RESOLUTION 2026-17

APPROVING AND ADOPTING A SECTION 125 CAFETERIA PLAN FOR EMPLOYEES OF THE PURISSIMA HILLS WATER DISTRICT

PURISSIMA HILLS WATER DISTRICT

WHEREAS, the Purissima Hills Water District ("District") understands that attracting and retaining top talent is imperative to achieve its operational goals; and

WHERAS, the District understands it must remain competitive in the job market in order to achieve this goal; and

WHEREAS, the District provides group health insurance benefits to its employees; and

WHEREAS, the District has determined it is in the best interests of the District to offer expanded health and welfare benefits to employees would further the goal of attracting and retaining a talented workforce; and

WHEREAS, the District desires to allow, effective July 9, 2026, its employees to utilize pre-tax dollars to fund a dependent care flexible spending account ("DCFSA") that will allow reimbursement of eligible dependent care expenses; and

WHEREAS, the District further wishes, effective January 1, 2027, to allow employees who enroll in an HSA-eligible high-deductible health plan to make pre-tax contributions to a health savings account ("HSA") or to allow eligible employees to make pre-tax contributions to excepted benefit medical Flexible Spending Arrangement ("FSA"); and

WHEREAS, the District has determined that in order to provide these benefits to employees, the benefits must be provided under a cafeteria plan that complies with Section 125 of the Internal Revenue Code ("Code"); and

WHEREAS, District staff recommends that the Board of Directors adopt a Code Section 125 compliant cafeteria plan to enable eligible employees to elect to participate in a DCFSA, HSA, and/or medical FSA on a pre-tax, salary reduction basis; and

WHEREAS, the Board of Directors of the Purissima Hills Water District ("Board") wishes to adopt a cafeteria plan that complies with Code Section 125, to enable its employees to elect to participate in a DCFSA, HSA and/or medical FSA benefits on a pre-tax, salary reduction basis.

NOW, THEREFORE, BE IT RESOLVED by the Purissima Hills Water District Board of Directors as follows:

1. Effective January 1, 2027 (Effective July 9, 2026 for the DCFSA component), the Board hereby adopts the Purissima Hills Water District Section 125 Cafeteria Plan (the "Cafeteria Plan") in substantially the form attached as Exhibit A.

2. The District's General Manager is hereby authorized to amend the Cafeteria Plan as necessary or desirable to obtain or maintain the Cafeteria Plan's compliance with applicable laws; no amendment, however, will be effective without the Board's prior written approval if the amendment increases the District's costs or adversely affects any participant.

3. The General Manager is further authorized and directed, for and on behalf of the District, to take such further action and execute such additional documents as they deem necessary or appropriate to carry out the provisions of the above resolutions, including execution of the Cafeteria Plan, as effective January 1, 2027 (Effective July 9, 2026 for the DCFSA component).

REGULARLY PASSED this 8th day of July 2026, by the following votes:

AYES: Directors Holtz, Jordan, Stone, Ranganathan, and Glassman.

NOES:

ABSTENTIONS:

ABSCENCES:

Board President
Purissima Hills Water District

ATTEST:

District Secretary

Purissima Hills Water District Section 125 Cafeteria Plan

As Adopted Effective July 9, 2026

Purissima Hills Water District Section 125 Cafeteria Plan

Table of Contents

Purissima Hills Water District Section 125 Cafeteria Plan

As Adopted Effective July 9, 2026

ARTICLE I. Introduction

1.1 Establishment of Plan

Purissima Hills Water District (the "Employer") hereby establishes the Purissima Hills Water District Section 125 Cafeteria Plan (the "Plan") effective July 9, 2026 (the "Effective Date") to provide benefit for certain of its employees. Notwithstanding the foregoing, the provisions of the Plan relating to the Health Savings Account and Medical Flexible Spending Arrangement shall be effective as of January 1, 2027, and no benefits shall be available under such components prior to that date. All other provisions of the Plan, including the Dependent Care Flexible Spending Arrangement, shall be effective as of 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:

A. Pay for their share of Contributions for the Benefit Plan Options in Appendix A on a pre-tax Salary Reduction basis; and

B. Contribute on a pre-tax Salary Reduction basis to an Employee's Health Savings Account, a Medical Flexible Spending Arrangement Account, and a Dependent Care Flexible Spending Arrangement Account.

1.2 Legal Status

This Plan is intended to qualify as a cafeteria plan under Code Section125 and will be interpreted and administered consistent with the requirements of Code Section 125 and the regulations issued thereunder.

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

Although reprinted within this document, the Medical FSA Component and the DCFSA Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129. The Medical FSA Component is also a separate plan for purposes of applicable provisions of HIPAA and COBRA. The HSA funding feature described in this Plan is not intended to establish an ERISA plan or to otherwise be part of an ERISA benefit plan. In the event that the Medical FSA Component is determined not to be a separate plan, the Plan will be designated as a hybrid entity for purposes of HIPAA, such that it will be a covered entity only with respect to the Medical FSA Component.

This Plan is sponsored by a local governmental entity and is not subject to ERISA and regulations thereunder.

ARTICLE II. Definitions

Account(s) means the Medical FSA Accounts and the DCFSA Accounts described in Sections 8.5 and 9.5. In some contexts, the term Account(s) may also include the record of HSA Contributions described in Section 7.3.

Benefits means the Premium Payment Benefits and the HSA Benefit and FSA Benefits offered under the Plan.

Benefit Plan Option means a qualified benefit under Code Section125(f) that is offered to a Participant under this Plan as set forth in Appendix A, as amended from time to time. The Employer may substitute, add, subtract, or revise at any time the menu of such Benefit Plan Options and/or the benefits, terms, and conditions of any such options or plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

Change in Status means any of the events described below, as well as any other events included under subsequent changes to Code Section125 or regulations issued thereunder, which the Plan Administrator, in their sole discretion and on a uniform and consistent basis, determines are permitted under Treasury 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 of a Dependent, adoption, and placement for adoption;

c. *Employment Status.* Any of the following events that change the employment status of the Participant or their Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or their Spouse or Dependents 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 this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), then that change constitutes a change in employment;

d. *Dependent Satisfies (or Ceases to Satisfy) Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the eligibility requirements for a particular benefit, such as attaining a certain age, gain or loss of student status, or any similar circumstances; and

e. *Change in Residence.* A change in the place of residence of the Participant or their Spouse or Dependents that would lead to a change in status (such as a loss of HMO coverage).

