plan Year.

1.19 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the self-funded Benefits described in Section 4.1.

1.20 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

1.21 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.22 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce their Compensation or to forego all or part of the increases in Compensation and to have amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and subsequently does not become currently available to the Participant.

1.23 **"Spouse"** means a legal spouse as determined under Federal and Montana law.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of their date of employment or the date of benefits eligibility (or the Effective Date of the Plan, if later) or the first day of the upcoming Plan year (July 1). However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective the first day of the month following the date on which the Employee met the eligibility requirements of Section 2.1.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Annual Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change their Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Annual Election Period for the Plan Year during which they wish to participate in this Plan. Any Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

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

(a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.5, or a reduction in work hours and are no longer eligible for benefits; or

(b) **Death.** The Participant's death, subject to the provisions of Section 2.6; or

(c) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, their participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insurance Benefit.** With regard to Benefits provided under Section 4.1, the Participant's participation in the Plan shall cease the last day of the month in which the Participant terminates employment, subject to the Participant's right to continue coverage under any Insurance Contract or self-funded benefit.

(b) **Health Flexible Spending Account (FSA).** Regarding the Health FSA, the Participant's participation in the Plan shall cease on the last day of the month in which the Participant ceases coverage due to events under Section 2.4. However, the Participant may submit claims for Health Expense reimbursements incurred through the end of the month in which the Participant ceases coverage and claims must be submitted no later than 90 days after the end of the Plan Year.

(c) **Dependent Care Flexible Spending Account (FSA).** Regarding the Dependent Care FSA, the Participant's participation in the Plan shall cease on the last day of the month in which the Participant ceases coverage due to events under Section 2.4. However, the Participant may submit claims for employment related Dependent Care Expense reimbursements incurred through the end of the month in which the Participant ceases coverage and claims must be submitted no later than 90 days after the end of the Plan Year.

(d) **COBRA applicability.** Regarding the Health FSA, the Participant may submit claims for expenses that were incurred through the end of the month in which the Participant ceases coverage due to events under Section 2.4 and claims must be submitted no later than 90 days after the end of the Plan Year. Thereafter, the health benefits under this Plan including the Health FSA shall be applied and administered consistent with such further rights a Participant and their Dependents may be entitled to pursuant to Code Section 4980B and Section 11.13 of the Plan.

2.6 DEATH

If a Participant dies, their participation in the Plan shall cease on the last day of the month in which the Participant was an active Participant. The Participant’s Spouse or Dependents may submit claims for expenses that were incurred through the end of the month in which the Participant terminates coverage and claims must be submitted no later than 90 days after the end of the Plan Year. In no event may reimbursements be paid to someone who is not a Spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health FSA.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce their pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of the Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for the Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's date of hire up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Annual Election Period and shall be irrevocable for the Plan Year. However, a Participant may make mid-year changes to a FSA Benefit election, or a Salary Redirection Agreement, after the Plan Year has commenced and/or make a new Dependent Care FSA election with respect to the remainder of the Plan Year, if both the revocation and the new Dependent Care election are on account of and consistent with a change in status and other permitted events as determined under Article V of the Plan and consistent with the Plan rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health FSA or Dependent Care FSA shall be credited to the fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to the account for the purpose of paying Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, regarding the Health FSA, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

(1) Health Flexible Spending Account

(2) Dependent Care Flexible Spending Account

(3) Health Insurance Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health FSA option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care FSA option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Contract for the Participant, their Spouse, and their Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from the health Contract shall be determined therefrom, and the Contract shall be incorporated herein by reference.

4.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of the Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election, or reduce contributions or non-taxable Benefits to assure compliance with this Section. Any act taken by the Administrator under this Section shall be conducted in a uniform and nondiscriminatory manner. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 may elect to participate in this Plan for all or the remainder of the Plan Year, provided they elect to do so on or after their effective date of participation pursuant to Section 2.2.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Annual Election Period prior to each subsequent Plan Year, each Employee shall be given the opportunity to elect which Benefit options they wish to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Annual Election Period. Regarding subsequent annual elections, the following options shall apply:

(a) An Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Annual Election Period.

(b) An Employee may waive their participation in the Plan by waiving all Benefit options during the Annual Election Period.

5.3 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which the election relates) has commenced and make new elections with respect to the remainder of the Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under the Plan rules and regulations.

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

A new Dependent Care FSA election can be made, or a current election can be changed or terminated, if there is a change in status event. A change to the current Health FSA election can be made due to a change in status event. A new Health FSA election cannot be made, nor an election terminated, due to a change in status event. Changes in FSA elections must be consistent with the change in status. Any new Dependent Care FSA election or change in Health FSA and/or Dependent Care FSA election due to a change in status event shall be effective the first of the month following the new election, change in election, or at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election is completed. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by the Plan:

(1) Legal Marital Status: Events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation, or annulment.

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent.

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

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstance.