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

Code means the Internal Revenue Code of 1986 and the Treasury Regulations issued thereunder, as amended.

Compensation means the cash wages or salary paid to an Employee by the Employer. For

purposes of determining an Employee's Compensation, any salary reduction election under Code Sections 125 or 132(f)(4) shall be disregarded and the Employee's Compensation shall be determined as if no such election had been made. Any salary reduction election under Code Section 457(b) shall be excluded from Compensation.

Contribution means the amount contributed to pay for the cost of Benefits, as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for HSA Benefits, Section 8.2 for FSA Benefits, and Section 9.2 for DCFSA Benefits.

DCFSA means Dependent Care Flexible Spending Account.

DCFSA Account means the account described in Section 9.5.

DCFSA Benefits has the meaning described in Section 9.1.

DCFSA Component means the component of this Plan described in Article IX.

Dependent means: (a) for purposes of accident or health coverage, (1) a dependent as defined as in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCFSA, a Qualifying Individual. Notwithstanding the foregoing, the Medical 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 Expense has the meaning described in Section 9.3.

Domestic Partner means either a registered domestic partner or non-registered domestic partner of an eligible Employee. Registered domestic partners mean an eligible Employee and his or her domestic partner who: (a) have filed a declaration of domestic partnership with a jurisdiction's Secretary of State or equivalent office; (b) were registered as a domestic partner in the registry for those partnerships; and (c) were issued a copy of the registered form and a certificate of registered domestic partnership. Non-registered domestic partners mean an eligible Employee and his or her domestic partner who:

- are 18 years of age or older;
- share a close personal relationship and are responsible for each other's common welfare;
- are each other's sole domestic partner;
- are unmarried;
- have not had a different domestic partner within the last twelve months;
- are not related by blood closer than would prohibit marriage in the state in which they reside;
- share the same principal residence(s), with the current intent to continue doing so for the foreseeable future;
- are financially interdependent;
- were mentally competent to consent to the contract when their domestic partnership began.

For a domestic partner who does not meet the definition of dependent in Code Section 152, the value of benefits provided to a domestic partner under this Plan may receive different tax treatment under state and federal law.

Earned Income will have the meaning given such term in Code Section 129(e)(2).

Effective Date of this Plan means July 9, 2026.

Election Form/Salary Reduction Agreement means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Benefit Plan Options(s) and authorizing Salary Reductions to pay for any of the Benefit Plan Options.

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 leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)); or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (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; and (c) any employee covered under a collective bargaining agreement, unless the agreement provides for the employee's participation in the Plan. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

Employer means the Purissima Hills Water District.

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

Grace Period means the period that begins immediately following the close of a Plan Year and ends on the day that is two (2) months plus 15 days following the close of the Plan Year.

High Deductible Health Plan means the health plan offered by the Employer as a Benefit Plan Option that is intended to qualify as a high deductible health plan under Code Section 223(c)(2), as described in materials provided separately by the Employer.

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

HSA means a health savings account established under Code Section 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian. Although funded by Salary Reduction under this Plan, the HSA is not part of or intended to be part of an ERISA-covered benefit plan.

HSA Benefits has the meaning described in Section 7.1.

HSA-Eligible Individual means an individual who is eligible to contribute to an HSA under Code Section 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.

Insurance Plan(s) means the plan(s) that the Employer maintains for its Employees (and for their Spouses, registered domestic partners, and Dependents that may be eligible under the terms of such plan), which provide benefits through a group insurance policy or policies (e.g., medical, dental and vision 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 Expense has the meaning described in Section 8.3.

Medical FSA means the medical flexible spending arrangement.

Medical FSA Account means the account described in Section 8.5.

Medical FSA Benefits has the meaning described in Section 8.1.

Medical FSA Component means the component of this Plan described in Article VIII.

Nonelective Contribution(s) means any amount that the Employer, in its sole discretion, may contribute under the Plan to provide benefits for individual Participants and their Spouses, domestic partners, and Dependents, as applicable, under one or more of the Benefit Plan Options offered under the Plan.

Open Enrollment Period means the period during the Plan Year during which Eligible Employees may elect to participate in the Plan or make changes to their elections for the next Plan Year. The Employer will determine the period each Plan Year, which the Plan Administrator will make known in the Plan's open enrollment materials.

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 those who elect one or more Benefit Plan Options under the Plan.

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

Plan means the Purissima Hills Water District Section 125 Cafeteria Plan as set forth herein and as amended from time to time.

Plan Administrator means any person(s), entity, or committee as may be appointed from time to time by the Purissima Hills Water District Board (or its authorized designee) to administer the Plan. If no such person, entity, or committee is appointed, the Plan Administrator is the Purissima

Hills Water District.

Plan Sponsor means the Employer.

Plan Year means the calendar year (*i.e.*, 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 will be the entire short Plan Year.

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

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

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

Qualifying Dependent Care Services has the meaning described in Section 9.3.

Qualifying Individual means (a) a tax dependent of the Participant as defined in Code Section 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code Section 152(a)(1); (b) a tax dependent of the Participant defined in Code Section 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child will, as provided in Code Section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code Section 152(e)) and will not be treated as a Qualifying Individual with respect to the noncustodial parent.

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 who is legally married to a Participant as determined under applicable state law and who is treated as a spouse under the Code. A domestic partner is not treated as a spouse under the Code. Notwithstanding the above, for purposes of the DCFSA Component the term Spouse does 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

All full-time Employees are eligible to participate in the Plan. To become a Participant, an Eligible Employee must make a timely election to participate in accordance with Article IV. Eligibility for any Benefit Plan Option will be subject to the requirements specified in the governing plan documents of the applicable Benefit Plan Option. The provisions of this Article are not intended to override any eligibility requirement or waiting period specified in the appliable Benefit Plan Options and the terms of eligibility and participation for any Benefit Plan Option offered under the Plan are subject to the requirements specified in the Benefit Plan Option's governing documents.

3.2 Use of Contributions

As a Participant, an Employee will be permitted to (1) elect Benefit Plan Options for which they are eligible, (2) receive available Nonelective Contributions for which they are eligible in the manner set forth in the enrollment materials, (3) pay their share of the cost of their elected benefits with Salary Reduction contributions, and (4) if permitted under the terms of the Benefit Plan Options and uniform rules adopted by the Plan Administrator, pay their share of the costs of the elected benefits with after-tax dollars (e.g., if Salary Reduction contributions are not available or are insufficient to pay their share of the cost of the Benefit Plan Option). In addition, as a Participant, an Employee may be permitted to elect health coverage for an individual who is not the employee's Spouse or Dependent if permitted under the terms of the Benefit Plan Options and in accordance with uniform rules adopted by the Plan Administrator; provided, however, that the fair market value of such coverage will be included in the Employee's gross income to the extent required by applicable law, and the Employee will be treated as having purchased the coverage with after-tax dollars.

3.3 Termination of Participation

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

a. the date the Participant makes a permitted election not to participate in the Plan;

b. the date that the Plan is either terminated or amended to exclude the Participant or the class of employee to which the Participant belongs; or

c. the date on which the Participant ceases to satisfy the eligibility requirements of this Plan or all the Benefit Plan Options. Notwithstanding the foregoing, for purposes of pre-tax COBRA coverage, certain Employees may continue eligibility for certain periods subject to the restrictions and terms otherwise described in this Plan.

Termination of participation in this Plan will automatically revoke the Participant's elections. Benefits under any Insurance Plan will terminate as of the date(s) specified in the Insurance Plan. Reimbursements from a Participant's HSA, Medical FSA or DCFSA after termination of participation will be made pursuant to Section 8.8 for Medical FSA and Section 9.8 for DCFSA Benefits. If revocation occurs under this Section 3.3, no new election may be made by such Participant during the remainder of the Plan Year except as set forth in Section 3.4.

3.4 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates their employment for any reason, including (but not limited to) disability,

retirement, layoff, or voluntary resignation, or otherwise loses eligibility and then is rehired or becomes eligible once again within 30 days or less after the date of a termination of employment or loss of eligibility, then the Employee will be reinstated with the same elections that such individual had before termination or other loss of eligibility. If a former Participant is rehired more than 30 days following termination of employment or become eligible after 30 days following a loss of eligibility and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 4.2. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the applicable Insurance Plan is reinstated.

3.5 FMLA Leaves of Absence

a. *Health Insurance 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 and HSA and 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 their coverage while on leave, the Employer will continue to pay its share of the Contributions for those benefits under this Plan.

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

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

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

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

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

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

agreed to by the Plan Administrator and the Participant.

If a Participant's health insurance benefits or Medical FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Premium Payment Component or Medical FSA Component as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose health insurance benefits or Medical 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 Medical FSA Benefits, a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Medical FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated Medical FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

b. *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCFSA 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 3.6. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment will be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.6 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 11.3 will apply.

ARTICLE IV. Method and Timing of Elections

4.1 Election to Participate

To become a Participant, an Eligible Employee must submit a completed and signed Election Form/Salary Reduction Agreement to the Plan Administrator in the time and in the manner required by the Plan Administrator.

4.2 Elections When First Eligible

a. *Currently Eligible Employees.* An Employee who is eligible to participate in this Plan as of the Effective Date must complete, sign, and file an Election Form/Salary Reduction Agreement with the Plan Administrator during the election period (as specified by the Plan Administrator)

immediately preceding the Effective Date of the Plan to become a Participant on the Effective Date. The elections made by the Eligible Employee on this initial Election Form/Salary Reduction Agreement will be effective for the Plan Year beginning on the Effective Date.

b. *New Employees or Newly Eligible Employees.* An Employee who first becomes eligible to participate in the Plan mid-year (and after the Effective Date) may elect to commence participation in the Plan after the eligibility requirements of Section 3.1 have been satisfied by completing, signing, and filing an Election Form/Salary Reduction Agreement with the Plan Administrator. Participation in the Plan will commence on the first day of the month following the Plan Administrator's receipt of a properly completed and signed Election Form/Salary Reduction Agreement. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 11.3. Eligibility for Premium Payment Benefits shall be subject to the additional requirements, if any, specified in the applicable Insurance Plans.

4.3 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 11.3. Notwithstanding the foregoing, the Plan Administrator may, in its sole discretion, permit an Employee who is eligible to participate in this Plan to submit an Election Form/Salary Reduction Agreement after the Open Enrollment Period ends, so long as the Election Form/Salary Reduction Agreement is submitted before the first day of the Plan Year to which it relates.

4.4 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 4.2 and 4.3, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Section 11.3. Notwithstanding any contrary provision in the Plan, if an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Benefits under an Insurance Plan and has made an effective election for such Benefits outside the Plan, then the Employee's share of the Contributions for such Benefits will automatically be paid with pre-tax dollars and will be deemed a "default election" under the Plan. Such default elections cannot be changed until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described under Section 11.3), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. No default election is permitted for HSA, Medical FSA, or DCFSA Benefits.

4.5 Irrevocability of Elections

Unless an exception applies (as described in Article XI), 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; and

b. HSA Benefits as described in Article VII;

c. Medical FSA Benefits as described in Article VIII; and

d. DCFSA Benefits as described in Article IX.

HSA Benefits cannot be elected with Health FSA Benefits.

In no event shall Benefits under the Plan be provided in the form of deferred compensation. Notwithstanding the foregoing, amounts remaining in a Participant's Medical FSA Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year as provided in Article VIII. No Grace Period is available for DCFSA Benefits.