For the Dependent Care FSA, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for group health coverage during a Plan Year and make a new election that is consistent with the Plan rules and corresponds with the

special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that the Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or a longer period as may be permitted by the Plan and communicated to Participants). Changes shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment or order due to divorce, legal separation, annulment, or change in legal custody which requires health coverage for a Participant's child:

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for the child, under that individual's plan and coverage is provided.

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

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease the Salary Redirections of all affected Participants for such Benefit.

(f) **Loss of coverage.** If the coverage under a Benefit ceases during a Plan Year, affected Participants may elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if the individual loses group health coverage sponsored by a governmental, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change in dependent care provider.** A Participant may make a prospective election change that corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care FSA only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(j) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health FSA due to a cost or coverage change under any health insurance benefits.

(k) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke coverage under the group health plan (that is not a Health FSA) which provides minimum essential coverage (as defined in Code §5000A(f)(1)) provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

(1) The Participant has been reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

(1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health FSA is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health FSA may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health FSA.

6.2 DEFINITIONS

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

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, their Spouse and their Dependents may be reimbursed.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the five (5) highest paid officers.

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining their tax liability under the Code. "Medical Expenses" can be incurred by the Participant, their Spouse, and their Dependents. "Incurred" means when the Participant is provided with the medical care that incurs a Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of other health coverage, such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or their Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health FSA.

6.3 FORFEITURES

The amount in the Health FSA as of the end of any Plan Year (and after the processing of all claims for the Plan Year pursuant to Section 6.7 hereof, excluding any carryover) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to the amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health FSA to the contrary, the maximum amount of salary reductions that may be allocated to the Health FSA by a Participant in or on account of any Plan Year is the statutory amount under Code Section 125(i), as adjusted for increases in the cost of living. The cost-of-living adjustment in effect for a calendar year applies to any Plan Year beginning with or within the calendar year. The dollar increase in effect on January 1 of any calendar year shall be effective for the Plan Year beginning with or within the calendar year. For any short Plan Year, the limit shall be an amount equal to the limit for the calendar year in which the Plan Year begins multiplied by the ratio obtained by dividing the number of full months in the short Plan Year by twelve (12).

(b) The minimum amount that may be allocated to the Health FSA by a Participant in or on account of any Plan Year is $120.

(c) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering Health FSAs maintained by members of a controlled group or affiliated service group, the Participant's total Health FSA contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health FSA.

(d) **Carryover.** A Participant in the Health FSA may roll over unused amounts in the Health FSA remaining at the end of one Plan Year to the immediately following Plan Year, up to 20% of the statutory amount under Code Section 125(i), as adjusted for increases in the cost of living. The cost-of-living adjustment in effect for a calendar year applies to any Plan Year beginning with or within the calendar year. The dollar increase in effect on January 1 of any calendar year shall be effective for the Plan Year beginning with or within the calendar year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit and will be forfeited and credited to the benefit plan surplus. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts. A Participant must re-elect a Health FSA for any unused contributions to carryover to the next Plan Year or they will be forfeited after the runout period and credited to the benefit plan surplus.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health FSA not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health FSA, it may, but shall not be required to, reject any elections, or reduce contributions or Benefits to assure compliance with this Section. Any act taken by the Administrator under this Section shall be conducted in a uniform and nondiscriminatory manner. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health FSA. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health FSA. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during the Plan Year.** All Medical Expenses incurred by a Participant, their Spouse, and their Dependents during the Plan Year shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of a claim occurs after their participation hereunder ceases, provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that incurs medical expenses, not when the Participant is formally billed or charged for, or pays, for the medical care.

(b) **Reimbursement available throughout the Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health FSA for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard

to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts more than any payments or other reimbursements under any health care plan covering the Participant and/or their Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, at the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of the expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health FSA, the amount will not be claimed as a tax deduction. The Administrator shall retain a file of all applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. If a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses incurred during the Plan year up to the coverage end date, must be submitted within 90 days after the end of the Plan Year or shall not be considered for reimbursement by the Administrator.

6.8 DEBIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit (stored value) cards ("cards') provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that the card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** The card shall be issued upon the Participant's Effective Date of Participation in the Health FSA. The card shall be automatically cancelled upon the Participant's death or termination of employment.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year, as set forth in Section 6.4.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by merchants and service providers that have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Copayments for doctor and other medical care.

(2) Purchase of drugs prescribed by a health care provider, including, over-the-counter medications and menstrual care products, as allowed under IRS regulations; and

(3) Purchase of medical items such as eyeglasses, syringes, crutches.

(f) **Substantiation.** Card purchases shall be subject to substantiation by the Administrator, usually by submission of an Explanation of Benefits from a claim's administrator and/or receipt from a service provider describing the service, the date, and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If a purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant.

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law.

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care FSA is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care FSA.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that incurs Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household.