5.2 Source of Benefit Funding

The cost of coverage under the component Benefit Plan Options will be funded by a Participant's Salary Reductions, Nonelective Contributions provided by the Employer, or a combination of the foregoing. The required Contributions for each of the Benefit Plan Options offered under the Plan will be made known to employees in annual enrollment materials. Salary Reduction Contributions that are allocated to any Benefit Plan Option will equal the Contributions required from the Participant less any available Nonelective Contributions allocated to that option. A Participant may elect to receive Nonelective Contributions in the form of cash to the extent described in the applicable annual enrollment materials. The maximum amount of Employee Contributions, plus any Nonelective Contributions made available by the Employer, will not exceed the aggregate cost of the Benefit Plan Options elected.

5.3 Employer Contributions

The Employer may, in its sole discretion, make Nonelective Contributions on behalf of a Participant toward the cost of one or more Benefit Plan Options. The amount of Nonelective Contributions that may be applied towards the cost of each of the Benefit Plan Option(s) for any Participant will be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the Employer's sole discretion. The amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer may prescribe.

No provision of this Plan will be construed to require the Employer or Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person will 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. The Plan does not create a trust in favor of a Participant or any person claiming on a Participant's behalf.

ARTICLE VI. Premium Payment Component

6.1 Benefits

An Eligible Employee can elect to participate in the Premium Payment Component by electing (a) to receive benefits under the Insurance Plans described in Appendix A; and (b) to pay for their share of the Contributions for those Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XI), such election is irrevocable for the duration of the Period of Coverage to which it relates. Notwithstanding any other provision in this Plan, the insurance benefits under the Insurance Plans are subject to the terms and conditions of the Insurance Plans, and no changes can be made with respect to such plans (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan.

6.2 Participant Contributions for Cost of Coverage

The annual Contribution for a Participant's portion of the Premium Payment Benefits is equal to the amount as set by the Employer in the annual enrollment materials.

6.3 Benefits Provided Under the Health Insurance Plans

Insurance Benefits will be provided by the Insurance Plans in accordance with their governing documents, and not this Plan. The types and amounts of insurance benefits, the requirements for participating in the Insurance Plans, and the other terms and conditions of coverage and benefits of plans are set forth in their governing documents. All claims to receive benefits under the Insurance Plans shall be subject to and governed by the terms and conditions of the Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance with those plans, 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 their Spouse and Dependents, as applicable, whose coverage terminates under an Insurance Plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same health coverage that they had under the applicable Insurance Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

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

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

ARTICLE VII. HSA Component

7.1 HSA Benefits

An Eligible Employee can elect to participate in the HSA Component by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited. The HSA is not part of this Plan and is not subject to ERISA, even though the Employer may make, but is not required to make, a contribution to the HSA, facilitate a participant's ability to make a contribution to the HSA through deductions from their Compensation and restrict the number of HSA trustees to whom it will forward contributions. HSA Benefits cannot be elected with Medical FSA Benefits. Such election can be increased, decreased, or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

7.2 Contributions for Cost of Coverage for HSA; Maximum Limits

The annual Contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant. The amount elected cannot exceed the statutory maximum amount for HSA contributions applicable to the Participant's High-Deductible Health Plan coverage option (*e.g.,* single or family) for the calendar year in which the Contribution is made (e.g., $4,400 for single and $8,750 for family for 2026). Participants who are age 55 or older can make additional catch-up Contributions of up to $1,000 for 2026 and thereafter.

In addition, the maximum annual Contribution shall be:

a. reduced by any matching (or other) Employer contribution made on the Participant's behalf made under the Plan; and

b. prorated for the number of months in which the Participant is an HSA-Eligible Individual.

7.3 Recording Contributions for HSAs

As described in Section 7.5, the HSA is not an employer-sponsored employee benefit plan. It is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The Participant will choose the HSA trustee/custodian, not the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax Salary Reductions. Such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

7.4 Tax Treatment of HSA Contributions and Distributions

The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.The Plan, the Plan Administrator, and the Employer do not make any warranty or other representation as to (a) whether any pre-tax contributions by any Participant to the HSA Account will be treated as excludable from gross income for federal or state income tax purposes, (b) whether any expenses that are reimbursed or paid from the HSA Account will receive favorable federal or state income tax treatment, or (c) whether contributions to the HSA Account fall within the federal tax limits. If for any reason it is determined that any amount contributed to or paid from the HSA Account or paid from an HSA that accepts a transfer of funds from the HSA Account is includible in an Employee or former Employee's gross income for federal or state income tax purposes or subject to federal or state penalties, then under no circumstances will the recipient have any recourse against the Plan, the Plan Administrator, or any Employer with respect to any increased taxes, penalties or other losses or damages suffered by the Employee or former Employee as a result thereof.

7.5 Trust/Custodial Agreement

HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2). The Employer has no authority or control over the funds deposited in an HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be a benefit plan sponsored or maintained by the Employer.

7.6 No Accelerated Funding

The HSA Component of this Plan is not designed to provide accelerated funding of a Participant's pre-tax salary reductions. HSA Contribution amounts will be forwarded to a Participant's designated HSA custodian/trustee on a payroll-by-payroll basis.

ARTICLE VIII. Medical FSA Component

8.1 Medical FSA Benefits

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

8.2 Participant Contributions for Cost of Coverage for Medical FSA Benefits

The annual Contribution for a Participant's portion of the Medical FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limit set forth in the annual

enrollment materials.

8.3 Eligible Medical Care Expenses for Health FSA

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

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 their Spouse or Dependents for medical care, as defined in Code Section 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere, then the Medical FSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VIII. Notwithstanding the foregoing, the term Medical Care Expenses does not include:

- premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer);

- 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 (for this purpose, "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); or

- any other expense excluded under Appendix B or otherwise under the terms of this Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.

8.4 Maximum and Minimum Benefits for Health FSA

a. *Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) will be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Medical FSA Account pursuant to Section 8.5. 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 8.8 or is entitled to submit expenses incurred during a Grace Period as provided in Section 8.4(e). Payment will be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective (or during a Grace Period, if applicable under Section 8.4(e)), provided that the other requirements of this

Article VIII 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 will be set forth in the enrollment materials but shall be no more than the contribution limit announced by the IRS for the applicable year. 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 is $0. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents will be charged against the Participant's Medical FSA Account. Unless otherwise permitted under applicable law, the maximum annual benefit may not exceed the maximum limit provided under such law.

c. *Changes; No Proration.* For each Plan Year, the maximum and minimum dollar limit may be changed by the Plan Administrator and will be communicated to Employees through the Election Form/Salary Reduction Agreement or other enrollment materials. If a Participant enters the Medical FSA Component mid-year or wishes to increase their election mid-year as permitted under Section 11.3, then 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 XI (other than under Section 11.3(c) for FMLA leave) that increases contributions to the Medical 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 will be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Medical FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 11.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

e. *Grace Periods; Special Rules for Claims Incurred During a Grace Period.* Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 8.4(e), an individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in their Medical FSA Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year Medical FSA Amounts") if they are either: (1) a Participant with Medical FSA coverage that is in effect on the last day of that Plan Year; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Medical FSA Component on the last day of that Plan Year.

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

- Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 8.7 will be reimbursed first from any available Prior Plan Year Medical FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the

Medical FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Medical Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year Medical FSA Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year Medical FSA Amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Medical FSA Amounts.

- Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than the April 30 following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Medical FSA Amounts. Any Prior Plan Year Medical FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period will not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 8.6(b).

8.5 Establishment of Medical FSA Account

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

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

b. *Debiting of Accounts.* A Participant's Medical FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period (or for reimbursement of Medical Care Expenses incurred during any Grace Period to which they are entitled as provided in Section 8.4(e)).

c. *Available Amount Not Based on Credited Amount.* As described in Section 8.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage (or during the Grace Period, if applicable); it is not based on the amount credited to the Medical FSA Account at a particular point in time. Thus, a Participant's Medical FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement will in no event exceed the maximum dollar amount elected by the Participant under this Plan.

8.6 Forfeiture of Medical FSA Accounts; Use-or-Lose Rule

a. *Use-or-Lose Rule.* Except as otherwise provided in Section 8.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Medical FSA Amounts for expenses incurred during a Grace Period), if any balance remains in the Participant's Medical FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance will not be carried over to reimburse the Participant for Medical

Care Expenses incurred during a subsequent Plan Year. The Participant will forfeit all rights with respect to such balance.

b. *Use of Forfeitures.* All forfeitures under this Plan will be used as follows: (1) first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (*i.e.,* providing Medical FSA Benefits) with respect to all Participants in excess of the contributions paid by such Participants through Salary Reductions; (2) second, to reduce the cost of administering the Medical FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs will be documented by the Plan Administrator); and (3) third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

8.7 Reimbursement Claims Procedure for Medical FSA

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

b. *Claims Substantiation.* A Participant who has elected to receive Medical FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the April 30 following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 90 days after the date that eligibility ceases, as described in Section 8.8) setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Participant).

The application must be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such expenses, along with any additional documentation that the Plan Administrator may request. If the Medical FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply

with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

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

d. *Claims Ordering; No Reprocessing.* All claims for reimbursement under the Medical FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

8.8 Reimbursements from Medical FSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in Section 8.4(e) (regarding certain individuals who may be reimbursed from Prior Plan Year Medical FSA Amounts for expenses incurred during a Grace Period), the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible (or during any Grace Period to which they are entitled as provided in Section 8.4(e)), provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and their Spouse and Dependents, as applicable, whose coverage terminates under the Medical FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) will be given the opportunity to continue on a self-pay basis the same coverage that they had under the Medical FSA Component the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 8.5, they have a positive Medical 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 Medical FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage will be subject to all conditions and limitations under COBRA. Notwithstanding the foregoing, a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Medical FSA Component on the last day of a Plan Year may be entitled to reimbursement of Medical Care Expenses incurred during the Grace Period following that Plan Year in accordance with the provisions of Section 8.4(e).

Contributions for coverage for Medical FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), contributions for COBRA coverage for Medical FSA

Benefits must be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

8.9 Coordination of Benefits

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

ARTICLE IX. DCFSA Component

9.1 DCFSA Benefits

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

9.2 Participant Contributions for Cost of Coverage for DCFSA Benefits

The annual Contribution for a Participant's portion of the DCFSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 9.4(b).

9.3 Eligible Dependent Care Expenses

Under the DCFSA 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, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

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

c. *Qualifying Dependent Care Services.* “Qualifying Dependent Care Services” means services that: (1) relate to the care of a Qualifying Individual that enable the Participant and their

Spouse to remain gainfully employed after the date of participation in the DCFSA Component and during the Period of Coverage; and (2) are performed—

- in the Participant's home; or

- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (*i.e.,* a facility (including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

d. *Exclusion.* Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant or their Spouse;

- a Participant's Spouse;

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

- a parent of a Participant's under age 13 qualifying child as defined in Code Section 152(a)(1) (e.g., a former spouse who is the child's noncustodial parent).

9.4 Maximum and Minimum Benefits for DCFSA

a. *Maximum Reimbursement Available.* The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) will only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's DCFSA Account pursuant to Section 9.5. 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 will 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 IX 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 Dependent Care Expenses incurred in any Period of Coverage will be no more than the applicable statutory limit for the applicable Plan year or, if lower, the maximum amount that the Participant has reason to believe will be excludable from their income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

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

- the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse who is not employed during a month in which the Participant incurs a Dependent Care Expense and is either (1) physically or mentally incapable of self-care, or (2) a Student will be deemed to have Earned Income in the amount specified in Code Section 21(d)(2)); or

- either one of the two amounts for the calendar year described below, as applicable:

(1) The amount of the annual maximum under the Code for the calendar year for a Participant if one of the following applies: (a) the Participant is married and files a joint federal income tax return; (b) the Participant is married, files a separate federal income tax return, and meets the following conditions: (i) the Participant maintains as their home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (*i.e.,* the Dependent for whom the Participant is eligible to receive reimbursements under the DCFSA); (ii) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (iii) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (*i.e.,* the Spouse maintained a separate residence); or (c) the Participant is single or is the head of the household for federal income tax purposes.