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of the Participant who is under the age of nineteen (19) or to an individual who is a Dependent of the Participant or the Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Dependent Care FSA purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age fourteen (14);

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for themselves, is a qualified tax dependent of the Participant, and qualifies for disability benefits through Social Security Disability Insurance; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care FSA.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care FSA for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care FSA benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care FSA shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that they have elected to apply toward their Dependent Care FSA pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care FSA shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care FSA, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of the expenses incurred during the Plan Year or portion thereof during which they are a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all benefits paid to or on behalf of the Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care FSA as of the end of any Plan Year (and after the processing of all claims for the Plan Year pursuant to Section 7.12 hereof) shall be forfeited after the run out period and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to the amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) **Plan limits.** Notwithstanding any provision contained in this Dependent Care FSA to the contrary, the following limits apply in addition to the Code limits. The minimum amount that may be allocated to the Dependent Care FSA by a Participant in or on account of any Plan Year is $120.

(b) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care FSA in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care FSA that contributions or benefits do not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care FSA that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouse or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections, or reduce contributions or non-taxable benefits to assure compliance with this Section. Any act taken by the Administrator under this Section shall be conducted in a uniform and nondiscriminatory manner. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care FSA. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care FSA. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of the expenses in a form satisfactory to the Administrator. However, at the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense was incurred during the Plan Year and the amount of the expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed.

(b) The nature of the services performed for the Participant, the cost of which they wish for reimbursement.

(c) The relationship, if any, of the person performing the services to the Participant.

(d) If the services are being performed by a child of the Participant, the age of the child.

(e) A statement as to where the services were performed.

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom the services were performed spends at least 8 hours a day in the Participant's household.

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than six (6) individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if they are employed, or

(2) if the Participant's Spouse is not employed, that

(i) they are incapacitated, or

(ii) they are a full-time student attending an educational institution and the months during the year which they attended the institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. If a Participant terminates employment during the Plan Year, claims for reimbursement incurred during the Plan year up to the coverage end date, must be submitted within 90 days after the end of the Plan Year or shall not be considered for reimbursement by the Administrator.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) **Insurance claims.** Any claim for Benefits underwritten by the self-funded plan shall be made to the Employer. If the Employer denies any claim, the Participant or beneficiary shall follow the Employer's claims review procedure.

(b) **Dependent Care FSA or Health FSA claims.** Any claim for Dependent Care FSA or Health FSA Benefits shall be made to the Administrator. For the Dependent Care FSA or Health FSA, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. If a Participant terminates employment during the Plan Year, claims for reimbursement for Employment-Related Dependent Care Expenses or Medical Expenses incurred during the Plan year up to the coverage end date, must be submitted within 90 days after the end of the Plan Year or shall not be considered for reimbursement by the Administrator. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based.

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why the information is necessary; and

(3) an explanation of the Plan's claim procedure.

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

(1) request a review upon written notice to the Administrator.

(2) review pertinent documents; and

(3) submit issues and comments in writing.

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

(f) **Forfeitures.** Any balance remaining in the Participant's Health FSA or Dependent Care FSA as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for the Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in their account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of the Participant or other person after reasonable efforts have been made to identify or locate such person, then the payment and all subsequent payments otherwise due to the Participant or other person shall be forfeited and returned to the Employer following a reasonable time after the date any payment first became due.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year in which the forfeitures arose. In no event shall the amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan (excepting any carryover); nor shall amounts forfeited by a particular Participant be made available to the Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal in writing (or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

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

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan.

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan.

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan.

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable to avoid discrimination under the Plan in violation of applicable provisions of the Code.

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits, or elections under the Plan.

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan.

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan; and

(h) To appoint agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

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

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee, and any other Employee of the Employer such records as it pertains to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

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

9.4 INSURANCE CONTROL CLAUSE

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

9.5 INDEMNIFICATION OF ADMINISTRATOR

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

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time, may amend any or all provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of the amendment, unless the amendment is made to comply with Federal, state, or local laws, statutes, or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Contract shall be paid in accordance with the terms of the Contract.

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

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.11.

11.2 GENDER, NUMBER AND TENSE

Wherever any words are used herein in one gender, they shall be construed as though they were also used in all genders in all cases where they would so apply; whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply; and whenever any words are used herein in the past or present tense, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

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

11.4 EXCLUSIVE BENEFIT

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

11.5 PARTICIPANT'S RIGHTS

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

11.6 ACTION BY THE EMPLOYER

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

11.7 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 the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

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

11.9 FUNDING

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

11.10 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as may be amended at any time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced, and administered according to the laws of the State of Montana.

11.11 SEVERABILITY

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

11.12 CAPTIONS

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

11.13 CONTINUATION OF COVERAGE (COBRA)

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

11.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

11.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

11.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

11.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

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

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

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

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

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform their duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

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

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

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law.

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information.

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section or required by law.

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards.

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

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

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

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

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

11.18 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

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

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

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

(c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.17.

11.19 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act.

11.20 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

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

11.21 WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

11.22 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

IN WITNESS WHEREOF, this Plan document is hereby executed this _____ day of _____.

Montana University System

By _____
EMPLOYER