(2) The amounts of the annual maximum under the Code for the calendar year for a Participant who is married and resides with the Spouse, but files a separate federal income tax return.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage is $0.

c. *Changes; No Proration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and will be communicated to Employees through the Election Form/Salary Reduction Agreement or other enrollment materials. If a Participant enters the DCFSA Component mid-year or wishes to increase their election mid-year as permitted under Section 11.3, then there will be no proration rule—*e.g.,* the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

d. *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XI affecting annual contributions to the DCFSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 9.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage will be calculated by adding (1) the contributions, if any, made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the DCFSA Account, reduced by (3) reimbursements during the Period of Coverage.

9.5 Establishment of DCFSA Account

The Plan Administrator will establish and maintain a DCFSA Account with respect to each Participant who has elected to participate in the DCFSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 9.6.

a. *Crediting of Accounts.* A Participant's DCFSA 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 DCFSA 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 9.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCFSA Account, less any prior reimbursements (*i.e.,* it is based on the amount credited to the DCFSA Account at a particular point in time). Thus, a Participant's DCFSA Account may not have a negative balance during a Period of Coverage.

9.6 Forfeiture of DCFSA Accounts; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCFSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance will not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year. The Participant will forfeit all rights with respect to such balance. All forfeitures under this Plan will be used as follows: (1) first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (*i.e.,* providing DCFSA Benefits) with respect to all Participants in excess of the contributions paid by such Participants through Salary Reductions; (2) second, to reduce the cost of administering the DCFSA during the Plan Year or the subsequent Plan Year (all such administrative costs will be documented by the Plan Administrator); and (3) third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, consistent with applicable regulations.

9.7 Reimbursement Claims Procedure for DCFSA

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

b. *Claims Substantiation.* A Participant who has elected to receive DCFSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the April 30 following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

- the person(s) on whose behalf Dependent Care Expenses have been incurred;
- the nature and date of the expenses so incurred;

- the amount of the requested reimbursement;

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

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

- the Participant's certification that they have no reason to believe that the reimbursement requested, added to their other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 9.4(b); and

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

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

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

9.8 Reimbursements from DCFSA After Termination of Participation

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions and election to participate will terminate. If any balance remains in the Participant's DCFSA Account when participation ceases, the former Participant may continue to receive reimbursements from their DCFSA Account balance for Dependent Care Expenses incurred after the date the Participant's employment terminates or the Participant otherwise ceases to be eligible, through the last day of the Plan Year in which their participation ceases, subject to the limitations in Section 9.4 and reimbursement claims procedures in Section 9.7. Any DCFSA Account balance remaining at the end of the Plan Year in which participation ceases is subject to forfeiture in accordance with Section 9.6.

ARTICLE X. HIPAA PROVISIONS FOR MEDICAL FSA

10.1 Provision of Protected Health Information to Employer

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

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or

future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Employer will have access to PHI from the Medical FSA only as permitted under this Article X or as otherwise required or permitted by HIPAA. HIPAA and its implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), the statutory provisions of which are incorporated herein by reference.

10.2 Permitted Disclosure of Enrollment/Disenrollment Information

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

10.3 Permitted Uses and Disclosure of Summary Health Information

Except as prohibited by 45 C.F.R. Section 164.502(a)(5)(i), the Medical 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 Medical 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 C.F.R. Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

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

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 10.5 and obtaining written certification pursuant to Section 10.7, the Medical 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 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 will the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 C.F.R. Section 164.504(f).

10.5 Conditions of Disclosure for Plan Administration Purposes

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

- not use or further disclose the PHI other than as permitted or required by the Medical FSA or as required by law;

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

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

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

- make available PHI to comply with HIPAA's right to access in accordance with 45 C.F.R. Section 164.524;

- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526;

- make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;

- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Medical FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Medical FSA with HIPAA's privacy requirements;

- if feasible, return or destroy all PHI received from the Medical FSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure that the adequate separation between the Medical FSA and the Employer (*i.e.,* the “firewall”), required in 45 C.F.R. Section 164.504(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 Medical 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 agree to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Medical FSA any security incident of which it becomes aware.

10.6 Adequate Separation Between Plan and Employer

The Employer will allow the following persons access to PHI: General Manager, the Plan Administrator, and payroll staff performing Medical FSA functions and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Medical FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other persons will have access to PHI. These specified employees (or classes of employees) will only have access to and use PHI to the extent

necessary to perform the plan administration functions that the Employer performs for the Medical FSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee will be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

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

10.7 Certification of Plan Sponsor

The Medical FSA will disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Medical FSA incorporates the provisions of 45 C.F.R. Section 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.5. Execution of the Plan by the Employer will serve as the required certification.

10.8 Privacy Official

The Employer will designate a Privacy Official, who will be responsible for the Medical FSA's compliance with HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third-party experts as the Privacy Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Privacy Official will have the authority to and be responsible for:

- accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article X;
- transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the Employer;
- establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Medical FSA with the requirements of HIPAA;
- establishing and overseeing proper training of personnel who will have access to PHI; and
- any other duty or responsibility that the Privacy Official, in their sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of the Article X.

10.9 Interpretation and Limited Applicability

This Article serves the sole purpose of complying with the requirements of HIPAA and will be interpreted and construed in a manner to effectuate this purpose. Neither this Article X nor the duties, powers, responsibilities, and obligations listed herein will be taken into account in determining the amount or nature of the benefits provided to any person covered under the Medical FSA Component, nor will they inure to the benefit of any third parties. To the extent that any of the provisions of this Article X are no longer required by HIPAA or do not apply to the Medical FSA because the Medical FSA is otherwise excepted from HIPAA, they will be deemed deleted and will have no force or effect.

10.10 Service Performed for the Employer

Notwithstanding any other provisions of this Plan to the contrary, all services performed by a business associate for the Medical FSA in accordance with the applicable service agreement will be deemed to be performed on behalf of the Medical FSA and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. Parts 160 through 164, except services that relate to eligibility and enrollment in the Medical FSA. If a business associate of the Medical FSA performs any services that relate to eligibility and enrollment in the Medical FSA, these services will be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Medical FSA.

ARTICLE XI. Irrevocability of Elections; Exceptions

11.1 Irrevocability of Elections

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

a. participation in this Plan;

b. Salary Reduction amounts; or

c. election of particular Benefit Plan Options.

However, as described further in Section 11.4, an election to make a Contribution to an HSA can be changed at any time on a prospective basis.

11.2 Procedure for Making New Election If Exception to Irrevocability Applies

a. *Timeframe for Making New Election*. A Participant (or an Eligible Employee who, when first eligible under Section 4.2 or during the Open Enrollment Period under Section 4.3, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 11.3 [or within 60 days of the occurrence of an event described in Section 11.3(e)(3) or (4)], 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. Notwithstanding the foregoing, a Change in Status (*e.g.*, a divorce or a Dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Insurance Plans shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

b. *Effective Date of New Election*. Elections made pursuant to this Section 11.2 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 11.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (*i.e.*, election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Plan 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 Medical FSA and DCFSA Components, see Sections 8.4 and 9.4, respectively.

11.3 Events Permitting Exception to Irrevocability Rule for All Benefits Other than HSA Benefits

A Participant may change an election as described below upon the occurrence of the stated events:

a. *Open Enrollment Period (Applies to all Benefit Plan Options)*. A Participant may change an election during the Open Enrollment Period in accordance with Section 4.3.

b. *Termination of Employment (Applies to all Benefit Plan Options)*. A Participant's election will terminate under the Plan upon termination of employment in accordance with Section 3.3.

c. *Leaves of Absence (Applies to all Benefit Plan Options)*. A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.5 and upon non-FMLA leave in accordance with Section 3.6.

d. *Change in Status (Applies to Premium Payment Benefits and to Medical FSA Benefits and DCFSA Benefits as limited further below)*. A Participant may change an election under the Plan upon the occurrence of a Change in Status, 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 Medical FSA coverage during a Period of Coverage; however, election changes may be made to cancel Medical 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 Medical FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Medical FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Medical FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

   The Plan Administrator, in their 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 their 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 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 their Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a Participant under this Plan), then the Participant may increase their election to pay for such coverage.

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

e. *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits under Medical Insurance Plans only, and not to any other Insurance Plan, Medical FSA, or DCFSA Benefits)*. If a Participant or their Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit option under a group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

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

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

3. the Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

4. the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of Section 11.3(e)(1), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit option is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

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

g. *Medicare and Medicaid (Applies to Premium Payment Benefits, to Medical FSA Benefits as Limited Below, but Not to DCFSA Benefits)*. If a Participant or their Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (*e.g.,* becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Medical FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Medical FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or their Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Medical FSA coverage may commence or increase.

h. *Change in Cost (Applies to Premium Payment Benefits, to DCFSA Benefits as Limited*

Below, but Not to Medical FSA Benefits). For purposes of this Section 11.3(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, (a) a medical FSA is not similar coverage with respect to an accident or health plan that is not a medical FSA; (b) an HMO and a PPO are considered to be similar coverage; and (c) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

1. *Increase or Decrease for Insignificant Cost Changes*. Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Plan Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in their sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

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

3. *Significant Cost Decreases*. If the Plan Administrator determines that the cost of any Benefit Plan Option significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Plan Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Plan Option (such as an HMO, but not the Medical FSA) may change their election on a prospective basis to elect the Benefit Plan Option that has decreased in cost; or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Plan Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Plan Option. The Plan Administrator, in their 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 DCFSA Benefits.* The above “Change in Cost” provisions [Sections 11.3(h)(1) through 11.3(h)(3)] apply to DCFSA 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 Sections 152(d)(2)(A) through (G), incorporating the rules of Code Sections 152(f)(1) and 152(f)(4).

i. *Change in Coverage* (*Applies to Premium Payment and DCFSA Benefits, but Not to Medical FSA Benefits*). The definition of "similar coverage" under Section 11.3(h) applies also to this Section 11.3(i).

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

    a. *Significant Curtailment Without Loss of Coverage*. If the Plan Administrator determines that a Participant's coverage under a Benefit Plan Option under this Plan (or the Participant's Spouse's or Dependent's coverage under their 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) during a Period of Coverage, the Participant may revoke their election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Plan Option that provides similar coverage (such as an HMO, but not the Medical FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

    b. *Significant Curtailment with a Loss of Coverage*. If the Plan Administrator determines that a Participant's Benefit Plan Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under their employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke their election for the affected coverage and may either prospectively elect coverage under another Benefit Plan Option that provides similar coverage (such as an HMO, but not the Medical FSA) or drop coverage if no other Benefit Plan Option providing similar coverage is offered by the Employer.

    c. *Definition of Loss of Coverage.* For purposes of this Section 11.3(i), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Plan Option, or an HMO ceasing to be available where the Participant or their Spouse or Dependent resides, or a Participant and their Spouse or Dependent losing all coverage under the Benefit Plan Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage: (1) a substantial decrease in the medical care providers available under the Benefit Plan 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 a PPO or HMO); (2) a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or their Spouse or Dependent is currently in a course of treatment; or (3) any other similar fundamental loss of coverage.

d. *DCFSA 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: (i) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (ii) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

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

3. *Loss of Coverage Under Other Group Health Coverage*. A Participant may prospectively change their election to add group health coverage for the Participant or their 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 under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Plan Option(s).

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

5. *Special Consistency Rule for DCFSA Benefits.* With respect to the DCFSA Benefits, a Participant may change or terminate their 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 Section 129.

A Participant entitled to change an election as described in this Section 11.3 must do so in accordance with the procedures described in Section 11.2.

11.4 Election Modifications for HSA Benefits

As set forth in Section 7.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed. No Benefit Plan Option election changes can occur because of a change in HSA election except as otherwise described in this Article XI.

A Participant entitled to change an election as described in this Section 11.4 must do so in accordance with the procedures described in Section 11.2.

11.5 Election Modifications Required by Plan Administrator

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

ARTICLE XII. Claims and Appeals Procedure

12.1 Claims Procedures for Insurance Benefits

Claims and reimbursement for Benefits under any Insurance Plan will be administered in accordance with the claims procedures for the Insurance Plans, as set forth in their governing plan documents and/or summary plan descriptions.

12.2 Procedure If Benefits Are Denied Under This Plan

a. *Initial Claims*. A Participant may file a claim with the Plan Administrator for a Plan benefit to which the claimant believes that they are entitled. Upon receipt, the Plan Administrator will review the claim and determine whether the claimant is entitled to receive any benefits pursuant to such claim. The Plan Administrator will notify the claimant in writing of any adverse decision with respect to their claim within 30 days after receipt of the claim. The notice of any adverse decision will be written in a manner calculated to be understood by the claimant and will include: (1) the specific reason(s) for the denial of the claim; (2) a reference to the Plan provision(s) on which the denial was based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an

explanation of why such material or information is necessary; and (4) an explanation of the Plan's claim review procedures. If the circumstances require an extension of time for processing the initial claim, the Plan Administrator will furnish a written notice of the extension to the claimant before the end of the initial 30-day period, which will indicate the circumstances requiring an extension of time. The extension will not exceed a period of 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete.

b. *Appeals.* If the Plan Administrator denies a claim for benefits or has not responded to a claim within the time period set out in Section 12.2(a), in which case the claim for benefits will be deemed to be denied on the last day of the applicable time period, the claimant or their duly authorized representative, at the claimant's sole expense, may appeal the denial by submitting written notice of appeal to the Plan Administrator within 60 days of (1) receiving the written notice of the denial, or (2) the date the claim is deemed to be denied. The claimant will be provided with written notification of the decision on the appeal within 60 days of receipt of the notice of appeal. The written response will include: (1) the specific reason(s) for the denial of the claim; (2) a reference to the Plan provision(s) on which to the denial was based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the denied claim. If the circumstances require an extension of time for processing the appeal, the Plan Administrator will furnish a written notice of the extension to the claimant before the end of the initial 60-day period, which will indicate the circumstances requiring an extension of time. The extension will not exceed a period of 60 days from the last day of the initial 60-day period. If the decision on the appeal is not furnished within the time specified above, the appeal of the claim will be deemed denied.

ARTICLE XIII. Recordkeeping and Administration

13.1 Plan Administrator

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

13.2 Powers of the Plan Administrator

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

a. to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

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

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

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

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

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

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

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

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

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

13.3 Reliance on Participant, Tables, etc.

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

13.4 Provision for Third-Party Plan Service Providers

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

13.5 Fiduciary Liability

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

13.6 Compensation of Plan Administrator

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

13.7 Insurance Contracts

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

13.8 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person will be escheated in accordance with applicable unclaimed property law.

13.9 Effect of Mistake

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

ARTICLE XIV. General Provisions

14.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 8.6 with respect to Medical FSA Benefits and Section 9.6 with respect to DCFSA Benefits, and then by the Employer. For HSA Benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's HSA trustee/custodian. Any such fees shall be the responsibility of the Participant; they will not be paid by the Employer.

14.2 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.

14.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action.

14.4 Governing Law

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

14.5 Compliance with Code and Other Applicable Laws

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. In addition, the Plan will comply with the requirements of all other applicable laws.

14.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the

Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

14.7 Indemnification of Employer

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

14.8 Non-Assignability of Rights

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

14.9 Headings

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

14.10 Plan Provisions Controlling

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

14.11 Facility of Payment

When any person entitled to benefits under the Plan is disabled or is in any way incapacitated so as to be unable to manage their affairs, the Plan Administrator may cause such person's benefits to be paid to such person's legal representative for their benefit, or to be applied for the benefit of such person in any other manner that the Plan Administrator determines appropriate.

14.12 Limitation of Rights

Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits under the Plan, shall be construed as giving to any Employee or other person any legal or equitable right against the Employer, the Plan Administrator or the Plan, except as specifically provided in this Plan document.

14.13 No Waiver of Terms

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan except by written agreement of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

14.14 Provisions Applicable During Periods of Military Service

Notwithstanding any Plan provision to the contrary, contributions, benefits, and service credit with respect to qualified military service will be provided as required by any law concerning veterans' rights.

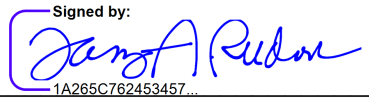
14.15 Severability

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.

* * *

To record the adoption of the Plan, the Employer's authorized representative hereby executes this document on this 9th day of July 2026.

Purissima Hills Water District

By: 

Tammy A. Rudock, General Manager

APPENDIX A

Benefit Plan Options

Benefit Plan Options will include the coverage available under the following plans maintained by the Purissima Hills Water District:

- Insurance Plans

  1) Medical Insurance
  2) Dental Insurance
  3) Vision Insurance

- Health Savings Account
- Medical Flexible Spending Arrangement
- Dependent Care Flexible Spending Arrangement

APPENDIX B

Exclusions: Medical Expenses that are Not Reimbursable from the Medical FSA

Purissima Hills Water District Section 125 Cafeteria Plan document contains the general rules governing what expenses are reimbursable. This Appendix B, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Medical FSA—that is, expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code Section 213(d) and may otherwise be reimbursable under the regulations governing Medical FSAs. Such "medical care" also includes expenses incurred for menstrual care products. A 'menstrual care product' means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital-tract secretions.

Exclusions: *The following expenses are not reimbursable from the Medical FSA*, even if they meet the definition of "medical care" under Code Section 213(d) and may otherwise be reimbursable under legal requirements applicable to Medical FSAs:

- Premiums for other health coverage, including but not limited to premiums for any other plan (whether or not 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.
- The salary expense of a nurse to care for a healthy newborn at home
- Funeral and burial expenses
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework)
- Custodial care
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement)
- Bottled water
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing
- Automobile insurance premiums
- Transportation expenses of any kind, including transportation expenses to receive medical care
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician
- Any item that does not constitute "medical care" as defined under Code Section 213(d)
- Any item that is not reimbursable due to the rules in Prop. Treas. Reg. Section 1.125-5(k)(4) or other applicable law or regulations